

Is ugliness a pathology? An ethical critique of the therapeuticalization of cosmetic surgery

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Abstract

Pathologizing ugliness refers to the framing of unattractive features as a type of disease or deformity. By framing ugliness as pathology, cosmetic procedures are re-framed as therapy rather than enhancement, thereby potentially avoiding ethical critiques regularly levelled against cosmetic surgery. As such, the practice of pathologizing ugliness and the ensuing therapeuticalization of cosmetic procedures require an ethical analysis that goes beyond that offered by current enhancement critiques. In this article, I propose using a thick description of the goals of medicine as an ethical framework for evaluating problematic medical practices. I first describe the goals of medicine based on Daniel Callahan's account. I then propose that the goals work best in conjunction with ancillary ethical concepts, namely medical knowledge and skills, standards of practice and medical duties and virtues. Next, I apply the thick description of the goals of medicine in critiquing the practice of framing ugliness as disease. Here, I demonstrate ethical conflicts between aesthetic judgments that underpin the practice of pathologizing ugliness and medical judgments that inform ethical medical practices. In particular, the thick description of the goals of medicine helps reveal ethical conflicts in at least three key domains common to clinical practices, which include (a) disease determination, (b) diagnostic evaluation and (c) establishing clinical indications. My analysis offers a novel way of critiquing the practice of pathologizing ugliness in cosmetic surgery, which tends to be neglected by enhancement critiques.

KEYWORDS

cosmetic surgery, goals of medicine, medical ethics, pathologization, ugliness

1 | INTRODUCTION

Current ethical discussions about cosmetic surgery generally frame cosmetic interventions as examples of medical enhancement.¹ Medical enhancement debates involve questions regarding the permissibility of improving biological, psychological and social

attributes.² One line of argument claims that cosmetic procedures are ethically problematic as they lie outside the goals and purview of medicine.³ Some authors argue that a healthcare system with limited resources should prioritize medical treatments over

¹See for example Little, M. O. (1998). Cosmetic surgery, suspect norms, and the ethics of complicity. In E. Parens (Ed.), *Enhancing human traits: Ethical and social implications* (pp. 162–176). Washington, DC: Georgetown University Press; Devereaux, M. (2009). Cosmetic surgery. In B. Gordijn & R. Chadwick (Eds.), *Medical enhancement and posthumanity* (pp. 159–174). Dordrecht, the Netherlands: Springer.

²These debates tend to rely on a prima facie distinction between treatment and enhancements. The distinction, however, has been continuously challenged. See Chadwick, R. (2008). Therapy, enhancement and improvement. In B. Gordijn & R. Chadwick (Eds.), *Medical enhancement and posthumanity* (pp. 25–37). Dordrecht, the Netherlands: Springer.

³Miller, F. G., Brody, H., & Chung, K. C. (2000). Cosmetic surgery and the internal morality of medicine. *Cambridge Quarterly of Healthcare Ethics*, 9(3), 353–364.

enhancements.⁴ Feminist critiques of appearance enhancements tend to appeal to principles of autonomy when analysing women's choices to undergo cosmetic modifications. On one side of the debate, feminist critics such as Susan Bordo and Kathryn P. Morgan assert that cosmetic enhancements are part of wider oppressive practices that coerce consumers to conform to problematic ideals of beauty.⁵ On the other side, some feminists contend that cosmetic enhancements are a means of empowering consumers.⁶ Kathy Davis in particular maintains that women undertake cosmetic enhancements in order to exercise agency over their bodies and control over their lives.⁷

Despite the breadth of literature in the enhancement critiques of cosmetic surgery, the practice of pathologizing ugliness has largely evaded in-depth ethical analysis. Pathologizing ugliness, understood here as the framing of unattractive features as a type of disease or deformity, can be understood as a response to the enhancement critique regularly levelled against cosmetic surgery.⁸ Framing ugliness as pathology implies therapeuticalization of cosmetic procedures, that is aesthetic enhancements performed by cosmetic surgeons are reclassified as therapy or medically necessary treatments. On this account, the practice of pathologizing ugliness blurs the already fraught distinction between therapy and enhancement, and the corresponding classifications of reconstructive and cosmetic surgeries. Reconstructive surgery generally refers to a set of surgical procedures 'undertaken to reconstruct the body's normal appearance or repair functional deficits', whereas cosmetic surgery involves interventions that modify normal features for aesthetic purposes.⁹ There are clear cases where corrective surgery is widely accepted as ethically permissible or necessary, and these include deformities resulting from injury or birth defects such as orofacial clefts. However, there are numerous cases where the distinction between cosmetic and therapeutic is not straightforward.¹⁰ For the purposes of this article, I focus my ethical critique on cosmetic surgery of features that by definition are normal in that they are not associated with deformities due to disease, disorder or injury.

While the practice of pathologizing ugliness has largely been met with scepticism,¹¹ some scholars offer support to treating ugliness as disease.¹² Francesca Minerva, for example, contends that pathologizing ugliness is justified given the widely accepted psychological and social harms associated with being unattractive, claiming that there is a small number of individuals with 'extremely unattractive' appearance who experience some form of impairment.¹³ Minerva argues that pathologizing ugliness provides justification for state funding of procedures that modify extremely unattractive features.¹⁴ Despite current bioethical analyses that highlight the potential benefits of pathologizing ugliness, the crucial question remains on whether therapeuticalization of cosmetic surgery is aligned with the norms that underpin ethical clinical practices. Therapeuticalization thus warrants an ethical analysis that expounds on Bjørn Hofmann's criticism of treating aesthetic norms as medical. The author specifically recommends against 'making aesthetic norms govern professional values'.¹⁵ My analysis will further expound on the conceptual and practical problems raised by framing aesthetic norms in cosmetic surgery as medically legitimate.

My approach in using the goals of medicine as an ethical framework is to take the claims integral in the practice of pathologizing ugliness as serious issues subject to moral appraisal as much as any mainstream medical practice might be. This approach will potentially lead to insights that are not otherwise available if we rely solely on existing enhancement critiques. I first describe the thick description of the goals of medicine based on Daniel Callahan's account. I then propose that Callahan's account reveals ancillary ethical concepts, namely medical knowledge and skills, standards of practice and medical duties and virtues. The thick description of the goals of medicine then consists of the interplay among the goals and the ancillary ethical concepts. Next, I situate the practice of pathologizing ugliness within the broader context of cosmetic surgery as a commercial practice. Finally, I offer an analysis of the specific manners in which the practice of pathologizing ugliness undermines the goals of medicine and ancillary ethical concepts based on ethical conflicts between aesthetic judgments (that inform the pathologization of ugliness) and medical judgments (that inform ethical medical practice). The ethical conflicts occur in at least three domains common among mainstream clinical practices, and these are disease determination, diagnostic evaluation and establishing clinical indications.¹⁶

⁴Sabin, J. E., & Daniels, N. (1994). Determining "medical necessity" in mental health practice. *Hastings Center Report*, 24(6), 5–13.

⁵Bordo, S. (1993). *Unbearable weight: Feminism, Western culture, and the body*. Berkeley, CA: University of California Press; Morgan, K. P. (1991). Women and the knife: Cosmetic surgery and the colonization of women's bodies. *Hypatia*, 6(3), 25–53; Dolezal, L. (2010). The (in)visible body: Feminism, phenomenology, and the case of cosmetic surgery. *Hypatia*, 25(2), 357–375.

⁶Davis, K. (1997). Cosmetic surgery as feminist utopia? *European Journal of Women's Studies*, 4(1), 23–37; Tait, S. (2007). Television and the domestication of cosmetic surgery. *Feminist Media Studies*, 7(2), 119–135.

⁷Davis, op. cit. note 6.

