The ethics of cosmetic enhancement

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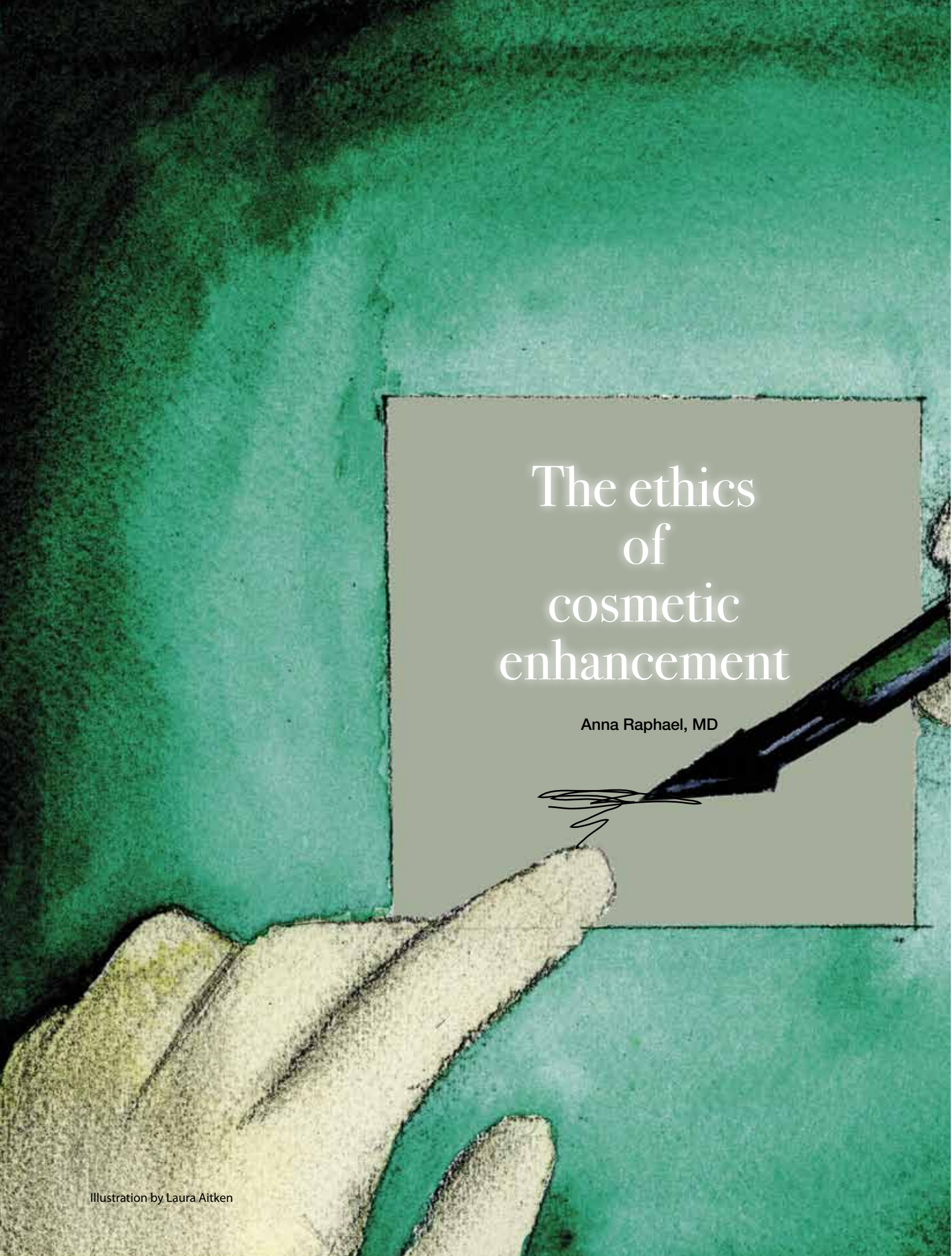

