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Slathered, Zapped, Nipped, and Tucked: An Ethical Analysis of Cosmetic Dermatology

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Slathered, Zapped, Nipped, and Tucked: An Ethical Analysis of Cosmetic Dermatology

Abstract

It has become common practice for dermatologists to offer cosmetic enhancing products and procedures and to do so alongside the medically required services offered (e.g., annual skin checks, treatment of rashes, removal of pre-cancerous moles, etc.). As a patient, it is likely that a visit to the dermatologist will include exposure to advertisements for these cosmetic products and procedures. Advertisements are found in the waiting area, examination room, and, in some cases, even at checkout in the form of a coupon for future use, all situated where the patient is a captive audience. This practice may not be the cause of our society's ubiquitous focus on beauty as perfection; however, these practices arguably contribute to this culture, harming not only individual patients but also society as a whole. Further, since the physician's endorsement of these products and procedures carries added weight, above and beyond that of a normal citizen or another non-medical professional, the impact on perpetuating a culture of beauty as perfection is even greater.

Given this, in this essay I argue that the practice of dermatologists advertising, offering, and profiting from cosmetic enhancing products and procedures is unethical, violating the most basic bioethical principles. To demonstrate how this is the case I unpack how the culture of beauty as perfection is oppressive and therefore problematic; how dermatologist feed into, perpetuate, and profit from this culture; and how this practice is an ethical violation. Central to my analysis is an account of the commonly accepted bioethical principles within a framework of a social conception of the self. The implications of this analysis and findings include a need for clear guidelines offered by various medical oversight associations including the American Academy of Dermatology (AAD), the American Society for Dermatological Surgery (ASDS) and the American Medical Association (AMA). These guidelines should reflect a robust ethical analysis of this practice, ideally in conversation with the analysis offered herein. Once offered, physicians should follow these guidelines and, until then, should proceed with an abundance of caution, ideally ceasing to advertise, promote, or use biotechnologies in their practices for solely cosmetic reasons until more nuanced guidelines are available.

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SLATHERED, ZAPPED, NIPPED, AND TUCKED: AN ETHICAL ANALYSIS OF COSMETIC DERMATOLOGY

BARBARA J. LOWE, PHD

Abstract

It has become common practice for dermatologists to offer cosmetic enhancing products and procedures and to do so alongside the medically required services offered (e.g., annual skin checks, treatment of rashes, removal of pre-cancerous moles, etc.). As a patient, it is likely that a visit to the dermatologist will include exposure to advertisements for these cosmetic products and procedures. Advertisements are found in the waiting area, examination room, and, in some cases, even at checkout in the form of a coupon for future use, all situated where the patient is a captive audience. This practice may not be the cause of our society's ubiquitous focus on beauty as perfection; however, these practices arguably contribute to this culture, harming not only individual patients but also society as a whole. Further, since the physician's endorsement of these products and procedures carries added weight, above and beyond that of a normal citizen or another non-medical professional, the impact on perpetuating a culture of beauty as perfection is even greater.

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Introduction

Inspire me with love for my art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures.

- Maimonides

Sandra Bartky, a recently deceased feminist philosopher, astutely analyzed and critiqued the lived experience of women in society, offering a phenomenological account of the contemporary experience of being a woman. One insight she offered was that, in regard to her appearance, women seem to have a “virtual duty” to “make the most of what we have” and use all available resources and technologies to do so. This “duty” assumes that it is, as Bartky describes it, within women’s power to make themselves “. . . look better—not just neater and cleaner, but prettier, and more attractive.” This leads to “intimations of inferiority” where the body is the source of one’s value and where whatever body one happens to have is “. . . never sufficient unto itself, stands forever in need of plucking or painting, of slimming down or fattening up, of firming or flattening” (Bartky 1990, 22-32). At first, the judgment of “inferiority” is externally located, ubiquitously found throughout our culture, especially in mainstream entertainment mediums. However, with time and repetition, this judgment of inferiority is internalized into the psyche of the woman. When this occurs, Bartky notes, the individual experiences a kind of psychological oppression, where the individual is “. . . weighed down in [her own] mind,” exercising “harsh domination” over her own self-esteem (22).