⁸Dolezal, op. cit. note 5.

⁹Devereaux, op. cit. note 1, p. 161. Other authors have similarly explored the fraught distinction between reconstructive and cosmetic surgery. See Miller et al., op. cit. note 3; Edmonds, A. (2013). Can medicine be aesthetic? Disentangling beauty and health in elective surgeries. *Medical Anthropology Quarterly*, 27(2), 233–252.

¹⁰Nuffield Council on Bioethics. (2017). *Cosmetic procedures: Ethical issues*. Retrieved from <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-full-report.pdf>

¹¹Hofmann, B. (2019). Expanding disease and undermining the ethos of medicine. *European Journal of Epidemiology*, 34, 613–619.

¹²Minerva, F. (2017). The invisible discrimination before our eyes: A bioethical analysis. *Bioethics*, 30(3), 180–189; Edmonds, A. (2010). *Pretty modern: Beauty, sex, and plastic surgery in Brazil*. London, UK: Duke University Press.

¹³Minerva, op. cit. note 12, p. 187.

¹⁴Ibid. The author clarifies, however, that the disease framing of ugliness should only be part of a wider societal programme that deals with appearance-based prejudice, with the programme including legal protection against discrimination and advocacies that seek societal change towards tolerance.

¹⁵Hofmann, op. cit. note 11, p. 617.

¹⁶Clinical indications refer to the threshold for clinical intervention and are based on signs, symptoms, details in the history of the illness, or combinations thereof. Clinical interventions provide valid reasons for using a test, procedure or treatment.

By way of clarification, my ethical critique is not a broad appraisal of cosmetic surgery. I focus specifically on the practice of pathologizing ugliness that employs disease framing of normal albeit unattractive features to justify the use of cosmetic interventions. In addition, I acknowledge that cosmetic surgery is not a singularly constructed, monolithic practice. Cosmetic surgery, like any medical practice, consists of practitioners with wide-ranging interests, motives and views. The British Association of Aesthetic Plastic Surgeons, for example, acknowledges and denounces cosmetic surgeons who target vulnerable people through 'aggressive and unethical' marketing tactics.¹⁷ As such, the association claims to have repeatedly called on the UK government to ban direct-to-consumer advertising of cosmetic surgery services.

2 | THICK DESCRIPTION OF THE GOALS OF MEDICINE

The function of a goal, broadly speaking, is to serve as a guide, providing directions for and constraints on decision-making and action.¹⁸ In the medical context, goals, conceptualized in terms of the promotion of health and treatment of diseases,¹⁹ take on this function by guiding physicians regarding the appropriateness, permissibility and necessity of clinical decisions and actions. Goals of medicine, then, are taken to be an important component of medical morality.²⁰

The moral relevance of the goals of medicine lies in their function of shaping clinical decisions and actions.²¹ In general, the goals are commonly conceptualized as informing the 'right and good healing actions undertaken by the physician on behalf of a sick patient'.²² In particular, Matthias Kettner asserts that goals help physicians 'to specify and also to justify the range of clinical treatment-indications' (emphasis in the original).²³ Consequently, the goals of medicine appear to be relevant in moral debates to do with the proper domain of medicine, understood as the generally agreed area of action that is within the responsibility of medical professionals.²⁴ Miller and Brody assert that medical responsibilities generally involve clinical decisions and actions within the domain of medicine that 'restore some measure of

wholeness, some measure of health' to a patient.²⁵ For example, on their account treating the physiological complications of smoking is within the domain of medicine, but enforcing public policies that deter smoking is not (medical professionals are however free to advocate and support such policies).

2.1 | Callahan's goals of medicine

One of the most well-known accounts of the goals of medicine is based on the international project led by Daniel Callahan and coordinated by The Hastings Center.²⁶ Callahan's account of the goals is based on a consensual approach that allows for the goals to change historically and socially while being constrained through a deliberative process. Callahan claims that consensus acknowledges how the goals start from medicine's own history and tradition, followed by modifications based on continuing dialogue with society. According to Callahan's 'Goals of medicine: Setting new priorities', the four goals are:

*1) prevention of disease and injury and the promotion and maintenance of health, 2) the relief of pain and suffering caused by maladies, 3) the care and cure of those with a malady and care of those who cannot be cured, and 4) avoidance of premature death and the pursuit of a peaceful death.*²⁷

The goals suggested by Callahan may be sufficient to capture our common intuition of what medicine ought to do, and may be comprehensive enough to set some standards against which to morally evaluate clinical practices.

Taken at face value, the practice of pathologizing ugliness might appear to be consistent with the goals of medicine in that the practice asserts that ugliness is a disease condition that requires medical or surgical treatment. In what follows, I propose a way to further operationalize the goals of medicine as an ethical framework by looking at ancillary concepts that help form what I refer to as the thick description of the goals of medicine.

2.2 | Ancillary ethical concepts arising from the goals of medicine

The strength of Callahan's account of the goals of medicine lies in its versatility, specifically by being able to incorporate other ethical concepts when critiquing problematic medical practices. Here, I propose that the goals of medicine as an ethical framework are best realized

¹⁷British Association of Aesthetic Plastic Surgeons. (2018, July 02). *BAAPS statement on cosmetic surgery adverts targeting vulnerable people*. Retrieved from https://baaps.org.uk/media/press_releases/1591/baaps_statement_on_cosmetic_surgery_adverts_targeting_vulnerable_people

¹⁸Liss, P. E. (2000). Setting goals in health promotion. A conceptual and ethical platform. *Medicine, Health Care and Philosophy*, 3(2), 169–173.

¹⁹Davis, F. D., & Crowe, S. J. (2009). Organ markets and the ends of medicine. *Journal of Medicine and Philosophy*, 34(6), 586–605.

²⁰Arras, J. D. (2001). A method in search of a purpose: The internal morality of medicine. *Journal of Medicine and Philosophy*, 26(6), 643–662; Callahan, D. (1996). The goals of medicine: Setting new priorities. *The Hastings Center Report*, 26(6), S1–S27; Brülde, B. (2001). The goals of medicine. Towards a unified theory. *Health Care Analysis*, 9(1), 1–13.

²¹Pellegrino, E. D. (2001). The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions. *Journal of Medicine and Philosophy*, 26(6), 559–579.

²²Davis & Crowe, op. cit. note 19, p. 595.

²³Kettner, M. (2008). The authority of desire in medicine. In M. Düwell, C. Rehmann-Sutter, & D. Mieth (Eds.), *The contingent nature of life: Bioethics and the limits of human existence* (pp. 97–108). Dordrecht, the Netherlands: Springer, p. 103.

²⁴Liss, op. cit. note 18.

²⁵Miller, F. G., & Brody, H. (2001). The internal morality of medicine: An evolutionary perspective. *The Journal of Medicine and Philosophy*, 26(6), 581–599, p. 596.

²⁶Callahan, op. cit. note 20.

²⁷Ibid: S9–S13. For other formulations or lists of medical goals, see Brülde's (2001) article, op. cit. note 20. The author cites various sources of goals of medicine that include laws and policy documents, health outcome measures, and specific descriptions of medical practices.

