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2.1 Introduction

When physicians concern themselves with the aesthetic aspects of their patients, public opinion varies on the topic. On the one hand, certain measures are required in order to improve the aesthetic appearance of a person. They are a normal part of the medical profession. For example, to reconstruct the deformed face of a car-accident victim or to give a patient with a serious skin disease the most “normal” appearance possible undoubtedly belongs to the art of medicine. On the other hand, there are several medical procedures that are concerned with the aesthetics of their patients being criticized. For example, one could mention television programs in which physicians help participants to look more like celebrities (“I want a famous face,” MTV). Furthermore, there are cases in which physicians performed aesthetic operations obviously too frequently and with harm to the patient or did not do so in accordance with safety standards [1]. Here the question arose whether physicians’ participation is ethically acceptable. The doubts were supported by the fact that medicine is expanding with the growing number of aesthetic measures to a field that frequently does not have anything to do with the treatment of illness anymore and goes beyond the traditional core of medicine.

At this point, it should be addressed whether and – if so – under what conditions physicians should perform aesthetic interventions on their patients.

This question cannot be answered without reference to the medical profession and its characteristics. Furthermore, one must systematize the various medical efforts for the aesthetics of the patient. Only then, it can be clarified to what extent certain measures are in accordance with the ethos of the medical profession and what responsibility physicians have. Aesthetic operations on children and adolescents as a special case should be examined as well.

At this point, the question concerning the participation of the medical profession in certain measures should be discussed. It should not be asked whether a person should have an aesthetic operation or not, but whether physicians should perform it.

2.2 Preliminary Remarks

1. The only measures to be addressed here are those that exclusively serve aesthetic purposes. If measures are carried out for medically functional reasons, then there are usually enough reasons to consider them medically necessary and ethically acceptable (the patient’s consent as a requirement). Furthermore, if medically functional measures happen to be aesthetically beneficial as well, like frequently in dentistry, then this additional characteristic does not provide a reason to doubt its ethical acceptability.
2. Actions for the sake of one’s own aesthetic improvement belong to the basic behavior of human beings. To consciously form the body beyond pure

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naturalness under aesthetic aspects distinguishes human beings from the animal world. They do this in many ways, be it clothes, cosmetics, care, or sport. It would therefore not be the activity itself, but the measures – the medical, especially surgical intervention – which give rise to a special investigation.

2.3 Moral Construction of the Medical Profession

Why should one ask the question whether physicians are allowed to take part in this genuinely human action with all their knowledge and capability? There are people who wish for better looks and physicians who can make this wish come true. What should be problematic about it – it could be asked. In other professions, expansion does not usually raise critical questions. So, why in the medical profession?

The medical profession is a unique profession, and whoever doubts it, can take a look in the “Declaration of Geneva of the World Medical Association”. There, the medical profession is committed to one particular goal, namely to the health of the patients: “The health of my patient will be my first consideration” [2]. This goal shapes physicians’ behavior, and for this reason, the medical profession is a profession and not a business. What does this mean? What makes the medical profession so unique?

Professions have established themselves in all developed industrial nations and possess the following traits [3]: They primarily aim for a worthwhile goal and not – like a business – primarily for the realization of profit. (That, of course, does not exclude that the members of certain professions earn their livelihood through their job.) However, professions are primarily committed to a socially deemed and important task. The task of medicine is clear: It is supposed to maintain and re-establish health, ease suffering and help sick people. The professions are geared toward the interests of their clients or – in medicine – their patients. For this, a high ethos is expected from the members, an ethos that puts the patient in the center of the considerations and actions. Or, as the World Medical Association International Code of Medical Ethics describes it: “A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity” [2]. In professions, the services frequently have to be locally based and be personally delivered. They cannot be delegated,

with the exception of assistant physicians. Advertising is only allowed within limits – at least in numerous countries – as to not induce demand.

Why is this orientation so important for physicians, why is a high ethos from the members of the medical profession demanded, why do they have to work in a patient-oriented fashion? If one puts oneself in the situation of a patient, then an answer can be found: people experience various difficulties in the course of their lives such as health problems, and it proved to be beneficial as an answer to these contingencies for sick people that the members of certain professions (in this case the medical profession) dedicate themselves to the patients’ problems, are competent and act patient-oriented. Sick people must expect that the members of the medical profession know exactly what they are doing, have a command of their duties and simultaneously use these abilities to the benefit of the patient. Patients must trust that physicians possess a certain ethos, a work-related, humane disposition. Physicians cannot guarantee the success of a medical measure, but they can guarantee that they possess abilities and take a certain moral stance.

