

Cosmetic Surgery and the Internal Morality of Medicine

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Cosmetic surgery is a fast-growing medical practice. In 1997 surgeons in the United States performed the four most common cosmetic procedures—liposuction, breast augmentation, eyelid surgery, and facelift—443,728 times, an increase of 150% over the comparable total for 1992.¹ Estimated total expenditures for cosmetic surgery range from \$1 to \$2 billion.² As managed care cuts into physicians' income and autonomy, cosmetic surgery, which is not covered by health insurance, offers a financially attractive medical specialty.

Although increasingly popular, cosmetic surgery is a most unusual medical practice. Invasive surgical operations performed on healthy bodies for the sake of improving appearance lie far outside the core domain of medicine as a profession dedicated to saving lives, healing, and promoting health. These cosmetic procedures are not medically indicated for a diagnosable medical condition. Yet they pose risks, cause side effects, and are subject to complications, including pain, bruising, swelling, discoloration, infections, formation of scar tissue, nerve damage, hardening of implants, etc.³ Moreover, cosmetic surgery is a consumer oriented entrepreneurial practice, heavily promoted by advertising in newspapers, magazines, the yellow pages of the telephone directory, and by marketing on the World Wide Web. The remarkable nature of cosmetic surgery is reflected on in the following comments of a plastic surgeon: "But then on top of it all we actually operate on people who are normal. It's amazing that we're allowed to do that, the idea that we can get a permit to operate on someone who is totally normal is an unbelievable privilege."⁴

Is cosmetic surgery a medical privilege or an abuse of medical knowledge and skill? With the exception of feminist scholarship, which focuses on the personal and social meaning and value of cosmetic surgery for the lives of women, the bioethics literature has neglected to pay attention to moral issues posed by cosmetic surgery.⁵ In this article we examine cosmetic surgery from the perspective of professional integrity and the internal morality of medicine—a perspective that we have explicated and defended in two previous essays.⁶

The Internal Morality of Medicine

All members of our society are likely to become patients, vulnerable to life-threatening or disrupting conditions and in need of medical attention and treatment to cure, prevent, or ameliorate disease, injury, or bodily dysfunction. Owing to this vulnerability and need for professional care, medicine is not a morally neutral technique. Rather, it is a professional practice governed by a moral framework consisting of goals proper to medicine, role-specific duties,

and clinical virtues. We call this framework “the internal morality of medicine.” The professional integrity of physicians is constituted by loyalty and adherence to this internal morality.

A variety of formulations have been proposed for the goals of medicine. A recent report of an international group of scholars, convened by The Hastings Center, recommended a comprehensive list of four goals: (i) “the prevention of disease and injury and promotion and maintenance of health”; (ii) “the relief of pain and suffering caused by maladies”; (iii) “the care and cure of those with a malady, and the care of those who cannot be cured”; and (iv) “the avoidance of premature death and the pursuit of a peaceful death.”⁷ For our inquiry into the ethics of cosmetic surgery, this list is noteworthy in two respects. The designation of multiple goals signifies that medicine is too complex and diverse in its legitimate scope to be encompassed by any single, essential goal, such as healing or promoting health. If healing is the single essential goal of medicine, then it is obvious that cosmetic surgery does not belong within legitimate medical practice. But this essentialist perspective would also rule out a variety of medical practices, such as contraception and sterilization, which *prima facie* are not devoted to healing or promoting health but are widely accepted as medically appropriate. The diversity of goals proper to medicine, and their openness to interpretation, makes mapping the moral domain of medicine complex and contested. Though broad in its scope, this list of goals is subject to limits. The central goal of relief of pain and suffering is confined to conditions that qualify as “maladies.” What counts as a malady warranting medical attention may be subject to conflicting interpretations and may change over time. The important qualification, however, means that it is not within the purview of physicians to attempt to relieve any and all pain and suffering that may afflict human beings.

Specification of the goals of medicine is necessary but not sufficient for mapping the normative domain of medicine. In addition to being oriented to a set of proper goals, medicine is guided and constrained by a set of internal duties that pertain to the legitimacy of practices in pursuit of medical goals. We have identified four internal duties incumbent on physicians of integrity: (i) competence in the technical and humanistic skills required to practice medicine; (ii) avoiding disproportionate harms that are not balanced by the prospect of compensating medical benefits; (iii) refraining from the fraudulent misrepresentation of medicine as a scientific practice and clinical art; and (iv) fidelity to the therapeutic relationship with patients in need of care.⁸ The internal morality of medicine also encompasses a set of clinical virtues—dispositions of character and conduct facilitating excellence in pursuit of the goals of medicine and the performance of professional duties. We hope to specify and explicate the medical virtues in a future undertaking, but this is not required for our purpose of critical examination of cosmetic surgery.

