Prison Plastic Surgery: 
The Biopolitics of Appearance 
and Crime in New York’s 
Civil Rights Era

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Abstract

From 1920 to 1990, around 500,000 US incarcerees received free plastic surgery during their incarceration. The majority of the surgeries — which included facelifts, rhinoplasty, chin implants, blepharoplasties, breast implants, etc. — were performed for purely cosmetic reasons, under the broad banner of prisoner rehabilitation. The underlying notion was to assist marginalized individuals in assimilating into society by capitalizing on prevailing beauty biases. New York was an early prison plastic surgery pioneer, alongside other rehabilitative offerings, but these programs were not without controversy. Concerned, in 1968, Governor Nelson Rockefeller charged the Department of Crime Control Planning to investigate the long-term outcomes of various recidivism programs, a project that spanned five years and covered 231 methodologies.

This research report outlines the early emphasis on prisoner beautification, and the broader shift in carceral policies from rehabilitative to punitive, based on a review of records in the Rockefeller Archive Center pertaining to correctional reform, access to healthcare, and civil rights issues. This report summarizes my preliminary findings from the archives, and adds additional context to my book, *Killer Looks: The Forgotten History of Plastic Surgery In Prisons*, (*Prometheus Books, 2021*), which explored the history of criminal reform through the lens of beauty and bias.

Using records, the majority unearthed from the Joint Commission on Correctional Manpower and Training in the Nelson A. Rockefeller Gubernatorial Records, along with records from the Bureau of Social Hygiene, the Ford Foundation, and the Rockefeller Brothers Fund archives, I discuss rehabilitative ideals and lookism, intermingled with political wrangling and efficacy in twentieth-century New York. My work deals with correctional healthcare and surgery, but more broadly, it is about the shift from a rehabilitative to a punitive approach to crime. As contemporary discourse returns to the importance of rehabilitation, the insights presented in this research will foster current conversations and enable us to learn from the past.
In October 1961, William E. Leonard, the deputy commissioner of correction for the State of New York, received a handwritten letter, forwarded by Governor Rockefeller’s office. “I am writing to you in reference to my son, George Finger, now an inmate at GreenHaven prison...he received a cutting up with a razor blade on his face,” wrote Mrs. Mary Finger, a housewife from Staten Island. “I was told, in time the scar would fade, and I have waited from February to September 1961 and find it not better. I want him to be given a fair chance when he comes home and with a scar of this type, he has a mark against him already.”

Leonard’s staff investigated the complaint about George Finger. In 1958, while imprisoned at Dannemora, a maximum-security prison in upstate New York, George was accosted by a prisoner who sliced his face with a razor blade. The wound spanned from his left eye to his ear. George was admitted into the prison hospital, where he received twenty-eight sutures. The prison surgeon reported that the outcome was, “a small linear scar extending from the canthus of the left eye almost to the ear,” that was “barely noticeable.” Leonard wrote back “It is felt that the doctor did an excellent job of plastic surgery resulting in great improvement in the facial appearance of your son,” pointing out that “There is no further need for surgery.”

Finger’s prison plastic surgery — and his mother’s plea for additional cosmetic work — was not an anomaly. Since the early days of New York State’s governance, a significant amount of attention and tax dollars had been apportioned to improving the physical appearance of incarcerees. The reasoning behind this was that it might lower recidivism — the idea being that improving prisoners’ physical appearance would boost their self-esteem and increase their employment and relationship prospects.

Many of these early surgeries stemmed from the burgeoning concept of “racial science,” which conflated certain physical traits with low intelligence, poor health, and criminality. Over time, these operations evolved from deracializing features to focus on improving an individual’s attractiveness, with prisoner beautification positioned as a recidivism treatment, akin to investment in prisoner education and reentry programs. Today, the notion of expending tax dollars to cosmetically improve prisoner’s appearance is long gone, for ethical reasons (performing surgery on a disenfranchised,
captive audience is dubious) and for economic and political ones, such as government directives that dissolved various rehabilitative programs.

Nonetheless, appearance bias continues to permeate society. The conventionally attractive receive better service in stores, better grades in schools, and better sentencing in the courtroom. Today, advances and access to cosmetic surgery have made it far easier to improve one's appearance. However, these treatments are reserved for those with funds, and historically, and up to today, the majority of incarcerated people fall into the low socioeconomic bracket.

But as current discourse returns to reevaluate rehabilitative programs, it is beneficial to examine the role that plastic surgery — under the umbrella of prison medical care — has played.

New York, historically, was an early adopter of appearance reform. “Often a man’s physical condition makes it easier for him to steal a dollar than to earn one,” Henry Solomon, New York’s prison commissioner, told the *New York Tribune* in 1910. “The relationship of physical defects to crime is generally not appreciated. We readily see how physical distress might conduce to crime.” The corresponding public outrage was peppered with sympathy: wanting to appear socially acceptable was easy to understand.