Since the patients cannot verify the stance of each and every member of the profession in advance, they have to rely on the fact that just because someone is a member of the profession, certain capabilities and moral stances can be expected. It is in the sense of professionalism, of a binding professional ethos, because it makes the so-called system of anticipatory trust possible [4]. A working party on “Doctors and Society Medical professionalism in a changing world” of the Royal College of Physicians defined in 2005 medical professionalism “as a set of values, behaviours, and relationships that underpin the trust the public has in doctors” [5]. The patient can expect certain behavior simply because of the membership in the medical profession. The system of medicine entitles one to the expectation. This confidence is certainly not to be understood as a nostalgically glorifying adjunct to a service relationship, but is essential in the doctor–patient relationship. With that, the profession agrees to a contract with society. “Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standard of competence and integrity” [6].

This should also be considered if one wants to answer the question to what extent physicians should

be devoted to the aesthetics of their patients. Then, one should study the measures taken to change the aesthetics of a person to determine whether they threaten the constitutive element of medicine, namely the “system of anticipatory trust.”

2.4 Classification of Aesthetic Interventions

First, the undisputed cases are discussed that were already mentioned above: there is no doubt that several aesthetic interventions are compatible with the medical ethos. As a profession, physicians are committed to health. When they treat the ill, thereby correcting the aesthetic drawbacks of a disease, there is no contradiction with the medical ethos.

However, with that the whole area of aesthetic interventions is not covered for the following two reasons:

1. The concept of disease is fuzzy around the edges; it also has changed historically. For many symptoms, it can be difficult to say whether they should be regarded as a disease or not. The best-known examples are the symptoms of aging: Are they diseases or the physiological course of events?
2. Certain aesthetic interventions to correct conditions are beyond what – despite all the uncertainty – is widely seen as a disease. How should physicians face up to that?

In order to assess these aesthetic interventions ethically, a subdivision is proposed here that is oriented to the attention of events. Medical interventions for the purpose of altering the aesthetic appearance can

1. diminish undesired, excluding or negatively perceived attention from other people,
2. increase positively perceived attention from other people.

We must realistically concede that this distinction is not clear-cut for all cases. There could be cases in which both aspects are touched upon. However, this distinction proves to be helpful for the issue discussed here.

2.5 Medical Ethos and Aesthetic Activities

The first group: This includes, for example, medical treatment of disfigurements or of characteristics that act stigmatizing and often but not always have a disease reference, which often but not always differs widely

from the average. The treatments are reconstructive in many cases, inasmuch as they want to restore a “normal” state as much as possible. With these treatments, people should get the chance to lead a life free of excessive, unwanted negatively perceived attention, a life free of stigmas. Basically, one wants to help them get to that “normal” level of attention as much as possible and avoid stigmatization and exclusion. These measures can be justified by considerations of justice: It’s about giving people chances for a good life, or, as the “Central Ethics Commission at the German Medical Association” recently formulated it, as a maxim for allocating resources in health care, making it possible for humans to “participate in social life” [7]. There is no doubt that measures to prevent stigmatization – within the scope of good medical treatment – are compatible with the medical ethos and do not compromise the medical profession in any way, provided that they are carried out *lege artis*. This is also true when it is a matter of aesthetic, not functional corrections.

The other group of aesthetic measures, including operations, however, intends to increase desired, positively perceived attention from others through physical changes. In addition, the changed appearance is supposed to contribute to the attractiveness in comparison with others. Frequently, these operations are supposed to correct the symptoms of old age or effects of excess weight. There is usually no sign of disease and no “medical” indication. The patient’s desire and money decide on the measure.

What happens in the relationship between physician and patient in this case? There is no medical indication and therefore the physician is not responsible for an indication. The physician is only responsible for proposing a method by which the patient’s goal should be achieved and for proper performance. Therefore, the physician’s responsibility has changed dramatically. Since it has nothing to do with the health of a patient, the physician is not obligated to perform such measures. But are physicians not allowed to perform for this reason? And if they do it, if physicians offer purely cosmetic measures, even operations, will the medical profession be compromised?

Simply because of the lacking reference to illness, trust in the medical profession is not necessarily compromised when it comes to purely aesthetic measures. For example, physicians are already working in areas beyond illness, whether it be abortion, contraception, improvement of performance through training in

sports, etc. However, what needs to be guaranteed to ensure that the “system of anticipatory trust” is not compromised?