The Distinction Between Business and Medicine

From the time of the ancient Greeks to the present, medicine as a professional practice has been distinguished from business.⁹ Governance by an internal morality underlies this distinction. Business, to be sure, does not lie outside the domain of morality. But medicine is subject to specialized and more stringent ethical constraints than are characteristic of and appropriate to business enter-

prise. The distinction between consumers and patients and the use of advertising are two key aspects of the traditional contrast between business and professional medical practice; and both are relevant to the evaluation of cosmetic surgery in the light of the internal morality of medicine.

Central to business in a market economy is the doctrine of consumer sovereignty: that subjective preferences and money determine access to commodities in the marketplace. In medicine consumer sovereignty is attenuated, if not foreign to the domain. Medical care is provided by physicians who diagnose presenting problems and recommend medically indicated treatment or preventive interventions. Patients may demand specific medical interventions, particularly in the context of intense public attention to health and ready access to health information. But interventions that patients request or demand are medically appropriate only if they are consistent with diagnostic criteria, medical indications, and professional judgment.

Patient autonomy is not the same as consumer sovereignty. Ethical medical treatment depends on the informed consent of patients, who have a right to refuse treatment, including medically indicated life-saving interventions. Patient autonomy, however, falls short of consumer sovereignty because patients do not have a right to receive whatever treatments they demand and are prepared to pay for. Preference and the ability to pay may be necessary for access to medical care in our society, but they are not sufficient. The extent to which cosmetic surgery is oriented toward and dependent on consumer demand is relevant to its moral assessment from the perspective of professional integrity.

In business, advertising functions as a standard means of linking sellers and buyers of products and services. Medical ethics, however, traditionally has prohibited advertising by physicians.¹⁰ This traditional prohibition may have reflected, in part, a concern for status: marketing by advertising was considered beneath the dignity of learned professionals as distinct from tradesmen. The traditional prohibition eroded in the wake of the successful legal challenge by the Federal Trade Commission in 1978 of the American Medical Association's ban on physician advertising. Nevertheless, the vulnerability of patients and the imbalance of knowledge and power between physicians and patients continue to make advertising by physicians ethically problematic. Here the truism applies that what is legal is not necessarily ethical.

Insofar as advertising by physicians is informational, it may alert individuals to unattended medical needs and appropriate treatments. But if it aims at stimulating demand for interventions that are not medically indicated, it potentially compromises professional integrity. Advertising cosmetic surgery puts physicians in the position of selling invasive procedures for which there is no medical need. Demand-stimulating advertising is especially problematic in medicine, since the willingness of physicians to provide treatments may operate as a legitimization in the mind of patients. That professionally qualified physicians are prepared to offer invasive procedures may encourage ambivalent patients to submit to medical intervention. Accordingly, advertising for interventions that are not medically needed to promote health is ethically suspect. What is acceptable business practice for selling consumer products and services is not necessarily appropriate for medical treatment. We argue below that the prevalence and unprofessional character of advertising contributes significantly to making the practice of cosmetic surgery ethically problematic.

Mapping the Normative Domain of Medicine

One of the major purposes of a conception of the internal morality of medicine is normative evaluation of practices by physicians to determine or question whether they belong within the proper domain of medicine. Violations of the internal morality of medicine consist of practices that are not supported by the goals of medicine and/or conflict with one or more of the internal duties of physicians. Examples include physician participation in capital punishment by lethal injection and prescribing anabolic steroids for athletes. Since these practices have nothing to do with treating or preventing a disease, injury, or malady, they do not serve the goals of medicine. Both involve causing or risking harms that are not compensated by medical benefits. Their performance by physicians fraudulently misrepresents medical practice by suggesting that it is proper for a physician to execute criminals or prescribe drugs to enhance athletic prowess. In addition, capital punishment is inconsistent with the context of a therapeutic relationship between physician and patient. Surgical procedures performed by a physician on close family members offer another example of a violation of the internal morality of medicine. Here the violation does not concern the goals of medicine, assuming that the procedure is medically indicated. However, the close family relationship has the potential to interfere substantially with competence (by impairing objectivity, clinical judgment, and thoroughness of medical inquiry) and with the therapeutic relationship between physician and patient.