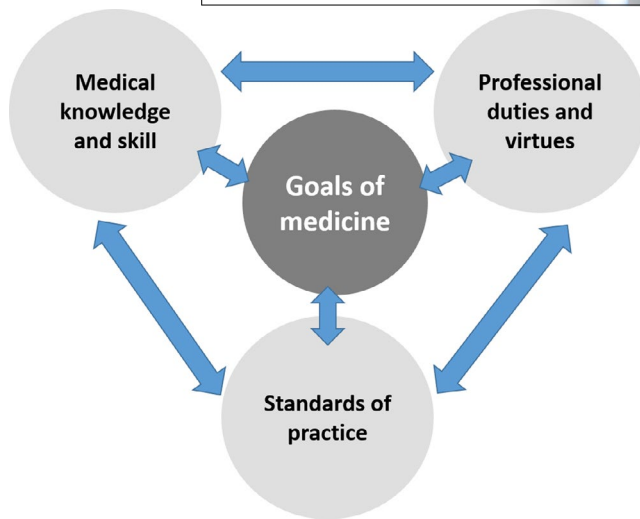


FIGURE 1 The proposed ethical framework consists of the goals of medicine, namely (1) prevention of disease and injury and the promotion and maintenance of health, (2) the relief of pain and suffering caused by maladies, (3) the care and cure of those with a malady and care of those who cannot be cured, and (4) avoidance of premature death and the pursuit of a peaceful death; and the ancillary ethical concepts, namely (1) medical knowledge and skills, (2) standards of clinical practice and (3) professional duties and virtues

when considered alongside ancillary ethical concepts, which are implicit normative assumptions that underpin elements of medical practice. These ancillary ethical concepts are medical knowledge and skills, standards of practice, and medical duties and virtues, and they inform and are informed by the four goals of medicine as identified by Callahan (see Figure 1). These three concepts help to flesh out the goals of medicine by clarifying the practical mechanisms that guide clinical decision-making. In addition, these ancillary concepts help to provide the basis for a more nuanced and grounded analysis of medical practices, including the practice of pathologizing ugliness in cosmetic surgery. For example, Callahan asserts that medical education should begin and end with a 'serious examination of medical goals: What is it we are trying to do?'²⁸ A physician with sufficient medical knowledge and skills cannot practice ethically if she is not informed by the relevant goals, duties and virtues; and a physician who is virtuous cannot practice ethically if she is not abiding by the standards of practice, and so on.

Medical knowledge and skills, the first set of concepts with ethical salience to the goals of medicine, are acquired through medical education and training spanning three main sectors: undergraduate, postgraduate and the continuing professional development of clinicians.²⁹ According to Swanwick, medical education's primary aim is to produce professionals 'who put patient care above self-interest and develop their expertise over the course of a

lifelong career'.³⁰ Clinicians who choose to specialize are required to undergo residency training, to refine their knowledge and skills through 'competency-based learning'.³¹ Davis and Crowe claim that 'the possession of expert knowledge and experience is a hallmark of medicine as a profession'.³² They assert that clinical decision-making should be based on knowledge of the human organism, 'especially of the mechanisms, signs, and symptoms of health and disease'.³³ Moreover, clinical decisions should also be based on knowledge of the effectiveness of diagnostic and therapeutic interventions. Medical knowledge, then, helps physicians determine how to achieve the goals of medicine, and which of the goals (or a combination thereof) is the most appropriate for a specific patient.

As the second ancillary ethical concept, standards of practice inform and are informed by the goals of medicine as an ethical framework. While I use the term standards of practice, other authors use synonymous terminologies such as 'practice policy, clinical [practice] guideline, practice parameter, clinical pathway, standard, [and] algorithm', among others.³⁴ Standards of practice are explicit statements that describe preferred courses of clinical actions, from various stages of evaluation to determining appropriate interventions.³⁵ Standards of practice codified through clinical guidelines are intended to improve the efficiency of medical interventions and reduce health care costs,³⁶ by synthesizing current knowledge and reducing inappropriate practice variation.³⁷ However, Callahan asserts that rigidly determined standards of practice can conflict with good clinical judgment when standards do not take into consideration individual- and culture-specific variations.³⁸ According to Callahan, the goals of medicine can inform standards of practice that accommodate variations in the treatment of different patient groups, such as the old versus the young, or the chronically ill versus the acutely ill.³⁹

The third of the ancillary ethical concepts relevant to my analysis refers to professional duties and virtues.⁴⁰ A common *prima facie* duty is minimizing harm, which motivates clinical actions that prevent or cure disease, or relieve pain and suffering caused by maladies.⁴¹ Other

³⁰Ibid: 3.

³¹van der Leeuw, R. M., Lombarts, K. M., Arah, O. A., & Heineman, M. J. (2012). A systematic review of the effects of residency training on patient outcomes. *BMC Medicine*, 10(1), 1–11, p. 2.

³²Davis & Crowe, op. cit. note 19, p. 591.

³³Ibid.

³⁴Berg, A. O., Atkins, D., & Tierney, W. (1997). Clinical practice guidelines in practice and education. *Journal of General Internal Medicine*, 12(Suppl. 2), S25–S33, p. S25.

³⁵Berger, J. T., & Rosner, F. (1996). The ethics of practice guidelines. *Archives of Internal Medicine*, 156(18), 2051–2056.

³⁶Saarni, S. I., & Gylling, H. A. (2004). Evidence based medicine guidelines: A solution to rationing or politics disguised as science? *Journal of Medical Ethics*, 30, 171–175.

³⁷Kung, J., Miller, R. R., & Mackowiak, P. A. (2012). Failure of clinical practice guidelines to meet institute of medicine standards: Two more decades of little, if any, progress. *Archives of Internal Medicine*, 172(21), 1628–1633.

³⁸Callahan, D. (1999). Remembering the goals of medicine. *Journal of Evaluation in Clinical Practice*, 5(2), 103–106.

³⁹For the conceptual and methodological problems arising from clinical practice guidelines and evidence-based medicine, see Miles, A., Loughlin, M., & Polychronis, A. (2007). Medicine and evidence: Knowledge and action in clinical practice. *Journal of Evaluation in Clinical Practice*, 13(4), 481–503.

⁴⁰Miller & Brody, op. cit. note 25; Liss, op. cit., note 18; Kenny, N. P., Mann, K. V., & MacLeod, H. (2003). Role modeling in physicians' professional formation: Reconsidering an essential but untapped educational strategy. *Academic Medicine*, 78(12), 1203–1210.

⁴¹Liss, op. cit. note 18.

²⁸Callahan, D. (2012). *The roots of bioethics: Health, progress, technology, death*. New York, NY: Oxford University Press, p. 19.

²⁹Swanwick, T. (2013). Understanding medical education. In T. Swanwick (Ed.), *Understanding medical education: Evidence, theory and practice* (pp. 1–6). Hoboken, NJ: Wiley Blackwell.

common professional duties include being competent with technical and humanistic skills, providing correct information about treatments, or refraining from fraudulent misrepresentation of medicine.⁴² Likewise, medical virtues facilitate clinical decisions that are aligned with the goals of medicine. Medical virtues, such as tolerance and empathy, ensure that physicians are motivated by concern for the patient,⁴³ thereby promoting Callahan's second goal ('the relief of pain and suffering caused by maladies') by enabling medical professionals to comprehend the cause, character and impact of suffering in individual patients.

The practical and ethical criteria of the goals of medicine are not free from criticisms or shortcomings.⁴⁴ Since its publication, the list has been revised and expanded, with some suggestions to explicitly integrate normative concepts (e.g. justice and virtue) into the goals of medicine.⁴⁵ However, the strength of the approach lies in the interplay of the goals and the ancillary ethical concepts, so that each is constrained by the others.

Based on the thick description of the goals of medicine as an ethical framework, a medical practice is ethical if it involves processes, aims or interventions that are consistent with the goals of medicine, as well as with the ancillary ethical concepts. In turn, medical practices whose aims, processes or interventions undermine or contradict these goals and ancillary concepts should be deemed ethically problematic. In the next section, I demonstrate the potential of the thick description of the goals of medicine as an ethical framework in critiquing the practice of pathologizing ugliness.

