

Medical Criminology Notes #2*

Cosmetic Surgical Treatment of Offenders

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Shakespeare's Richard III, Victor Hugo's Quasimodo, and Robert Louis Stevenson's Mr. Hyde all illustrate the persistent belief that bodily disfigurement is associated with villainy. This belief was more formally introduced into Western criminology by Cesare Lombroso, who toward the end of his career (in the 1900s) attached considerable significance to the associations that he discerned between atavistic physical attributes and moral imbecility and between such disfigurements as tattoos or scars and criminality.^{1,2} The presumed association between disfigurement and crime has, since Lombroso, been variously attributed to common biological causes, intervening psychological variables, and intervening social variables. Whatever the true relationship might be, the fact that some incarcerated criminals present bodily disfigurements has led to the efforts of plastic surgeons that are reviewed here.

As with most phenomena in medicine and criminology (and possibly in every branch of learning), the early accounts of cosmetic surgery in the treatment of criminals take the form of case reports. Bankoff in 1952 described the cases of two juvenile and two adult offenders whose criminal actions appeared to stop after plastic corrections of facial disfigurements, both congenital and traumatically acquired.³ Ten more cases were described in a popularized casebook by George Sava, who advocated that a plastic surgeon be present during the examination of every criminal and of every young person brought before the juvenile courts, for "it takes the skilled, experienced eye of the plastic surgeon to detect those minor disfigurements which, especially with women, can produce psychological ills hardly less surely than major deformities can" (p. 281).⁴

The next stage of inquiry is represented by those publications comparing recidivism ratios for prisoners who were operated upon and for some sample of the general inmate population. Many of the studies in this group fail to take account of offender age, category of offense, type of disfigurement, or the extent of psychological screening of surgical candidates (the effect of which may be to eliminate from the experimental group those subjects with the worst prognosis); the comparison groups, being made up of individuals who were not operated upon, can be presumed to comprise individuals who

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lack disfigurement, who refuse surgery, or whose disfigurements or psychological conditions render them unsuitable for surgery. Moreover, the comparison groups could well differ from the experimental group in age distribution, offense distribution, or mean length of follow-up where these are not specified or controlled.

The first such study was that of Ogden, who reported that two years following release from a borstal institution, 45.4% of surgically treated subjects had been reconvicted, as compared with 65.5% of all untreated persons released from the same institution during the same time period.⁵ Lewison reported 42% recidivism among 450 surgically treated prison inmates as compared with 75% among the general inmate population.⁶ Spira *et al.* reported that 17% of prisoners who had been operated upon and released during a five-year period were returned to prison, as compared with 31.6% of the general inmate population; they also indicated that plastic and reconstructive surgery were being conducted in the prison systems of some 22 states in the mid-1960s, involving about one-fourth of the nation's approved residency programs in plastic surgery.⁷ Velasco *et al.* found that 21.3% of 127 treated parolees were recommitted during a longer period of post-release follow-up than that in which 30% of randomly selected parolees were recommitted.⁸

In contrast to the earlier studies reported above, a study by Schuring and Dodge eliminated from consideration those inmates lost to follow-up through transfer to other institutions prior to release; a comparison group of offenders without deformities was selected in an appropriate manner and resembled the treatment group in mean age, marital status, type of offense, and type of sentence (the study was conducted among inmates of a federal reformatory with a relatively homogeneous population). Also unlike the authors of earlier papers, Schuring and Dodge indicated that they tried to determine whether subjects were returned to any penal institution, not just the study site. Moreover, surgery in the treatment group was limited to rhinoplasty and otoplasty, whereas earlier studies involved a great variety of surgical procedures. Under these conditions no difference was observed between groups: 48.3% of 185 treated inmates and 48.9% of 185 control subjects were returned to a penal institution during the period of follow-up. Although the authors report that over two-thirds of each group had a follow-up of five years or more, they do not indicate whether the mean length of follow-up is comparable between groups.⁹ An apparently negative effect of surgery was reported by Lehman and Conklin, but they compared the 34% of parole violators among 127 treated inmates of a single institution with the 22% statewide recidivism ratio for parolees "during a similar time period."¹⁰