The case file of Johnny Durkin, 15, arrested for attempted retail theft in NYC in 1915, exemplifies this. Due to his age, Durkin was given six months of probation. His relatives refused to house him, and he slept on stoops and at friends’ homes. “He was an inferior looking lad, small and flabby...mild acne on the face...forehead broad, nose small, eyes rather sly...chin pointed and receding,” wrote Arthur Woods, the police commissioner of New York City, in Durkin’s case file.

Further investigation via interviews with Durkin’s family and friends uncovered that he had a history of being “sulky, tricky, and sneaky,” the opposite of his sisters, who were described as “blue eyed...attractive...sweet, refined looking, delicately featured, likable.” Woods tracked Durkin for the next decade, until his execution via electric chair at Sing Sing Prison, at age 24.
Of course, much of the blame for Durkin’s demise can be tracked to his poverty, lack of privilege and education, and his own behavior, but his perceived “beauty” was also a factor. Commissioner Woods detailed descriptions of Durkin’s physical attributes are indicative of the wider, troubling narrative that a person’s looks directly related to their social behavior. Hence, why the concept of pairing prisoners with plastic surgery has persisted over the decades.

In fact, the beautification of incarceratedes was so integral to the idea of rehabilitation that in 1954 the American Correctional Association added a plastic surgery provision to their Manual of Correctional Standards, a 451-page volume which had been nationally distributed to jails and prisons since 1946.

Plastic and other types of elective surgery to correct or reduce disfigurements of the body, especially repulsive facial disfigurements, has a definite place in the rehabilitation of prisoners...Such corrective measures tend to reduce feelings of inferiority, encourage greater self-confidence, and make it easier to obtain and hold a job. — Manual of Correctional Standards.

In the 1950s and 1960s, as acceptance of using psychology and sociology to treat people grew, New York State became known for its progressive and rehabilitative policies towards offenders. The concept that one could “treat” offenders in the way that one could treat pneumonia became the dominant approach to prisoner care. W. Averell Harriman, the governor of New York State, was a big supporter. “We know that there are some types of persons who have committed anti-social acts who can be rehabilitated. Medical treatment, including plastic surgery, often helps change a man’s whole viewpoint,” he told delegates at the National Probation and Parole Association Conference. “We need new knowledge — penitentiaries do not make men penitent and reformatories do not reform.”

The next governor, Nelson Rockefeller, spearheaded innovative ways of treating offenders, replacing punitive measures with therapeutic treatment. In 1965, he set up the Governor's Special Committee on Criminal Offenders, consisting of subject matter experts. Their focus was to curb recidivism of first-time offenders, by studying the issues involved in recurrences. To gauge the scope of the problem, the committee segmented people into categories: first time offenders professional criminals, female
offenders, offenders struggling with mental health issues, alcoholism and addiction, and juvenile offenders. Based on the data, Governor Rockefeller proposed new anti-crime bills, which focused on mental health treatment and job opportunities. “Seven out of every ten persons convicted of a crime in New York State have a prior arrest record. The State must do a better job in helping first offenders go straight before we can expect to make New York a safer place in which to live,” he said in a press release. New York’s approach was echoed federally: In 1965, Congress amended the Manpower Development and Training Act to allow usage by prisons.8

Plastic surgery was part of the package. In 1966, a program was developed at the Western Reformatory for Women in Albion, and by 1969, 96 surgeries had been performed. That same year, 108 operations (including nose jobs and chin implants) were performed at Clinton Prison for Men.9 In 1968, a pamphlet titled, “Guidelines for Plastic Surgery Program in Corrections,” was widely distributed across the US by the Bureau of Prisons.10

But as New York’s crime rate skyrocketed — from 1965 to 1968, violent crime, robbery, and theft grew almost twofold, and murders rose 58%— Governor Rockefeller grew uneasy.

It did not help that there was a dearth of good data pertaining to the efficacy of rehabilitative treatments. “More embarrassing Is the void of information as to what correctional Interventions, if any, have been effective in meeting rehabilitative objectives,” wrote Robert Fosen, a criminological researcher from the American Institutes for Research, in a Ford Foundation-sponsored report on correctional facilities. “Less than half of the reporting jurisdictions indicate even a minimal attempt to determine an overall recidivism rate within their domains. For the most part, comparative statistics are simply unavailable.”11

There was one ray of light: the creation of the Joint Commission on Correctional Manpower and Training, a national non-governmental organization, established in 1966 to examine correctional needs, with a focus on the staffing of the various correctional facilities. If staff retention could be increased, this would be one way to
address some of the systemic problems, such as the shortage of medical care and vocational training.\textsuperscript{12}