In a previous essay we discussed a number of “borderline” medical practices, which belong within the legitimate domain of medicine but are not clearly supported by the goals of medicine and seem to conflict to some extent with one or more of the internal duties.¹¹ Examples include contraception and sterilization. On further reflection, we suggest that it is preferable to describe such procedures and practices as “peripheral” rather than borderline, since there are no precise, specifiable borders circumscribing unqualifiedly legitimate medical practices and defining violations. Among the definitions of “periphery” is “a zone constituting an imprecise boundary,” which we think aptly characterizes the normative terrain. Thus we suggest a normative mapping of medicine that encompasses a core of legitimate medical practice, consistent with the goals and internal duties of medicine, a periphery of more or less acceptable procedures and practices outside the core, and a range of violations beyond the pale of medical legitimacy. Designating the zone within which a procedure or practice belongs is a matter of judgment based on coherence or fit with the internal morality of medicine.

Reasonable differences of opinion are likely with respect to mapping practices and procedures as within the core or the periphery. Consider the case of contraception and sterilization. Although not a disease or a malady, pregnancy is a condition that in our society brings women under medical attention. Unwanted pregnancy can be understood as a disability, which interferes with the ability of women to function normally in social life. This suggests the conclusion that contraception promotes the health of women. The health promotion rationale for contraception or sterilization is stronger in the case of women who are likely to experience serious health risks from becoming pregnant, which would support including these procedures within the core of medicine in these circumstances. Male sterilization via vasectomy, in contrast, would

seem to lie more clearly in the periphery. If undertaken to prevent unwanted pregnancy, the pregnancy it prevents belongs to another person, not to the one sterilized. Unwanted paternity, unlike unwanted pregnancy, does not qualify as a medical condition to be prevented. Vasectomy, then, appears more like a “life-style” procedure than tubal ligation—a medical means of permitting sexual intercourse without risking pregnancy and paternity. This surgical procedure does pose some risks and complications not compensated by medical benefits. Yet we consider it an acceptable peripheral medical practice that does not threaten or violate professional integrity.

Is Cosmetic Surgery Compatible with the Internal Morality of Medicine?

From the perspective of the ethics of the marketplace, governed by consumer sovereignty and honesty and fair play on the part of providers of commercial services, there appears to be nothing wrong with cosmetic surgery. It falls within the vast domain of commercial and consumer activity devoted to enhancing appearance. Cosmetic surgery involves certain risks and complications, but so does a range of other legitimate consumer activities, such as driving cars and engaging in recreational sports. In a “free society” what grounds are there for restricting the freedom of adults to purchase, and of medical practitioners to sell, cosmetic surgery? According to business ethics there are no ethical objections to cosmetic surgery as long as patients are adequately informed about risks and complications and are not subject to fraudulent marketing, and practitioners are technically competent. “Shaping up” by liposuction, for example, would seem to be an ethically acceptable, though less virtuous, alternative to jogging and working out, which are not without risks and potential complications.

Outside the minimalist ethics of the marketplace, a variety of value considerations are relevant to ethical appraisal of cosmetic surgery. The practice of cosmetic surgery may be criticized on the grounds that it is fueled by vanity and narcissistic fixation on bodily appearance. It reinforces intense concern with body image and culturally prescribed standards of beauty, especially among women, who are the major “consumers” of cosmetic surgery. It contributes to a youth culture that disdains and stigmatizes aging and the elderly. Cosmetic surgery upholds culturally specific standards of beauty—Caucasian, Anglo-Saxon, or Northern European—that stigmatize the appearance of ethnic groups that deviate from this standard. Finally, it promotes inequality between those who have and those who lack the resources to purchase the marketplace advantages of enhanced appearance via cosmetic surgery. None of these considerations, however, is relevant to the internal morality of medicine.

How, then, does cosmetic surgery stand with respect to the internal morality of medicine and professional integrity? It is difficult to find any solid support for cosmetic surgery within the goals of medicine. Those who seek to enhance their appearance by cosmetic surgery do not suffer from a diagnosable disease or injury. The qualifier “cosmetic” signifies that the surgery is not medically indicated or needed to promote health.