The first and only study to use an appropriate experimental design was that conducted by Kurtzberg *et al.* among male inmates of Rikers Island who requested plastic surgery for various disfigurements. This study, known as the Surgical and Social Rehabilitation of Adult Offenders Project (SSR), has been thoroughly documented.¹¹⁻¹³ The project plastic surgeon examined 1,424 inmates responding to publicity about the project; after the elimination of those with minimal disfigurement or minimal reparability, 663 candidates remained. After psychological screening, consisting of an

individual interview and a battery of psychological tests, 425 candidates remained.* The major psychological contraindications to surgery were considered to be "focusing" (an irrational overemphasis on the disfigurement) or overt psychosis.¹²

The 425 candidates were each assigned to one of four treatment groups through a procedure that was intended to approximate random assignment while insuring comparability of groups in ethnic distribution and proportion of drug addicts. The four groups were: I. Surgery and social-vocational services; II. Surgery only; III. Social-vocational services only; and IV. No treatment.** A number of subjects were lost at each stage of the study between assignment to groups and follow-up, but the only detected deviation from a random distribution of variables among groups was a higher proportion of subjects with tattoos and needle tracks in Groups III and IV, resulting from a tendency of subjects with these disfigurements to refuse surgery as the time grew near.

The distribution of drug addict subjects consisted of 28, 21, 31, and 38 subjects in Groups I-IV, respectively. Surgery alone resulted in no significant improvement in recidivism ratio, but Groups I and III (receiving such services as drug rehabilitation and detoxification, welfare services, and vocational services) had significantly lower recidivism ratios than Group IV (no treatment). Moreover, the proportion of recidivism-free months for addicts receiving surgery (Groups I and II) was not significantly different from that of addicts not receiving surgery (Groups III and IV). The number of cases in each cell is too small to allow for valid conclusions to be drawn regarding several other provocative findings that emerged when groups were subdivided by type of disfigurement.

The distribution of non-addict subjects consisted of 15, 10, 9, and 16 in Groups I-IV, respectively. The overall recidivism ratio of 32% for the groups receiving surgery (I and II) was for non-addicts significantly lower than the 68% recidivism ratio for groups not receiving surgery (III and IV). Similarly, the proportion of recidivism-free months for non-addicts receiving surgery was significantly greater than for those not receiving surgery. A greater proportion of non-addict subjects receiving services alone recidivated (89%) than was the case for those receiving surgery alone (30%), surgery plus services (33%), or no treatment (56%). When subdivided by type of disfigurement, the proportion of recidivism-free months was greater for inmates receiving surgery than for those not receiving surgery for subjects with developmental facial deformities, traumatic facial disfigurements, and hand disfigurements, but was lower for subjects with tattoos. Only for those with traumatic facial disfigurements were the numbers large enough to achieve statistical significance.

Although alternative explanations can be formulated, it seems reasonable

*The Ns differ in the various reports;¹¹⁻¹³ those from the final report are cited here.

**Paradoxically, the one feature of this experiment that probably rendered it most acceptable to the subjects and to the prevailing authorities (viz., the fact that cosmetic surgery could be expected to be in the subject's interest quite apart from any possible rehabilitative effect) raises serious ethical questions about the assignment of some disfigured applicants for surgery to non-surgery treatment conditions. Experiments using treatments that are of doubtful value to either inmates or the criminal justice system (such as psychotherapy or antianxiety chemotherapy) would be more ethical but less acceptable to the authorities who now appear to prevail.

on the basis of the cumulative evidence to conclude that surgical correction of facial disfigurements contributes to a reduction in the rate of return to prison for non-addict offenders. Although none of the studies reviewed has provided a completely satisfactory measure of recidivism over time, the evidence certainly suggests at least some delay in return to prison among non-addict, surgically treated inmates. Moreover, several authors have observed an increase in cooperation, morale, and optimism,^{6,7,13} and a decrease in hostility^{6,7} among disfigured inmates following cosmetic surgery.

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