3 | PATHOLOGIZATION AND COMMERCIALIZATION

The practice of pathologizing ugliness can then be viewed as an inevitable extension of the commercialist tendencies in cosmetic surgery. Cosmetic surgery has often been described as a prime example of 'a private medical market' or 'consumable health care' that is subject to the same market forces as other business enterprises more than any other medical specialty.⁴⁶

The practice of pathologizing ugliness is partly rooted in the historical correlation of beauty and virtue in Western cultural tradition. Ancient Greek philosophers viewed physical beauty as a marker of virtue, if not a condition that leads to a virtuous life. Aristotle, for example, argues that physical beauty reflects the excellence of the body and produce other positive activities or experiences that contribute to human flourishing.⁴⁷ Contemporary societies appear to maintain the correlation between beauty and morality. Social psychologists refer to the notion of the 'halo effect' of beauty to describe a cognitive bias that ascribes positive moral and intellectual attributes to individuals who are attractive.⁴⁸ Correspondingly, the negative counterpart of the halo effect is the (devil's) 'horns effect', which refers to the ascription of vice and/or moral failure to individuals with unattractive features.⁴⁹ Heather Widdows asserts that modern society's obsession with outward appearance results in ugliness—or beauty failure—becoming subject to moral condemnation, with individuals suffering from moral shame if they cannot abide by dominant aesthetic ideals.⁵⁰ The shame and suffering associated with beauty failure potentially contribute to the reframing of ugliness in pathologizing terms.

In cosmetic surgery, pathologizing practices were considered implicit during the early 20th century.⁵¹ In the 1980s, pathologization was made more explicit by cosmetic surgeons' use of the term 'inferiority complex'.⁵² Elizabeth Haiken argues that during this period, cosmetic surgeons attempted to link the inferiority complex to biological or physical characteristics. In particular, physical features that are deemed unattractive were identified as the primary cause of the inferiority complex in some individuals. As a result, cosmetic surgeons gained support from other experts in medicine, including child psychologists.⁵³ What followed was a widespread shift in language, particularly with the use of the term 'deformity' to describe undesired features. According to Haiken, the disease framing of unattractive features made it easier for surgeons 'who saw their function as dealing with serious problems to justify their work, to themselves, to others, and to official bodies such as the American Medical Association and American Board of Surgery'.⁵⁴ Currently, pathologizing claims that appeal to the inferiority complex tend to invoke the notion of well-being, which is reflected in the WHO's definition of health as the complete state of physical, psychological and social well-being.⁵⁵ Edmond's

⁴²Miller & Brody, op. cit. note 25.

⁴³Kenny et al., op. cit. note 40.

⁴⁴See for example, Brülde, op. cit. note 20, p. 5. Brülde revises the goals into a list of seven 'irreducible' components, including goals 'to promote functional ability', 'to promote quality of life' and 'to help patient cope well with his or her condition', among others. Christopher Boorse also offers his own version of goals consisting of seven items split into two main categories, which are 'goals of benefit to the patient' and 'knowledge goals'. Boorse, C. (2016). Goals of medicine. In É. Giroux (Ed.), *Naturalism in the philosophy of health: Issues and implications* (pp. 145–177). New York, NY: Springer, p. 170. Similarly, ancillary ethical concepts such as medical knowledge and skills are increasingly subject to conceptual and ethical analysis. For debates regarding the scientific and social context of clinical knowledge, see Loughlin, M., Buetow, S., Cournoyea, M., Copeland, S. M., Chin-Yee, B., & Fulford, K. (2019). Interactions between persons—Knowledge, decision making and the co-production of practice. *Journal of Evaluation in Clinical Practice*, 25(6), 911–920.

⁴⁵Miller et al., op. cit. note 3; Daniels, N. (1996). Justice, fair procedures, and the goals of medicine. *The Hastings Center Report*, 26(6), 10–12.

⁴⁶Adams, J. (2013). Medicalization and the market economy: Constructing cosmetic surgery as consumable health care. *Sociological Spectrum*, 33(4), 374–389, p. 374.

⁴⁷Heinaman, R. (1993). Rationality, eudaimonia and kakodaimonia in Aristotle. *Phronesis*, 38(1), 31–56.

⁴⁸Gupta, N. D., Etcoff, N. L., & Jaeger, M. M. (2016). Beauty in mind: The effects of physical attractiveness on psychological well-being and distress. *Journal of Happiness Studies*, 17(3), 1313–1325.

⁴⁹Synnott, A. (1993). *The body social. Symbolism, self, and society*. London, UK: Routledge, p. 74.

⁵⁰Widdows, H. (2018). *Perfect me: Beauty as an ethical ideal*. Princeton, NJ: Princeton University Press.

⁵¹Gilman, S. L. (1999). *Making the body beautiful: A cultural history of aesthetic surgery*. Princeton, NJ: Princeton University Press.

⁵²Haiken, E. (1997). *Venus envy: A history of cosmetic surgery*. London, UK: The Johns Hopkins University Press.

⁵³Ibid.

⁵⁴Ibid: 122.

⁵⁵World Health Organization. (2006). Constitution of the World Health Organization. Retrieved from www.who.int/governance/eb/who_constitution_en.pdf

empirical investigation, for example, shows that surgeons in Brazil invoke the broad notion of psychosocial well-being to reclassify some individuals as 'aesthetically suffering'.⁵⁶

More recently, surgeons have employed the medical designation of 'aesthetic pathology', to further pathologize normal variations that are deemed undesirable.⁵⁷ Blum argues that in cosmetic surgery, unattractive but otherwise 'healthy bodies begin to appear 'diseased''.⁵⁸ For example, in describing indications for facial cheek implants, cosmetic surgeons claim that cheek implants help in the 'restoration' and 'rejuvenation' of the ageing face that results in 'midfacial hollowing and a gaunt appearance'.⁵⁹ Naomi Wolf offers 'cellulite' as another example of aesthetic pathology based on the disease framing of variations in normal physiology.⁶⁰ The author claims that cosmetic clinicians have described cellulite or visible fatty deposits in women as pathological, and allegedly caused by 'proliferating [fat] cells' that may be 'disfiguring', 'unsightly', and 'polluted with toxins'.⁶¹ The examples show the ways in which cosmetic surgeons drive the process of pathologization, reframing normal variations using the language of disease, deformity or disfigurement.

Although the unattractive features being pathologized in cosmetic surgery differ from pathological deformities as traditionally defined in mainstream medicine, the distinction is not straightforward. For example, Miller and colleagues argue that cosmetic and reconstructive procedures lie along a continuum, 'without any clear boundary between therapeutic reconstructive surgery for a diagnosable problem and purely cosmetic surgery'.⁶² However, my critique of pathologizing ugliness focuses on features that are free from disease, injury or disorder, but are deemed to be unattractive based on some aesthetic ideal. The use of aesthetic pathology, then, refers not to deformities caused by disorder or injury but to unattractive features that surgeons claim 'can be 'cured' through the use of cosmetic surgery'.⁶³ I argue that pathologizing ugliness in this case implies that 'ugly' features do not involve any functional deformity but are framed as if these features are pathological to establish the legitimacy of cosmetic interventions.

In establishing the purported legitimacy of cosmetic surgery, economic competition further fosters pathologizing practices. According to medical sociologists and anthropologists, the beauty industry has created a strong economic contest that entailed cosmetic surgeons are no longer just competing amongst themselves and other surgeons.⁶⁴ Currently, cosmetic surgeons are now competing with other practitioners in non-medical beauty industries. These non-medical

practitioners include cosmeticians, beauticians and make-up artists, among others. In competing for their market share, cosmetic surgeons increasingly promote themselves as having the legitimate expertise and jurisdiction on beauty. Thus, pathologization of ugliness exists in an economy in which expansive notions of health and disease stimulate demand for aesthetic procedures performed by cosmetic surgeons.