1. Measures that the patient wants but cannot really help the patient in any way should not be performed. For example, if the patient’s desire for a change in appearance is caused by a serious mental disorder, a medically obtained change in appearance will probably not relieve the suffering of the patient. Here, it is the physician’s duty to recognize this and suggest other helpful measures such as further discussions or psychotherapy. The International Code of Medical Ethics of the WMA states: “A physician shall act in the patient’s best interest when providing medical care” [2].
2. The consultation must also be geared toward the goal of assisting the patient and searching for an appropriate approach for him or her. The consultation shall not serve the purpose of “selling” a particular measure. “Placing the interests of patients above those of the physician” [6] is one of the fundamental principles of professionalism.
3. The patients also have to be thoroughly informed that there is no medical indication to be found. They have to be informed in detail about the measure and must give their free informed consent.
4. The high standards of avoiding harm must be maintained. Medical measures generally bear risks, but the avoidable ones should be avoided, especially those that come with voluntary operations. Otherwise, it would go against the basic principle of “setting and maintaining a standard of competence of professionalism” [6].
5. Advertising should be limited to factual information as not to induce demand.

These conditions must be met in order to exclude that a measure, which is most likely not helpful, is implemented, that the patient is forced to do it, is not sufficiently informed and that preventable damage occurs. All this would jeopardize the “system of anticipatory trust” in the medical profession. But, if this is largely excluded, then the answer to the central question of how aesthetic actions jeopardize the medical profession is: This is not the case, provided that the orientation towards the patient and the high quality of consultation and implementation are guaranteed.

Cosmetic medicine and particularly cosmetic surgery expand what medicine has to offer, but they do not demonstrate any unknown, new dimension of

medical practice. It would certainly give cause for concern if physicians displayed in their traditional area (the treatment of diseases) even some of the attitude from aesthetic medicine, namely that only the will and financial power of the customer can make something happen. However, provided that this is not the case for the main medical duty – the prevention, treatment or alleviation of disease – the medical profession would with certain cases of cosmetic interventions, in particular of purely cosmetic surgery, only expand their services. If the medical profession makes this expansion recognizable, and a high standard of quality in aesthetic medicine and patient orientation is guaranteed, there is no reason for a threat to the “system of anticipatory trust” and the medical profession to be seen.

2.6 Aesthetic Measures for Children and Adolescents?

The suggested distinction between “reducing undesired attention” and “increasing desired attention” is also supportive for assessing the situation of children and adolescents. Of course, a clear-cut line cannot always be found even in these cases. Nevertheless, one can divide the interventions according to the previously noted distinction concerning attention to events into two groups: How should aesthetic medical interventions, even operations on children and adolescents be assessed, that are supposed to reduce undesired, exclusionary, negatively perceived attention from other people and those intended to increase positively perceived attention?

In the first group, for example, could be operations on injuries that caused disfigurement or characteristics that can have a stigmatizing effect. A good example would be bat ears. Their correction carried out on children and adolescents can be justified insofar as one would like to provide the child or adolescent with the chance of an unencumbered childhood or adolescence without frequent, undesired, negatively perceived attention, without a stigma. Exclusion and teasing should be prevented. At this particular period in life, social contacts and confidence are extremely important because they facilitate opportunities for a further good life. Orientations on a concept of illness in the process are not helpful and are not even mentioned, for example, at the surgery on bat ears.

The assessment looks completely different for operations or measures that only serve the purpose of drawing desired, positively perceived attention from others onto oneself through physical change. With such operations or measures, children or adolescents enter a contest for additional attention. The contest is present anyway and is largely unavoidable, especially in youth. However, this raises the question as to whether this contest should be exacerbated by the possibilities of medicine. There are convincing reasons to speak against it, especially when it comes to aesthetic operations.

First, the medical risks should be mentioned: In addition to the usual medical risks, the results of operations during childhood or adolescence are more difficult to be predicted because of their growth. The possibility of an unwanted result is increased in case of some surgical procedures. Furthermore, cosmetic operations and other medical measures confirm and strengthen the competition for desired, positively perceived attention through physical appearance just by being yet another available tool. The pursuit of altering the aesthetic appearance (that does not stop at surgery) is problematic in two senses: It suggests that we must be beautiful on the one hand and must be willing to have cosmetic surgery for beauty on the other. This could induce increased suffering, while simultaneously offering services for the reduction of suffering. It would be more desirable to not dictate new standards and suggest new measures for rule compliance, but to provide an unencumbered childhood and adolescence without additional aesthetic pressures. These arguments speak for a restriction of aesthetic measures and operations on children and adolescents that only serve the purpose of increasing the desired attention. Nevertheless, there are convincing arguments for the avoidance of stigmatization of children and adolescents through medical interventions.

2.7 Conclusions

Medical interventions that are only supposed to increase the desired, positively perceived attention from others are not necessary according to medical ethos. However, they do not go against them, provided that high quality requirements are guaranteed. The measures have to be deemed beneficial to the patient in advance, a patient must be informed and the avoidance of harm must be guaranteed. Aesthetic measures, especially operations, which only serve the purpose of increasing desired, positively perceived attention, should not be performed on children and adolescents. Nevertheless, there are convincing arguments for an avoidance of stigmatization of children and adolescents, even through medically aesthetic measures.

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