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The burgeoning use of cosmetic procedures and the potential ethical implications of this trend have been on my mind since I came face to face with these issues as a medical student rotating through the dermatology and surgery departments. I had already seen shows like *Extreme Makeover* and knew that going under the knife wasn't for me. However, now that I was going to be a physician, I not only had to consider what I would do for myself, but what I could do and would do for others. The struggle to define the boundary between treatment and enhancement is not unique to the fields of plastic surgery and dermatology. Many specialties, from psychiatry to medicine, raise the possibility of making us "better than well,"[1pxv] offering drugs for social anxiety or erectile dysfunction, for example. Still, plastic surgery and dermatology remain the two fields with the most potential for enhancing the healthy rather than simply treating the ill.

Over the past few decades, cosmetic plastic surgery and dermatology procedures have been democratized for the public and adopted with great enthusiasm by physicians. In 2007, board-certified physicians performed 11.8 million cosmetic procedures in the United States.[2] The top four surgical procedures—breast augmentation, liposuction, nose reshaping, and eyelid surgery—accounted for 1,175,500 of these procedures,[2] up from 443,728 of the top four surgical procedures combined in 1997.[3] Annual expenditures have increased from an estimated $1 to $2 billion in 1996 to $12.4 billion in 2007.[2,3]

1975—The FTC permits physicians to advertise. The flood gates open.

This enormous growth in cosmetic procedures results from changes in the law, technology, attitudes, and finances. In the past, cosmetic surgery was a well-guarded secret of mostly wealthy and upper-middle-class clients. At the same time, physicians were prohibited from advertising their services. In

1975, the Federal Trade Commission lifted its ban on physician advertising, and physicians began promoting cosmetic services.[4] The introduction of less invasive procedures such as Botox injections and injectable wrinkle fillers fueled much of the more recent growth, and nonsurgical cosmetic procedures accounted for eighty-five percent of total cosmetic procedures in 2007.[2,5] Botox injection is by far the most common, with 4.6 million treatments given by board-certified physicians in 2007, an increase of 488 percent from 2000.[2] The visual nature of cosmetic procedures made them well-suited to exposure on television and in women's magazines. Not surprisingly, the American public became more aware and accepting of cosmetic procedures.[5,6] Finally, health care reform in the 1990s that reduced reimbursement for reconstructive and medical procedures prompted many physicians to start offering cosmetic procedures or expand existing cosmetic practices.[6] Physicians partnered with financial agencies so that more people could secure cosmetic surgeries with credit or monthly installments. Today, more than two-thirds of American cosmetic surgery patients earn less than $50,000 per year.[7]

While cosmetic procedures have boomed in number, there has been a simultaneous shortage of reconstructive plastic surgery and medical dermatology services. Evidence for this relative workforce shortage is not as clear-cut as the evidence of the increase in cosmetic procedures, but it is still highly compelling. It is suggested anecdotally within the specialties and by surveys of residency faculty, physician practice mix, and patient wait times for noncosmetic appointments. A study using physician data from the American Medical Group Association and *Medical Economics* magazine showed that between 1992 and 2002 cosmetic procedures as a percentage of plastic surgery practice increased from twenty-seven percent to fifty-eight percent, and the average number of cosmetic procedures per surgeon annually increased from fifty-two in 1994 to 105 in 2002.[8] In a recent survey of burn centers, thirty-eight percent anticipated needing to recruit a new burn surgeon in the next five years and eighty-nine percent expected it would be difficult to do so.[9]