Moreover, the practice of pathologizing ugliness appears to align with other commercialist features of cosmetic surgery. A common commercialist feature is cosmetic surgery's reliance on marketing strategies that contain misleading images and slogans that appeal to emotional vulnerabilities.⁶⁵ Miller and colleagues argue that marketing strategies commonly seen in cosmetic surgery highlight benefits but downplay risks and complications, showing the intent of increasing demand for invasive surgical procedures at the expense of patient safety.⁶⁶

Another commercialist feature of cosmetic surgery refers to 'conversion practices', which are communication strategies used by cosmetic surgeons to 'convert consultations into surgical procedures'.⁶⁷ For example, some patients may visit a cosmetic surgery clinic with minor aesthetic concerns about their appearance, which, through conversion practices, are presented to the patient as medically treatable conditions. Based on her empirical analysis of cosmetic surgeons' discursive practices during initial consultations, Julien Mirivel argues that surgeons tend to convince consumers that the cosmetic procedures are not only desirable but medically necessary.⁶⁸ The author claims that surgeons' communicative performance is not merely educational but mainly persuasive in order to maximize the 'project of 'closing the deal''.⁶⁹ As such, marketing and conversion practices demonstrate the ways in which consultations in cosmetic surgery are driven by interests to increase demand and uptake of cosmetic procedures. Accordingly, the background of commercialist tendencies in cosmetic surgery provides a lens through which one must evaluate the practice of pathologizing ugliness and the ensuing therapeutization of cosmetic surgery.

It must be acknowledged that commercialist tendencies are not exclusive to cosmetic surgery. In practice, medical services can range from providing legitimate care consistent with the goals of medicine at one extreme, and profiteering at the other extreme. Somewhere in the middle, health services can be prone to ethically problematic practices such as overservicing or overselling. The private health market in particular has been criticized as promoting financial considerations over the interest of individuals. For example, authors describe the private health market as a means of providing care, such as diagnosis and treatment, to consumers who can afford to pay for it.⁷⁰ They argue that due to commercial interests, private health care has contributed to the overmedicalization of various concerns, including infertility and sexual

⁵⁶Edmonds, op. cit. note 12, p. 114.

⁵⁷Dolezal, op. cit. note 5; Morgan, op. cit. note 5.

⁵⁸Blum, V. L. (2003). *Flesh wounds: The culture of cosmetic surgery*. Berkeley, CA: University of California Press, p. 13.

⁵⁹Niamtu, J. III. (2008). Accurate and anatomic midface filler injection by using cheek implants as an injection template. *Dermatologic Surgery*, 34(1), 93–96, p. 93.

⁶⁰Wolf, N. (1991). *The beauty myth: How images of beauty are used against women*. New York, NY: William Morrow and Company.

⁶¹Ibid: 226–227.

⁶²Miller et al., op. cit. note 3, p. 358.

⁶³Dolezal, op. cit. note 5, p. 368.

⁶⁴Ghigi, R. (2009). The medicalization of ugliness. *Salute E Società, EN2*, 67–77; Edmonds, op. cit. note 12.

⁶⁵Miller et al., op. cit. note 3.

⁶⁶Ibid.

⁶⁷Bhangoo, K. S. (2014). The art of consultation. *Indian Journal of Plastic Surgery*, 47(2), 167–174, p. 167.

⁶⁸Mirivel, J. C. (2008). The physical examination in cosmetic surgery: Communication strategies to promote the desirability of surgery. *Health Communication*, 23(2), 153–170.

⁶⁹Ibid: 166.

⁷⁰Conrad, P., & Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and Social Behavior*, 45, 158–176.

dysfunction. Although it is beyond the scope of this paper, further analysis may demonstrate the ways in which my ethical critique of pathologizing ugliness extends to private health care and other medical services that promote overservicing or overselling.

4 | ETHICAL CRITIQUE OF PATHOLOGIZING UGLINESS

Here, I demonstrate the ethical conflicts arising from the practice of pathologizing ugliness and the ensuing therapeuticalization of cosmetic surgery. In particular, I discuss incompatibilities between aesthetic judgments and medical judgments using the thick description of the goals of medicine. The practice of pathologizing ugliness implies not only that aesthetic goals are legitimate goals of medicine but also that aesthetic judgments of cosmetic surgeons can be considered as legitimate medical judgments. Based on the ethical and practical criteria of the goals of medicine, I argue that the conflicts between aesthetic judgments and medical judgments are based on incompatibilities in at least three key domains common to clinical practices, namely (a) disease determination, (b) diagnostic evaluation and (c) establishing clinical indication. These domains are overlapping components in the clinical process, which is a complex activity that involves information gathering and clinical reasoning to manage a patient's medical problem.

4.1 | Incompatibility based on disease determination

The first incompatibility focuses on the tendency of the practice of pathologizing ugliness to undercut the clinical reasoning necessary for the process of disease determination that enables clinical practices to be consistent with the goals of medicine. I use the term 'disease determination' to capture the clinical process of initially 'sifting' to assess whether a person has a condition that warrants clinical investigation or intervention.

Disease determination commonly involves establishing an initial differential diagnosis based on history and clinical examination alone, prior to the application of any kind of medical intervention, including diagnostic tests. Clinical interactions that aim to determine the presence of a disease typically begin when a patient seeks medical attention due to a health concern.⁷¹ At the initial consult, the clinical process involves a complex activity that allows a clinician to organize subjective complaints based on history taking, as well as objective findings acquired through the initial physical examination, in order to proceed.⁷²

According to the National Academies of Sciences, Engineering, and Medicine based in the USA, establishing a differential diagnosis follows an 'iterative process of information gathering, information integration and interpretation'.⁷³ Clinicians typically consider 'more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained' in additional diagnostic tests.⁷⁴ Moreover, Siegenthaler and Aeschlimann assert that establishing the differential diagnosis requires careful consideration of various elements of diseases, which include the aetiology or cause, the course of the disease, diagnostic criteria, possible individual expression of the disease, and risk factors, among others.⁷⁵ The authors add that the clinical picture of many disease conditions is often variable, thus requiring robust clinical reasoning by medical practitioners.

The feature of disease determination that I wish to highlight involves the clinical reasoning that determines whether a certain concern has a likely pathological cause that merits further medical investigation. For example, dealing with a complaint of leg pain requires a medical understanding that can distinguish a normal response to physical exertion from a pathological condition. If the leg pain is pathological, adequate medical knowledge should enable doctors to diagnose and establish the cause, severity and complications of the condition. In cases when leg pain is not pathological, such as when it is caused by muscle fatigue after prolonged physical activity, a clinician offers reassurance and may decide that further medical investigation is not warranted. The clinical process of disease determination then involves a clinician's use of her medical knowledge to distinguish the normal from the pathological. Disease determination thus promotes the goals of medicine by providing valid reasons to initiate the clinical process, either by providing possible disease conditions that may be causing the complaint, and by determining whether the complaint merits further medical investigation.

In contrast, the practice of pathologizing ugliness deviates from the ethical medical judgments that promote the goals of medicine by offering a problematic version of disease determination. Critics argue that the pathologization of ugliness is a superficial attempt at creating an appearance of medical legitimacy that simultaneously promotes and obfuscates cosmetic surgery's commercialist tendencies.⁷⁶ Consequently, the process of disease determination in the practice of pathologizing ugliness must be understood in the context of cosmetic surgery as a commercial enterprise. Cosmetic surgery's manipulation of disease concepts is driven, not by robust clinical reasoning, but by the desire to seek legitimacy for cosmetic procedures in order to increase profits.⁷⁷ Ideally, robust clinical reasoning is informed by the appropriate application of medical knowledge and skill. For example, when a patient seeks advice because of a health concern, medical

⁷¹National Academies of Sciences, Engineering, and Medicine. (2016). *Improving diagnosis in health care*. Washington, DC: National Academies Press. I note here that there are cases where clinical interactions are not initiated by patient-reported health concerns. For example, annual examinations involving routine tests for healthy individuals may reveal that an individual has an abnormal test result. The abnormal test result may warrant further investigation, initiating the clinical process in the absence of patient-reported symptoms.