In our culture of perfection in which images found on social media, on television, in magazines, and on the Internet are edited, trimmed, and reshaped to make the model look flawless, it is not surprising that this feeling of being “weighed down” is ubiquitous.¹ These unrealistic images are everywhere, woven into our consumer-driven culture, offered to us in order to encourage the purchase of particular products that promise similar results for the user. Further, these images and the products represented are typically gendered according to norms of masculinity and femininity, encouraging boys and men to be tough, independent, and action-focused and girls and women to be docile, sexy, dependent, and fashion-focused.²

In itself, this situation is already ethically suspect, relying on the exploitation of the vulnerable in order to profit from the individual need to address some perceived flaw or weakness.³ However, it is even more disconcerting to imagine that the medical community also participates in creating, exploiting, and profiting from this culture of physical perfection. With this in mind, I am interested in evaluating the ethics of the increasingly common practice of medical dermatologists advertising and offering enhancement products and procedures⁴ as part of their practice. I will ultimately argue that both the offering of and the advertising of procedures and products for cosmetic enhancement reasons is ethically wrong. Medical advertising is particularly suspect as it contributes to and profits from the already prevalent culture of perfection discussed above and, if the advertisements occur in the medical practice, targets a captive audience not themselves seeking out and inquiring about cosmetic options.⁵

As physicians, dermatologists offer messages that have an added prestige and carry an additional force in society.⁶ Because of this, these messages have weighted influence on how the public (and the physician’s patients) receives them. The physician has the potential to reinforce, diminish, or otherwise mitigate the power of the norms of society. However, when a physician uses this power in a way that reinforces and perpetuates problematic societal norms, we must ask ourselves whether doing so is ethically permissible. In this case, the answer is an emphatic no.

It is not ethically permissible because the norms being perpetuated and from which the dermatologists then profit are not conducive to fostering the health of the individual or the society as a whole. Instead of profiting from this culture of perfection, dermatologists should be using their influence to highlight and critically consider it. To put this in bioethical terms, dermatologists violate the principle of nonmaleficence when they advertise cosmetic products and procedures in their medical practice, subjecting their patients, a captive audience, to additional messages that their body, as Bartky said, is not “sufficient unto itself.” This potentially harms the patient psychologically and increases the likelihood that the patient will choose to undergo cosmetic procedures, which, since many of these procedures come with certain risks, could cause them medically unnecessary physical harm. While, arguably, dermatologists did not create this culture of perfection that results in the “intimations of inferiority” that can lead to psychological oppression, they are certainly feeding into it when they advertise and sell products that reinforce the previously discussed problematic norms of society. They are taking advantage of the virtual duty that women have come to believe they have, offering biotechnology applications within cosmetic dermatology that sometimes seem without limit. Affordability need not even be a limitation as it is possible to finance the procedures much like one might finance the purchase of a car or other consumer good.

When physicians choose not to use their powers of influence to turn a critical eye on this culture they fail in terms of the principle of beneficence as they are failing to promote the well-being of individuals and of society. To understand how this analysis holds true requires that we look a bit more closely at the principles of bioethics and couple this with careful considerations of how conceiving of the self as necessarily social makes clear, in ways that might otherwise be obscure, the ethically problematic nature of this practice.

Principles of Biomedical Ethics & a Social Concept of the Self

As noted in the *Code of Medical Ethics* created and promoted by the American Medical Association, “a physician must recognize responsibility to patients first and foremost . . .” and, according to the AMA first principle of medical ethics a physician must “. . . be dedicated to providing competent medical care, with compassion and respect for human dignity and rights” (American Medical Association). Similarly, a commonly accepted and often-repeated ethical command in medicine is that the physician should “. . . make the habit of two things—to help, or at least to do no harm.”⁷ These principles are encompassed in the standard four principles of bioethics. These include: autonomy, beneficence, nonmaleficence, and justice.⁸