Botox first, then maybe look at skin cancer

In dermatology, the reported amount of cosmetic work is also significant. According to a 2007 American Academy of Dermatology (AAD) practice survey, fifty-four percent of dermatologists reported that cosmetic procedures made up about ten percent of their practice.[10] Regardless of whether media exposure and the popularity of cosmetic procedures make the proportion of cosmetic work done by dermatologists seem higher than what it actually is, surveys of patients show problems with access and patient dissatisfaction. Surveys reported in 2006 and 2007 showed that patients were more likely to get a timely appointment with a dermatologist when they requested Botox injections than when they reported a changing mole, with an average wait time of six to eight days for the former and twenty-six to thirty-eight days for the latter.[11,12] Doctors themselves note that specialists in pediatric plastic surgery and dermatology are harder to find.[13] Pediatric dermatology and plastic surgery practices are less lucrative than those treating adults, which get higher insurance reimbursements and often incorporate out-of-pocket cosmetic procedures into their practices. One dermatology resident professed an interest in pediatric dermatology to me, but acknowledged that pursuing it would decrease her future income by $100,000 per year.

Beyond the practical dilemmas that a relative workforce shortage creates for the medical profession and patients in need of noncosmetic services, we need to consider the ethics of the burgeoning availability and use of cosmetic procedures. Key to the ethics of cosmetic and reconstructive procedures are these questions:

- What is *normal*?
- What does *functional impairment* mean?
- What are the goals of medicine?
- What is the morality of medicine?
- What official position, if any, should the specialties of plastic surgery and dermatology take on cosmetic procedures?

The cosmetic/noncosmetic boundary—how to define functional impairment?

The line dividing cosmetic and noncosmetic procedures is often difficult to define. However, when public resources are used to finance procedures along this continuum, as in certain countries with national health insurance, a distinction must be made. People generally agree that reconstructive surgery for disfigurement due to burns, trauma, surgery (e.g., mastectomy for breast cancer), or congenital abnormality should be covered by government-financed health care. On the other hand, surgery to correct unattractive appearances due to age or heredity is more difficult to justify when public funds are used.

In the 1980s, the Netherlands established objective appearance criteria for cosmetic procedures to be covered by national health insurance. These included women having breasts whose nipples were at or below the level of their elbows, women with greater than four dress sizes difference between their upper and lower bodies, and people who looked

at least ten years older than their chronological ages.[14] The seemingly arbitrary nature of these criteria leads us to wonder how they were decided. At the same time, such standards illustrate that large variations to "normal" appearance must be present before intervention can be considered. No other national insurance program I examined provided coverage for the type of cosmetic procedures once subsidized in the Netherlands.

The philosopher John Rawls spoke of the virtue of equal opportunity for individuals, which would require eliminating social disadvantages caused by racism, sexism, or lower socioeconomic status.[15] Norman Daniels interprets equal opportunity as it relates to health care as the ability of individuals to remain as close to "normal functioning" as possible and thereby enjoy their "fair share of the range of opportunities reasonable people would choose in a given society."[15] The economic and social advantages of being tall and good-looking are well-known. Tall men and attractive men and women have higher incomes and are more likely to find desirable mates (i.e., similarly tall, attractive and/or wealthy) than their short and unattractive counterparts. Thus, even if shortness and unattractiveness are part of the range of human variation, one could argue that such people are functionally impaired in their ability to reach the highest strata of society.

It is no surprise that women comprise the vast majority of patients undergoing cosmetic procedures, making up approximately ninety percent of cosmetic patients in 2000 and 2007.[2,14] The pressure on women to conform to stereotypical Western notions of beauty results in Asian woman having eyelid reconstruction surgery and Jewish or Iranian women growing up with the expectation of getting a "nose job." When a mother takes her teenage daughter to the mother's plastic surgeon, a new kind of family resemblance is perpetuated.[14]

The American Society of Plastic Surgeons (ASPS) distinguishes between cosmetic and reconstructive surgery on its web site in an extensive section for "Patients & Consumers." This distinction hinges on the term "normal"—cosmetic surgery is performed on normal structures, while reconstructive surgery is performed on abnormal structures to "improve function" or "approximate a normal appearance."[16] Rhinoplasties and eyelid surgeries, typically cosmetic procedures, could be considered reconstructive if they improved obstructed breathing or vision. The ASPS does not make any ethical or moral distinctions between cosmetic and reconstructive surgery on its web site, nor in its 2006 code of ethics. Its explanation that cosmetic surgery is not usually covered by health insurance "because it is elective"[16] seems incomplete, however. Many reconstructive surgeries, such as reconstruction following mastectomy or the autotransplantation of a toe for an amputated thumb could also be considered "elective" because they do not improve patient survival, and patients still have to choose to have them done. It would be more appropriate to say that cosmetic procedures are not usually covered by insurance because they are performed on normal, instead of abnormal structures. Noncosmetic procedures still better serve what we traditionally view as the goals of medicine.