It might be objected that the description of cosmetic surgery as an appearance enhancement fails to do justice to the real, often prolonged, suffering from a negative body image that typically precedes choice of cosmetic surgery.¹² The point is well taken, but it does not follow that the suffering involved belongs within the purview of medicine. As discussed above, the goals of medicine

concern not all human suffering, but only that suffering connected with a malady. "Malady" in the medical context suggests an objectively diagnosable condition calling for medical treatment; and this is precisely what is lacking in the case of cosmetic surgery. The "need" for cosmetic surgery is a function entirely of subjective preference.

Kathy Davis conducted fieldwork in the Netherlands to study individuals who sought cosmetic surgery during a time in which it was covered by national health insurance. She observed 55 individuals who were examined by an official medical inspector to determine eligibility for cosmetic surgery. Davis observes,

With one exception, a man with a cauliflower nose, I was never able to guess what the person had come in for. In some cases, I had a suspicion, as, for example, when a woman with a rather prominent nose appeared, only to have them dashed when she explained that she wanted an eyelid correction because her five-year-old son was always asking her 'why she had been crying.' My first impression confirmed that applicants for cosmetic surgery looked no different than the run-of-the-mill woman (or man) on the street and some were even decidedly attractive. Their appearance did not seem to warrant corrective measures as drastic as cosmetic surgery.¹³

Davis's inability to perceive the deficit in appearance prompting a request for cosmetic surgery was matched by a similar inability on the part of the responsible medical inspector. "Despite attempts to develop objective criteria for appearance, my observations of the Inspector's difficulties in actually making decisions about who should have cosmetic surgery presented a different picture. In practice, he routinely complained that he was unable to see why the applicant wanted cosmetic surgery."¹⁴

Whether all cosmetic surgery falls outside the core domain of medicine may be subject to conflicting interpretations. Reconstructive plastic surgery to correct ravages of disease and injuries as well as gross physical abnormalities constitutes a core medical practice. Reconstructive procedures, however, lie along a continuum, without any clear boundary between therapeutic reconstructive surgery for a diagnosable problem and purely cosmetic surgery. In addition, reconstructive surgery in response to deformity is guided by aesthetic considerations. Yet compare, for example, plastic surgery to remove a port-wine stain causing severe facial disfigurement, but without any functional impairment, with liposuction to produce a trimmer appearance or a facelift to "rejuvenate" facial features. The former appearance problem qualifies as a malady that is objectively discernable by all observers, and it is reasonable to describe corrective surgery as medically indicated. In the latter cases the appearance problems giving rise to a request for cosmetic surgery are a matter entirely of subjective judgment. If surgery to remove a disfiguring port-wine stain is regarded as in part cosmetic, then at least some cosmetic procedures belong within the core of medical practice. This conclusion has no bearing, however, on the vast majority of purely cosmetic surgery procedures performed on normal bodies, which are not supported by the goals of medicine.

To give an aura of standard medical legitimacy to cosmetic surgery, cosmetic surgeons have concocted diagnostic categories warranting cosmetic surgical intervention, most notably, the "inferiority complex."¹⁵ The extent to which this disposition to construct diagnostic categories can be taken is exemplified by

Davis's account of a case conference by an eminent Dutch plastic surgeon, who described a rhinoplasty for a 15-year-old Moroccan girl. The rationale for surgery was explained in terms of a new syndrome: "inferiority complex due to racial characteristics."¹⁶ Although on critical reflection such a medical diagnosis is apt to appear blatantly bogus, the felt need to invoke some diagnostic category to warrant cosmetic surgery testifies to the point that objective diagnosis underlies legitimate medical treatment.

Let us imagine for a moment what would be required of cosmetic surgery if we really believed that dissatisfaction with one's bodily appearance was a legitimate medical diagnosis. We have a model for such a state of affairs in the surgical treatment of transsexuals, who find their body appearance totally at odds with their perceived gender identity, and suffer considerable anguish as a result. It is considered a legitimate surgical practice to operate on such persons to change their secondary sexual characteristics. But it is important to note how this is done in centers that can claim to be competent and comprehensive in their care. In particular, it is common to have sex change surgeons working very closely with teams of psychiatrists and other mental health workers, who do intensive screening of each applicant before the team decides that surgery should be performed. If the mental health assessment uncovers any evidence of psychological problems, so that managing those problems might relieve the gender dysphoria without doing surgery, then surgery is withheld and the appropriate psychotherapy is recommended instead.