In 1967, Rockefeller charged the Department of Crime Control Planning to investigate the long-term outcomes of various recidivism programs, a project that spanned five years and covered 231 methodologies, including plastic surgery.\textsuperscript{13} Plastic surgery was a low priority for the governor, besieged by problems plaguing the state’s prisons, which included inadequate medical care,\textsuperscript{14} lack of washing facilities,\textsuperscript{15} overcrowding, racial tension, all the way down to severe budget shortages for prisoner food.\textsuperscript{16}

The philosophy of the Department of Correction has changed from an emphasis on custody and security to bring equal emphasis on inmate well-being and rehabilitation. A plastic surgery program was established at Clinton Correctional Facility for males, and at Western Correctional Facility for females, to take care of needed and elective surgery.\textsuperscript{17}

Rockefeller also had to take the feelings of the general public into consideration. A 1968 report from the Department of Health, Education, and Welfare disclosed that 89% of Americans believed that crime had increased or plateaued, something they widely attributed to poverty, poor parenting, lack of education, and “violent” television programming. Even so, they widely opposed raising taxes to fund rehabilitative projects (aside from juvenile programs) — if they had to pay more tax, they would prioritize punitive treatment, they said.\textsuperscript{18}

By early 1970, Rockefeller’s task force had completed its analysis of recidivism programs. Its findings, which took up a hefty 1,400 pages, were inconclusive. For the most part, correctional treatments, as a whole, had not significantly curbed recidivism. Some studies showed promise, but there were concerns about the data. An analysis of a correctional plastic surgery program on Rikers Island found recidivism rates lowered for prisoners who reported no struggles with addiction, but closed with the need for further research, “before one may conclude that plastic surgery is an effective method for reducing recidivism.”\textsuperscript{19}

Large political shifts were also in play. President Nixon was elected in 1968, after a “tough on crime” campaign, and, enticed by a potential cabinet position, Governor
Rockefeller reversed his stance on corrections. He established mandatory minimum life sentences for drug dealers, and stripped judges of the autonomy to direct first-time offenders to community or probation services instead. This change, in addition to Rockefeller’s stop-and-frisk and “no-knock” laws — both of which disproportionately targeted poor, Black bodies — created a state-wide return to the punitive approach of corrections. The greater emphasis on punishment and incarceration overshadowed the rehabilitative approaches he had previously championed. Governor Rockefeller’s hardline to crime rolled back funding to rehabilitative programs and, as a result, many closed.

Despite this, researchers continued investigating the intersection of early intervention, economic status, and medical treatment.

> There was a near unanimous feeling that physically derived problems might play a role in the etiology of negative/aversive behavior in some portion of these juvenile offenders.... management of these organically based problems could divert some offenders from a life of escalating criminality. — 1979 study of juvenile offenders’ medical health.

Throughout this period, appearance discrimination continued to plague New York, with lawsuits about people denied jobs or promotions based on arbitrary weight and height requirements that discriminated against women and minority applicants, to people getting forced into early maternity leave or compulsory retirement. Ignoring appearance discrimination did not stop it from adversely affecting people. Cutting rehabilitative offerings did not lower the prison population.

By recognizing the failures of such approaches and advocating for more progressive policies, society can strive for a criminal justice system that promotes fairness, equality, and opportunities for positive change. In conclusion, discriminatory practices based on physical appearance perpetuate social inequalities and hinder individuals’ opportunities for reintegration into society. By fostering inclusive environments and challenging societal biases, we can work towards a more equitable justice system that acknowledges the value and potential for positive change in every individual, regardless of their physical appearance.
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1 Letter from Mrs. Mary Finger to Governor Rockefeller and response to her letter by Commissioner William B. Leonard. Nelson A. Rockefeller Gubernatorial Records, Office Subject Files, First Administration, Subseries 37.1, Microfilm Reel 20, Rockefeller Archive Center, Sleepy Hollow, NY (hereafter RAC).


5 Bureau of Social Hygiene Records, “Abnormals,”; “Are Criminals Abnormal: A Policeman’s Point of View” - Outlines, Series 5, Box 1, Folder 780-793. RAC.


12 Joint Commission on Correctional Manpower and Training, Inc. (1965-1968) Rockefeller Brothers Fund Records, Projects (Grants), RG 3, Subgroup 1 and Subgroup 2. RAC.


14 Department of Correction program meeting report (Nov 2, 1960), Nelson A. Rockefeller Gubernatorial Records, Departmental Reports, Department of Corrections, Series 28, Box 2, Folder 31, RAC.

15 Letter from Russell G. Oswald, commissioner, to Governor Nelson A. Rockefeller. (June 9, 1971) Nelson A. Rockefeller Gubernatorial Records, Departmental Reports, Department of Corrections, Series 28, Box 2, Folder 31, RAC.

16 State of NY Department of Correction, Quarterly Report (April 1-June 30, 1963) Nelson A. Rockefeller Gubernatorial Records, Departmental Reports, Department of Corrections, Series 28, Box 2, Folder 31, RAC.