By and about Anna Raphael

Primarily raised in upstate New York, I graduated from Wellesley College with a degree in biological chemistry and worked as a medical writer before entering the University of Pittsburgh School of Medicine, where I edited the literary and arts magazine *Murmurs*. My interests include the intersections of sociology and literature with medicine. In June 2009 I began my internship in internal medicine in New York City.

Providing big breasts—is this the "healing good"?

The goals of medicine, like the morality of medicine, have been described in various ways. Daniels takes a Rawlsian approach to propose that the goals of medicine are to keep all individuals as close to normal functioning as possible, to create "normal competitors" for the world's opportunities, even if not equal ones.[15p316] But with limited health care resources, physicians are not obligated to do everything possible to normalize people's functions, let alone enhance them.[15] We cannot create a world of "normal competitors" because even assuming an ideal situation in which everyone has the ability to pay for health care (i.e., universal health insurance), geographic disparities in the numbers of health care providers and the availability of technologies will still exist. Moreover, care itself is imperfect. This nevertheless leaves the door open for people to privately purchase cosmetic procedures.

In the Aristotelian essentialist position of Edmund Pellegrino, the goal or "end" of clinical medicine is a healing good intimately bound up in the physician-patient relationship.[17] This internal good is distinct from external goods such as physician fees for consultation or treatment. The good is comprised of a "medical good" (technical skills or knowledge); the patient's perception of good; the "good for humans as humans," rooted in common principles of autonomy, beneficence, nonmalfeasance, and justice; and the spiritual good that

respects the patient as a divine or spiritual being and is the highest good that must be served.[17] Cosmetic procedures fit these different "goods" to varying degrees. They certainly involve technical competence and knowledge. Something seemingly as simple as a Botox injection is done in a systematic way, taking into account facial muscle and nerve anatomy and titrating to a proper dose of the toxin over time. Many patients and surgeons testify to how a cosmetic procedure radically changed a patient's life for the better. The availability of cosmetic procedures is consistent with the principle of patient autonomy; favorable results can count as beneficence. One can argue, however, that such procedures violate the principle of nonmalfeasance, since healthy patients with *normal* anatomy thus experience the risks and complications associated with cosmetic procedures. Cosmetic surgeons and dermatologists point out that complication rates are low and risks versus potential benefits must be weighed by each patient. At first it seems difficult to see how cosmetic procedures serve a spiritual good, but if we consider one's spirituality to include self-esteem and outlook, it can surely be positively affected by cosmetic procedures.

Franklin Miller and Howard Brody take the position that the goals and the morality of medicine "are not timeless and unchanging; of necessity they evolve along with human history and culture."[18p585] The goals of medicine developed by the Hastings Center that Miller and Brody cite are examples of this evolution, as they allow that physicians may pursue a "peaceful death" for patients, something that would have been unthinkable before the concepts and principles of patient autonomy, withdrawal of life-sustaining measures, and, to a lesser extent, physician-assisted suicide, became more accepted by mainstream medicine.[3] According to Miller and Brody, the problems treated by cosmetic procedures simply do not qualify as maladies.[3] While they may cause suffering, physicians are not obligated to "relieve any and all pain and suffering."[3p354] Only certain physicians, such as psychiatrists, might find themselves compelled to relieve the suffering associated with the failures and disappointments of everyday life, and even they must establish boundaries. Patients with borderline personality disorder, for example, may be told that they can call as late as 6 PM to speak with their psychiatrists; after that time, they must leave a message.