⁷²Siegenthaler, W., & Aeschlimann, A. (2007). *Differential diagnosis in internal medicine: From symptom to diagnosis* (Vol. 485). New York, NY: Thieme Stuttgart.

⁷³National Academies of Sciences, Engineering, and Medicine, op. cit. note 71, p. 32.

⁷⁴National Academies of Sciences, Engineering, and Medicine, op. cit. note 71, p. 32.

⁷⁵Siegenthaler & Aeschlimann, op. cit. note 72.

⁷⁶Dolezal, op. cit. note 5.

⁷⁷Miller et al., op. cit. note 3.

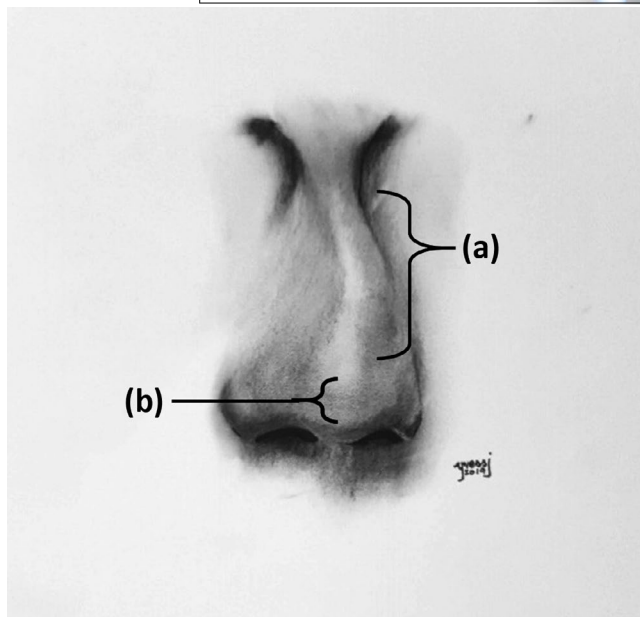


FIGURE 2 A fractured nose with apparent bony deformity involving deviation of the dorsum (a) and nasal tip (b) from the midline

knowledge and clinical reasoning should help clinicians determine whether the concern involves a disease condition that warrants further investigation. In addition, medical knowledge and clinical reasoning should help clinicians to distinguish normal variations or normal responses from pathological states. However, commercialist tendencies exemplified by the marketing and conversion practices as described above compromise medical knowledge and clinical reasoning by promoting a simplistic understanding of disease.

To illustrate the issue of disease determination, I compare cases of a pathological nasal deformity and a pathologized nasal feature (due to aesthetic reason). An example of deformity is nasal fracture caused by blunt injury (see Figure 2). Common signs and symptoms associated with nasal fracture include bony deformity, swelling in surrounding areas, and obstruction of the nasal airway.⁷⁸ One way to classify the severity of nasal fracture takes into account the extent of deviation from the midline, which is assessed through physical examination and confirmed using X-ray imaging.⁷⁹ In contrast, an example of a pathologized nasal feature is a 'bulbous' nose, described by surgeons as nasal tips that are 'too wide'.⁸⁰ According to surgeon Dr Michael Evan Sachs, one possible cause of the 'aesthetic pathology' is a 'mass of tissue in between the 'body' of the cartilages that are widening the tip'.⁸¹ The surgeon does not

provide further information on what counts as 'too wide'. Bulbous nasal tips are not associated with dysfunction nor caused by a developmental disorder, injury or disease. However, cosmetic surgeons appear to refer to bulbous nasal tips as deformities to demonstrate that surgical modification is a valid, if not necessary, intervention.

The process of disease determination becomes a means to justify the use of diagnostic and therapeutic interventions for cosmetic purposes, rather than the result of the iterative process that integrates information and observation from an initial consult. Consequently, the practice of pathologizing ugliness compromises the ancillary ethical concept of robust medical knowledge and skills that make clinical practices consistent with the goals of medicine. Hence, aesthetic judgments that underpin the pathologization of ugliness appear incompatible with the thick description of the goals of medicine.

4.2 | Incompatibility regarding diagnostic evaluation

The second incompatibility between aesthetic judgment and medical judgment is with regards to diagnostic evaluation. Diagnostic evaluation refers to the use of tools, procedures or examinations to evaluate or establish a pathology. Diagnostic tests help to narrow the differential diagnosis, establish the cause of the symptoms, or confirm the presence of disease (if initial evaluation points to a specific condition). Additionally, diagnostic evaluation guides medical decision-making by providing clinicians with the means to evaluate disease progression and to determine therapeutic aims.⁸² In some cases, diagnostic tests facilitate decisions to transition from curative interventions to palliative care (for example, in the case of terminal conditions), reflecting the different components of the goals of medicine as stated in Callahan's list.

One key feature of diagnostic evaluation is objectivity in employing clinical tests or examinations. Objectivity of diagnostic evaluation is based on the collective production of evidence involving inter-laboratory studies, clinical trials and research consortia, among others.⁸³ Objectivity in diagnostic tests should demonstrate 'a sufficient degree of reliability and validity', with the former referring to consistency and replicability of test results and the latter to the accuracy of a clinical test in 'measuring what it is purporting to measure'.⁸⁴ Objectivity in diagnostic evaluations helps to minimize variability due to human error through the standardization of diagnostic tests, which are generally codified in clinical practice guidelines.⁸⁵ Standardized diagnostic practices allow medical professionals to make decisions and perform actions that are consistent with medically related goals of treating disease, preventing injury or providing

⁷⁸Koh, J. H., Bhatti, O., Mahmood, A., & Agar, N. (2016). Traumatic nasal injuries in general practice. *Australian Family Physician*, 45(9), 650–653.

⁷⁹Park, J., Suhk, J., & Nguyen, A. H. (2015). Nasal analysis and anatomy: Anthropometric proportional assessment in Asians—aesthetic balance from forehead to chin, Part II. *Seminars in Plastic Surgery*, 29(04), 226–231.

⁸⁰McKinney, P. (2000). Management of the bulbous nose. *Plastic and Reconstructive Surgery*, 106(4), 906–917.

⁸¹Sachs, M. E. (2006). *Mastering revision rhinoplasty*. New York, NY: Springer-Verlag, p. 211.

⁸²Bruno, P. (2011). The importance of diagnostic test parameters in the interpretation of clinical test findings: The Prone Hip Extension Test as an example. *The Journal of the Canadian Chiropractic Association*, 55(2), 69–75.

⁸³Cambrosio, A., Keating, P., Schlich, T., & Weisz, G. (2006). Regulatory objectivity and the generation and management of evidence in medicine. *Social Science and Medicine*, 63(1), 189–199.

⁸⁴Bruno, op. cit. note 82, p. 69.