This model suggests that if cosmetic surgeons truly believed that they were treating "real" psychiatric "maladies," then in order to provide minimally competent care, they ought to be working in tandem with mental health teams of this sort, and offering nonsurgical options to at least some of their patients. To our knowledge, very few if any cosmetic surgery offices and clinics are run in this fashion, which tends to suggest that cosmetic surgeons themselves do not take very seriously the claim that their practices are legitimated by the reality of psychiatric disease.

In addition to lacking support by the goals of medicine, cosmetic surgery is also ethically questionable with respect to the internal medical duties. These procedures pose risks of harm and have the potential for complications that are not compensated by any medical benefits. Furthermore, it is arguable that the willingness of physicians to perform cosmetic surgery on bodies that are not diseased, injured, or grossly abnormal fraudulently misrepresents medicine. This practice suggests a medical need and rationale for intervention, when in fact there is no diagnosable condition warranting medical treatment.

These considerations lead to the hardly surprising conclusion that cosmetic surgery lies outside the core of normative medical practice. But they leave open the question whether cosmetic surgery is a legitimate practice within the periphery of medicine or should be considered a violation of the internal morality of medicine. It is interesting to note that some of the early leaders of plastic surgery in the 1920s and 1930s expressed ethical concerns about cosmetic surgery.¹⁷ They distinguished ethically appropriate reconstructive surgery in response to deformity and injury from purely cosmetic surgery, which they saw as the province of unprofessional "beauty doctors." For example, in an influential 1926 article published in *Annals of Surgery*, John Staige Davis wrote: "What is the ethical difference between doing an abdominal operation and removing wrinkles from a sagging face? The abdominal operation is necessary to the

health of the patient, the operation for removal of wrinkles is unessential and is simply decorative surgery. True plastic surgery without question . . . is absolutely distinct and separate from what is known as cosmetic or decorative surgery."¹⁸ Although a persuasive argument might be advanced that purely cosmetic surgery, not associated with any diagnosable deformity, violates the internal morality of medicine, we do not take this position. The continuum between reconstructive and cosmetic surgery, which makes it difficult to determine where the former ends and the latter begins, casts doubt on a blanket judgment that cosmetic surgery lies outside the domain of legitimate medical practice.

The Ethical Relevance of Advertising for Cosmetic Surgery

Professional integrity concerns the fit between commitment to the norms of the internal morality of medicine and medical practice. All peripheral medical procedures and practices challenge professional integrity, since they are at best weakly supported by the goals of medicine, and they are apt to conflict with one or more of the internal duties. We submit that professional integrity is threatened, and potentially compromised, when peripheral procedures are not isolated or occasional occurrences within practice dedicated to core medical activities but are the predominant or exclusive focus of medical practice, as commonly characterizes cosmetic surgery. Moreover, the consumer-oriented, business context of cosmetic surgery risks compromising professional integrity, particularly insofar as it makes use of demand-stimulating marketing.

Advertisements for cosmetic surgery are prevalent in newspapers and the yellow pages of the telephone directory. Hundreds of sites on the World Wide Web are devoted to cosmetic surgery. For example, in the October 1997 yellow pages for suburban Washington, D.C., seven of the eight largest ads for physicians are for cosmetic surgery; and of those ads that take up one-quarter of a page or more, 18 of 31 are for cosmetic surgery. The weekly Health section of the *Washington Post* routinely contains ads placed by physicians for cosmetic surgery. These ads typically feature pictures of scantily clad, well-proportioned women and slogans such as "Bikini Time," "Let your mirror image be a masterpiece," "Reshape your future," "Spring into summer with a new look," "A New You for The New Millennium." In the *Washington Post Magazine* glossy ads have appeared recently for cosmetic surgery focusing on large-breasted women, with the slogans "Big and Believable," and "A Bustline for the Shoreline." These ads also feature the names, medical degrees, and board certification of plastic surgeons. Such advertisements juxtapose the lowest common denominator of marketing—sex sells—with markers of professional competence. The role of physician as salesman is displayed by the frequent offer in cosmetic surgery ads of free consultations, often with the aid of computer imaging. Targeted at women, these ads play on, and possibly contribute to, widespread dissatisfaction with body image and foster unrealistic expectations of what can be achieved by cosmetic surgery. Moreover, they give no indication of risks or complications from cosmetic surgery or the chance of less than fully satisfying outcomes.