Treating the pain of "insufficiency of physical appearance"

Related to the goals of medicine is the morality of medicine. Depending on whether we value autonomy or a broadly-defined patient spirituality more than the principle of nonmalfeasance, cosmetic surgery may or may not be acceptable according to the essentialist position of Pellegrino. Robert Veatch takes an entirely externalist position, arguing that medicine has no common internal core values and that all medical values come from external, culturally-specific sources.[19] According to this view, the practice of a nonmedically indicated procedure such as castration by physicians would be acceptable because a particular society values the outcome, in this case the preservation of a high-pitched, beautiful singing voice.[19] Cosmetic surgery would be entirely permissible according to this view because our society values the results.

Miller and Brody take a position in between the internalist/essentialist and the externalist positions. They hold that both the goals and morality of medicine are influenced by internal professional virtues related to the commonality of healing, as well as by external cultural factors. This position may be the closest to reality. Miller and Brody have stringent criteria for what defines a "malady" and for the types of communications that physicians can have with patients.[3] They argue that the "defects" cosmetic patients choose to change must be clearly visible. A defect that, to others, may appear perfectly normal may cause the person with the defect intense dissatisfaction or unhappiness. Like other types of pain, pain associated with one's physical appearance may be at once undeniable to the sufferer but unverifiable to others.[20]

Though Miller and Brody would not consider healthy patients with normal (if undesired) features as having maladies, perhaps the increasing prevalence and acceptability of cosmetic procedures is changing the commonly understood definition of "malady," along with the definition of "normal" itself. This appears to be more prevalent in certain affluent communities. According to Alex Kuczynski, a New York City style reporter, people in certain parts of the country expect women's breasts to be augmented.[7] Most breast implants are round instead of the more naturally shaped teardrop.[7] The unnatural upper fullness that round implants create is valued, as is the way that augmented breasts remain erect when women are lying down. Surgical "vaginal rejuvenation"—removing excess skin to tighten sagging labia—while still uncommon, is one of the fastest-growing areas of cosmetic surgery.[7] Equally worrisome are the hymenoplasties performed on women who have had premarital sex but who for cultural reasons need to appear to be virgins. In all these cases, different norms are imposed on women and perpetuated through cosmetic procedures—painful, expensive, and not without risk.

We may have to accept the evolving concept of "normal" using Miller and Brody's evolutionary position on medicine,

at least in specific groups of society. Nevertheless, they point out other ethical issues in the field of enhancement: cosmetic procedure advertisements often misrepresent benefits in proportion to risks to play on the public's insecurities, violations of the morality of medicine, as well as the ASPS's own code of ethics in the case of misrepresentative advertising.[3] Cosmetic surgeons claim to enhance self-confidence, although they generally do not work with a team of mental health professionals, as would those serving sex reassignment surgery patients.[3]

No conclusion with which all doctors could agree

Few would argue that cosmetic procedures should not be permitted. The relative shortage of medical dermatology and reconstructive plastic surgery services is a related ethical problem that our profession will have to address. Perhaps the creation of dedicated medical and reconstructive tracks within residency programs should emphasize improved noncosmetic patient care, thus retaining more physicians in such practices.

The public also bears responsibility for creating the current environment. In trying to become prettier, thinner, younger-looking, or more virginal, the public recasts the collective definition of "normal" in ways that discriminate against women, the elderly, minorities who don't conform to mainstream ideals of beauty, and the poor who, despite being able to splurge on a procedure or two using credit cards, can never attain the maintained chic of the rich achieved through regular cosmetic procedures.

As physicians we have the ability to choose what services to provide our patients. Discouraging sexism and other forms of discrimination, providing timely access to noncosmetic services, and adhering to a morality of medicine that values restoration to normal more than manipulation of the normal are to me the most compelling reasons for physicians to limit their cosmetic practices.

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