⁸⁵Lee, B., Lee, J. S., Lee, Y.-W., Jang, M., Song, J., Kim, J.-H., ... Lee, Y. K. (2018). Effect of the standardization of diagnostic tests on the prevalence of diabetes mellitus and impaired fasting glucose. *Journal of Korean Medical Science*, 33(10), 1–10.

care.⁸⁶ Thus, diagnostic evaluation that informs ethical medical judgments depends on notions of objectivity and standardization.⁸⁷

Based on the idea of objective diagnostic evaluation to inform ethical medical judgments, can aesthetic evaluation embedded in the practice of pathologizing ugliness fulfil the same function? Diagnostic evaluation of aesthetic concerns is less straightforward than evaluation in uncontroversial disease conditions. According to plastic surgeons Johanna D'Agostino and Marek Dobke who are based in the USA, cosmetic surgery is scientific and objective, using 'an evidence-based approach' to evaluate concerns and formulate recommendations.⁸⁸ Although the authors admit that beauty is defined as a subjective notion, they maintain that subjectivity regarding beauty only means that 'less hard-core scientific evidence is needed ... for the decision-making process'.⁸⁹ However, the authors' interpretation of aesthetic objectivity as 'less hard-core' is too generous and fails to capture the non-objective, non-standardized foundations of aesthetic evaluation.

As a response to the charge that aesthetic evaluation is subjective, the practice of pathologizing ugliness has increasingly involved the use of allegedly valid diagnostic tests to evaluate aesthetic concerns. Cosmetic surgeons discuss the face and the body in aesthetic microunits that lend the practice an air of objectivity.⁹⁰ Blum claims that surgeons elaborate on the nasal angle, for example, based on the distance between the nasal base and the lips, as well as the width of the nasal base in relation to the width of the lips.⁹¹ The author adds '[Cosmetic surgeons] divide the face into thirds and measure the relative proportions. If the bottom third is too short, they believe they should add a chin implant or move the lower jaw forward'.⁹² Another example is the aesthetic evaluation of ear protrusion. Protrusion is associated with projection of the helix, or upper third of the external ear, at a greater than '30-degree angle from the scalp'.⁹³

In reality, perceived unattractiveness is difficult to diagnose in precise terms.⁹⁴ For example, additional details about the aesthetic pathology of an ear reveal that most criteria tend to be less clearly specified. For example, aesthetic pathology of an ear can be described as 'inadequate' formation of the antihelical fold or conchal excess that result in ear protrusion or prominence (see Figure 3).⁹⁵ No quantitative

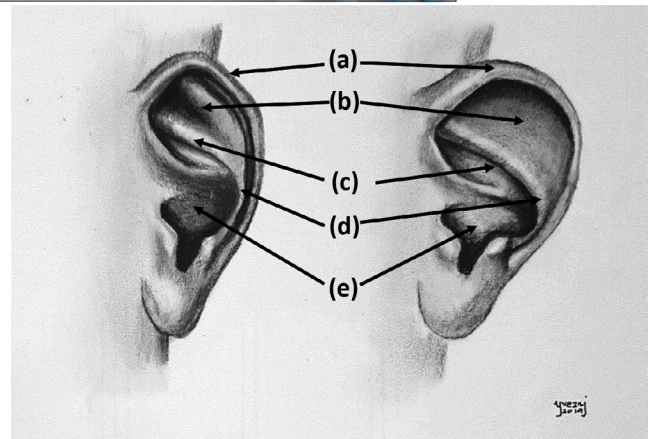


FIGURE 3 Anatomical descriptions of protruding ears include aesthetic deviations in the helix (a), antihelical fold (d) and concha (e). The antihelical fold splits into the superior crus (b) and inferior crus (c). Compared to a 'normal' ear (left), a protruding ear (right) is commonly associated with flattened superior crus and/or elongated helix

criteria for assessing adequacy or excess are provided. Another example is the diagnostic evaluation of 'eyebags', also referred to as dermatochalasis or periorbital puffiness.⁹⁶ There is no standardized way to determine at which stage some puffiness under the eyes may be classified as dermatochalasis, thereby becoming a concern amenable to surgical intervention. These examples show that cosmetic surgery's claims about objectivity are not sufficiently robust, reflecting the imprecise character of aesthetic concerns.

Furthermore, despite the attempts at standardizing reference values for diagnostic evaluation, aesthetic judgment is highly variable among individual cosmetic surgeons.⁹⁷ In her research involving cosmetic surgeons in the USA, Virginia Blum asks, 'Whose aesthetic prevails?'⁹⁸ The author claims that surgeons tend to reproduce a particular look on every face or body they operate on, indicating not only an imprecise but also an individualistic view about aesthetic judgments in cosmetic surgery. According to Blum, 'There's a surgeon whose face-lifts I would recognise anywhere. His procedure is always the same: yank up that brow, stretch the back those nasolabial folds, insert ... implant into the chin'.⁹⁹ In addition, the author contends that cosmetic surgeons see individuals with an aesthetic gaze that is simultaneously normative and transformative, with many surgeons acknowledging that they tend to look at people outside clinical interactions with an eye to the features that they deem can be modified or improved. Meredith Jones' empirical research involving cosmetic surgery practice in Australia reveals a similar pattern of variations in professional aesthetic judgment.¹⁰⁰ In particular, the author asserts that such variabil-

⁸⁶Randall, G., & Taylor, D. W. (2000). Clinical practice guidelines: The need for improved implementation strategies. *Healthcare Management Forum*, 13(1), 36–42.

⁸⁷Here, I am appealing to a simplified and idealistic notion of diagnostic practices and medical objectivity. Clearly, there are medical subspecialties that rely on diagnostic practices with subjective criteria. Generally, medical conditions involve diagnostic criteria that are standardized in ways that appeal to notions of objectivity.

⁸⁸D'Agostino, J., & Dobke, M. (2017). A plastic surgeon's perspective on stereotyping and the perception of beauty. In M. P. Levine (Ed.), *Perception of beauty* (pp. 173–188). London, UK: InTech, p. 185.

⁸⁹Ibid: 185.

⁹⁰Blum, op. cit. note 58.

⁹¹Ibid.

⁹²Ibid: 38.

⁹³Janis, J. E., Rohrich, R. J., & Gutowski, K. A. (2005). Otoplasty. *Plastic and Reconstructive Surgery*, 115(4), 60e–72e, p. 62e.

⁹⁴Haiken, op. cit. note 52.

⁹⁵Ibid.

⁹⁶Vij, A., & Bergfeld, W. F. (2015). Madarosis, milphosis, eyelash trichomegaly, and dermatochalasis. *Clinics in Dermatology*, 33(2), 217–226.

⁹⁷Blum, op. cit. note 58; Jones, M. (2008). *Skintight: An anatomy of cosmetic surgery*. Oxford, UK: Berg.

⁹⁸Blum, op. cit. note 58, p. 14.

⁹⁹Ibid.

¹⁰⁰Jones, op. cit. note 97.

ity of aesthetic judgments is demonstrated by the self-appointed role of cosmetic surgeons as artists. Jones claims that based on her analysis of advertising materials of cosmetic surgery clinics, surgeons even refer to artistic hobbies, such as painting and photography, as if such hobbies lend credence to their surgical skills.¹⁰¹ On this account, aesthetic evaluation cannot commit to objective standards, demonstrating a possible tension between aesthetic judgments and legitimate medical judgments. This failure to ensure objective standards is further complicated by the commercial nature of cosmetic surgery.

As a commercial enterprise, cosmetic surgery appears to foster the variability of aesthetic evaluation.¹⁰² The reliance on variable aesthetic evaluations seems to indicate that in pathologizing ugliness, practitioners readily dispense with notions of reliability and validity inherent in diagnostic tests in other medical specialties. Thus, cosmetic surgery's 'professional' aesthetic evaluation potentially undermines the task of establishing standards of practice that help synthesize knowledge, reduce inappropriate practice variation and improve safety of health care. In the absence of standards of practice, it is difficult to ensure that medical interventions are aligned with the goals of medicine, including prevention of injury or relief of pain and suffering caused by maladies. As such, the practice of pathologizing ugliness cannot guarantee that the diagnostic evaluations for aesthetic concerns are consistent with the thick description of the goals of medicine.