The marketing of cosmetic surgery to consumers as a commercial service is particularly accentuated in a recent ad in the *Washington Post* health section. Under the bold headline, "Body Sculpting," it depicts the silhouette of a nude

woman with an hourglass figure. Also in bold is the announcement of "100% Financing" followed by a list of cosmetic procedures offered and the following sales pitch: "Call today to arrange for a free consultation with one of our experienced plastic surgeons who'll use computer imaging to demonstrate how you could look after cosmetic surgery. You'll also learn about our finance plan with no down payment and low monthly payments."

It is revealing to evaluate the professional appropriateness of cosmetic surgery marketing by comparing samples of advertisements for cosmetic surgery, such as those described above, with statements from the Code of Ethics for the American Society of Plastic and Reconstructive Surgeons, approved in 1992.¹⁹ Under the heading of Specific Principles, conditions are listed under which "Each member may be subject to disciplinary action, including expulsion." The category pertaining to advertising is the following: "The member . . . uses or participates in the use of any form of communication (including computer imaging and electronic communications) containing a false, fraudulent, deceptive, or misleading statement or claim." Included among unethical communication is a statement or claim that "[i]s intended or is likely to create false or unjustified expectations of favorable results"; "[a]ppeals primarily to layperson's fears, anxieties, or emotional vulnerabilities"; and "[i]s intended or likely to attract patients by use of puffery or exaggerated claims."

We contend that advertisements for cosmetic surgery routinely violate these professional ethical guidelines. They purvey misleading images and slogans, appeal to emotional vulnerabilities, and foster unrealistic expectations, rather than convey useful information about cosmetic surgery. These advertisements suggest that there is "a quick fix" for bodily improvement. They trade on glamour and dreams without drawing attention to risks and complications. Unprofessional advertising aimed at stimulating demand for invasive surgical procedures that are not medically indicated threatens, if not violates, professional integrity. Moreover, apart from the unprofessional character of much advertising for cosmetic surgery, the very use of advertising for cosmetic surgery is ethically problematic. Physicians should not be in the business of promoting medically unnecessary surgery on normal individuals.

It is a very basic component of the internal morality of medicine that physicians not be involved in the deliberate creation of disease just so that they can expand their practices and increase their earnings. For example, sprinkling resistant microorganisms into the town water supply would be the grossest possible violation of the internal morality of medicine. Yet if we imagine that an individual's dissatisfaction with his or her own bodily appearance is the (so-called) "disease" that cosmetic surgery is designed to treat, then it is arguable that the most extreme and misleading advertisements are analogous to this physician-as-Typhoid-Mary example. The ads are deliberately designed to convince people who might previously have thought that their appearance was acceptable that they are in fact seriously inadequate unless they seek a surgical correction for their newly discovered "problem."

An obvious rejoinder is that a medical "problem" can never be defined completely in isolation from the state of the art of medical therapy. On this view, advertising does not create a new perception of a problem that did not previously exist. Instead, people who all along had problems, but imagined that nothing practically could be done, are now being informed that a relatively safe and effective treatment exists so that they can be encouraged to come

forward and seek relief. But this response seems disingenuous when we reflect how dependent body image is on the prevailing social norms of beauty. The more extreme ads for cosmetic surgery convey the message that the models shown in the ads represent the standard of beauty to which all sensible people should aspire, and that these models have achieved that standard of beauty precisely because they have themselves submitted to cosmetic surgery (perhaps numerous times). By promoting *dis-ease* and thus stimulating demand for cosmetic surgery, such advertisements clearly violate the internal morality of medicine.