4.3 | Incompatibility regarding clinical indications

The third incompatibility between aesthetic judgment and medical judgment is with regards to establishing clinical indications. Clinical indications, which refer to a threshold that determines whether a person has a condition requiring medical intervention (diagnostic or therapeutic), are based on the information gathered during the initial process of disease determination and diagnostic evaluation. Clinical indications are established by clinicians based on 'the facts, opinions, and interpretations about the patient's physical and/or psychological condition that provide a reasonable basis for diagnostic and therapeutic activities aiming to realize the overall goals of medicine.'¹⁰³ Clinical indications are then potentially relevant when evaluating clinical practices based on the thick description of the goals of medicine.

Whether or not an intervention is clinically indicated depends on the balance of benefits and harms.¹⁰⁴ The evaluation of benefits and harms, in turn, is informed by medical knowledge and standards of practice and is constrained by professional virtues and duties. Ethical reasoning about clinical indications should avoid 'disproportionate harms that are not balanced by the prospect of compensating medical benefits'.¹⁰⁵ Miller and colleagues assert that the duty to avoid dispro-

portionate harm requires medical professionals to have medical virtues of integrity and good conduct.¹⁰⁶ Both medical duties and virtues, along with regulatory and legal constraints, help to ensure that doctors' decisions and actions are performed in pursuit of the goals of medicine. In turn, the notion of clinical indications encourages clinicians to think carefully about whether interventions are necessary, and which interventions are appropriate for a given patient.

In the practice of pathologizing ugliness, aesthetic indications are presented as clinical indications for cosmetic procedures.¹⁰⁷ Aesthetic indications arise in the form of aesthetic discomfort as reported by patients, or aesthetic flaws as determined by cosmetic surgeons. There is a leap from aesthetic to clinical that is concealed by the use of medical jargon to describe alleged aesthetic pathology that requires a range of cosmetic interventions. As such, aesthetic indications must be further evaluated given the context of cosmetic surgery as a commercial enterprise.

One implication of pathologizing ugliness is that medical judgments need not be informed by medical knowledge or skill since aesthetic flaws can be manufactured easily through conversion and marketing practices. Conversion practices in cosmetic surgery can take advantage of negative self-perception experienced by individuals who feel physically inferior to idealized images, which are popularized through mass and social media. For example, a recent trend has seen the increase in uptake of cosmetic surgery due to social media, which offer apps that allow users to edit and filter their photographs to achieve an ideal look.¹⁰⁸ For example, scholars argue that social media apps drive individuals to seek cosmetic surgery to look like filtered versions of themselves.¹⁰⁹ It is likely that during clinical consultations, conversion practices translate negative self-perception into allegedly legitimate clinical indications to promote an interventionist approach to aesthetic concerns. Cosmetic surgeons frame aesthetic indications as serious concerns that merit 'treatment' while downplaying the risks and complications that come with medical and surgical interventions.¹¹⁰ Serious complications can involve wound infection, nerve damage, or death.¹¹¹

The use of aesthetic indications to justify potentially harmful interventions contradicts the goals of medicine. In particular, subjecting patients to injury on the basis of flaws manufactured by surgeons is in conflict with Callahan's first goal, which is the 'prevention of injury and the promotion and maintenance of health'.¹¹² Furthermore, the practice of pathologizing ugliness that relies solely on surgeon-identified aesthetic indications compromises ancillary ethical concepts as sources of constraint that guide ethical medical judgment. Relying on aesthetic

¹⁰¹Ibid.

¹⁰²Dolezal, op. cit. note 5.

¹⁰³Jonsen, A. R., Siegler, M., & Winslade, W. J. (2010). *Clinical ethics: A practical approach to ethical decisions in clinical medicine* (7th ed.). New York, NY: McGraw-Hill, p. 10.

¹⁰⁴Ibid.

¹⁰⁵Miller et al., op. cit. note 3, p. 354.

¹⁰⁶Ibid.

¹⁰⁷Hyman, D. A. (1990). Aesthetics and ethics: The implications of cosmetic surgery. *Perspectives in Biology and Medicine*, 33(2), 190–202.

¹⁰⁸Brown, Z., & Tiggemann, M. (2016). Attractive celebrity and peer images on Instagram: Effect on women's mood and body image. *Body Image*, 19, 37–43.

¹⁰⁹Youn, A. (2019). What is the ideal Instagram filter? *Aesthetic Surgery Journal Open Forum*, 1(2), 1–8.

¹¹⁰Miller et al., op. cit. note 3.

¹¹¹Khunger, N. (2015). Complications in cosmetic surgery: A time to reflect and review and not sweep them under the carpet. *Journal of Cutaneous and Aesthetic Surgery*, 8(4), 189–190.

¹¹²Callahan, op. cit. note 20, p. S10.

indications to justify interventions implies that medical judgments do not have to depend on virtues of honesty and integrity to ensure patient safety, and that notions of (ill-defined) aesthetic flaws easily justify potentially harmful surgical interventions. In compromising knowledge, duties and virtues that constrain medical judgments, appeal to aesthetic indications undercuts the ability of medical professionals to ensure that medical or surgical interventions are consistent with the goals of medicine.

Moreover, the practice of pathologizing ugliness promotes an interventionist approach by appropriating therapeutic concepts from mainstream medicine. Aesthetic indications that underpin therapeuticization of cosmetic interventions are now being used to justify 'preventative' measures for cosmetic purposes. Cosmetic surgeons in the USA currently advertise 'early interventions' that allegedly improve the longevity of cosmetic modifications.¹¹³ Surgeons claim that since younger skin is more elastic, early interventions will require less extensive and less frequent surgeries than interventions performed on bodies at older ages. Blum argues that the consequence, which may be bad for the patient but good for the surgeon's income, is that early intervention will 'require maintenance'.¹¹⁴ In cases of face lifts, dermal fillers can be marketed as preventative, in a sense that the fillers are meant to delay the appearance of crow's feet or wrinkles around the eyes—even if a problem does not yet exist at the time of the consult. Such cosmetic procedures are now being performed in younger individuals with the aim of delaying the appearance of visible signs of ageing. The example illustrates the manner by which cosmetic surgery manipulates our understanding of health and disease by appropriating established therapeutic norms, such as prevention, from mainstream medicine. Additionally, the example shows the role of aesthetic indications in enabling interventionist tendencies, which further demonstrates the way in which pathologizing ugliness undermines the goals of medicine.

5 | CONCLUSION

In sum, the thick description of the goals of medicine can help clarify the practical and ethical limits of medical practice against which to evaluate the practice of pathologizing ugliness and the ensuing therapeuticization of cosmetic interventions. As an ethical framework, the goals of medicine are strengthened by considering them alongside ancillary ethical concepts, specifically professional duties and values, medical knowledge and skills, and standards of practice. I argued that based on this ethical framework, the practice of pathologizing ugliness raises ethical conflicts between aesthetic judgments

and medical judgments on the levels of disease determination, diagnostic evaluation and establishing clinical indications.

A practical implication of my critique that focuses on pathological framing of ugliness is the need for a nuanced and robust regulatory framework for cosmetic surgery. A nuanced framework implies a set of regulations that go beyond ensuring that procedures are safe, and that patients have proper recourse when malpractice occurs (although these measures are necessary in their own right). Regulations should also look into the communication practices, from textbook definitions to marketing materials, that underpin and promote the ethically problematic practice of pathologizing ugliness and unwarranted therapeuticization of aesthetic interventions.

Another implication of my critique potentially goes beyond cosmetic surgery. Further analysis could demonstrate the ways in which the ethical framework developed in this paper can be applied to mainstream medical practices and private health market that may be prone to overservicing or overselling.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

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¹¹³Blum, op. cit. note 58, p. 72.

¹¹⁴Ibid.