Implications

Our argument suggests that cosmetic surgery is ethically questionable from the perspective of the internal morality of medicine, which makes it at best a peripheral medical practice. Ethical concern is heightened by the organization of cosmetic surgery as a consumer-oriented business supported by heavy use of marketing, much of which is misleading and unprofessional. Accordingly, we conclude that the current state of cosmetic surgery practice threatens professional integrity. Some might go further and conclude that cosmetic surgery does not belong within medicine.²⁰ This rigorist position may seem appealing theoretically but is unlikely to have any practical effect. More importantly, if cosmetic surgery should be ruled out of medicine because it does not serve the goals of medicine, then other widely endorsed procedures and practices that also are not supported by the goals of medicine, such as contraception and sterilization, may be ethically imperiled. We contend that the marketing of cosmetic surgery raises especially serious concern from the perspective of professional ethics—concern that ought to be addressed in practice. Cosmetic surgeons who engage in misleading or fraudulent advertising appear to want to have it both ways. In marketing cosmetic surgery, they use standard, but contextually objectionable, techniques of consumer advertising, coupled with drawing attention to their professional medical credentials. The incoherence between projection of professional competence and trust, and the reliance on sleazy advertising techniques, compromises professional integrity.

Those wishing to defend the ethics of cosmetic surgery as consistent with the internal morality of medicine may take comfort in our labeling of the practice as “peripheral” rather than as outside the boundaries. But the preceding discussion suggests that a price is paid when a practice is accepted as peripheral within medicine. The more a practice occupies a peripheral rather than a central position in relation to the goals and duties internal to medicine, the more physicians are obligated to free that practice from any association with potentially distracting or corrupting influences such as a profit motive. To see what this entails, recall how surgical sterilization was often handled by many physicians 20 or 30 years ago, when there tended to be more moral unease than there is today about the peripheral position of that practice. In a day when concern about informed consent had not yet been felt in most of medical practice, physicians went to great lengths to assure that patients were fully informed and had carefully thought about sterilization before being willing to do the procedure. It was as if these physicians were bending over backwards to demonstrate that it was not a desire to expand their practices and make more money that stimulated them to do those surgeries.

On this view, if cosmetic surgeons took the internal morality of medicine seriously, they would scrupulously refrain from ethically suspect advertising and minimize the profit-making orientation of their practice—even more so than physicians whose daily work was more safely nestled within the core of medicine. By contrast, in the practice of cosmetic surgery we find the coexistence of two factors: (i) a practice within medicine that is demonstrably quite peripheral; and (ii) heavy reliance on questionable advertising and other signs that an ethic of business rather than of medicine is operating. We conclude that a serious threat to the internal morality of medicine exists in the way this practice is conducted, even though we do not contend that the practice itself is totally outside the bounds of allowable medical activity.

Leaders of the medical profession, particularly those connected with the practice of plastic surgery, should take steps to curb unethical marketing of invasive procedures that are not medically indicated. In addition, they should promote attention to professional ethics in the context of specialty training of plastic surgeons. More broadly, teaching the internal morality of medicine, by precept and example, may discourage medical students and physicians in training from diverting their careers to a peripheral and ethically problematic practice, outside the core domain of medicine.

On the theoretical level we suggest that the critical evaluation of cosmetic surgery from the perspective of the internal morality of medicine demonstrates the significance of this ethical approach. Focus on the internal morality of medicine brings to light ethical considerations and concerns that lie beneath the surface of the mainstream of bioethics. As new interventions are developed that are aimed at enhancing human abilities and subjective well-being, in contrast to treating disease, injury, or dysfunction—e.g., growth hormone to combat the effects of aging, “cosmetic psychopharmacology,” drugs to enhance sexual performance, and genetic engineering—attention to the internal morality of medicine and professional integrity is likely to grow more prominent, and this perspective is likely to achieve greater refinement and depth.

Notes

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8. See note 6, Miller, Brody 1995.
9. Plato, *The Republic*, trans. HDP Lee. Harmondsworth, U.K.: Penguin, 1955:69–70.
10. Dyer AR. Ethics, advertising and the definition of a profession. *Journal of Medical Ethics* 1985;11:72–8.
11. See note 6, Brody, Miller 1998;23:384–410.
12. See note 3, Davis 1995.
13. See note 3, Davis 1995:70.

14. See note 3, Davis 1995:72.
15. Haiken E. *Venus Envy: A History of Cosmetic Surgery*. Baltimore: Johns Hopkins University Press, 1997:90–130.
16. See note 3, Davis 1995:2.
17. See note 15, Haiken 1997:50–2, 93–103.
18. See note 15, Haiken 1997:93.
19. American Society of Plastic and Reconstructive Surgeons. *Code of Ethics*, rev. 1992.
20. Hyman DA. Aesthetics and ethics: the implications of cosmetic surgery. *Perspectives in Biology and Medicine* 1990;33:190–202.