On the one hand, these principles seem pretty straightforward. However, what they require of a physician depends in part on how we conceive of the self and the self in relation to other beings and institutions. If we were to see the self as, idealistically, an atomistic self, functioning best when acting independently, rationally, and unimpeded by emotion or situational context, then how we define the concept of autonomy and how we conceive of what it means to harm, to promote well-being, and to advocate for justice would be skewed in certain ways. More specifically, these principles would focus on assuring independence and individual autonomy, prioritizing the individual’s right to choose for him or herself. To do this, the practicing physician would insist

on patients being fully informed, with an understanding of the various aspects of the procedures being considered, and would want to make sure the decisions made were rational ones, made with realistic expectations of the probable outcomes and with the ability to articulate why his or her choice makes sense given his or her situations and his or her particular desires. Once autonomy is secured through understanding and informed consent, the goal would then be to assist that individual in actualizing his or her desired outcome, whether that be Botox-enhanced lips, skin tone treatment, or, among other things, fat-emulsifying Ionithermie.⁹

The priority would be to promote individual actualization, to the extent that this is possible, and to do this would require attending primarily to the individual's stated wants and needs.¹⁰ With this focus, to harm the patient or to benefit the well-being of the patient would primarily be an isolated question, honing in on the individual's stated wants and needs alone rather than critically considering the larger context in which the individual lives, makes decisions, and formulates the wants and needs that guide his or her decisions.

Similarly, an atomistic conception of justice becomes a matter of ensuring individual rights and perhaps only a weak nod to the outside influence that societal norms, such as the culture of perfection, have on the individual. Justice then is a matter of moving toward equal access of all individuals to all available technologies and doing this without a deeper critique of the ethical parameters of the use of these technologies from a broader point of view.

Thus, in the context of enhancement technologies and considerations of justice, the physician addresses inequalities in society as a whole by, for example, offering payment plans or discounts to lower-income individuals so that they too can benefit from the biotechnologies used in the field of cosmetic dermatology. They may also, in the interest of justice individualistically conceived, offer medical treatment for free or at reduced rates for those who might not otherwise be able to afford these services.¹¹ In other words, with an atomistic conception of the self, issues of justice become a matter of clearing the way for the individual to have access to the same enhancement tools and technologies as individuals better situated economically.

Similarly, with the atomistic conception of the self, the principle of autonomy would require that the patient is informed, gives consent, and is not being "unduly influenced" where being "unduly influenced" is defined by some practitioners in the field as occurring when ". . . an individual who is in a more powerful position persuades a more vulnerable individual to do something that he or she would not have done otherwise" (Imadojemu 2012, 138). While situating this analysis within a social conception of the self leads to a broad definition of "undue influence," including not only the influence of individuals in positions of greater power than the patient but also the influence of advertisements on the patient as well as society as a whole, an analysis of "undue influence" within an atomistic conception of the self may arguably be more narrow, focusing on influence that is directed by an individual toward another individual (e.g., a particular physician toward a particular patient during a particular moment). As long as this narrower conception of "undue influence" is met, the patient is informed about the procedure, and the patient consents to the procedure to be performed, then this is enough for the physician to move forward. In fact, it may even

be ethically required for the physician to do so in order to facilitate the achievement of the patient's stated wishes and thereby promote the patient's autonomy.

In this conception, offering cosmetic procedures and products to patients can become, oddly, an ethically praiseworthy act, empowering the patient to meet both cultural standards of actualization as well as the individual's internalized versions of the same. As a result of the enhancement services offered, the individual fits better in society, perhaps even receives certain social and career benefits for doing so, and may experience a greater sense of individual well-being.¹² Marking this as ethically praiseworthy based on this analysis, however, assumes that the social norms to which the patient is now conforming are in themselves ethically acceptable, and, further, it assumes that the physician has no role to play in critically examining the status quo of society as part of their medical practice.¹³

In contrast, if we understand the self to be a social self, always "in-process" and necessarily contextualized within discursive, co-constitutive transactions,¹⁴ then we come to see the roles and responsibilities of the dermatologist differently. First, how the bioethical terms are understood are more nuanced and interrelated than with the atomistic understanding. What it means to respect autonomy, promote the well-being, and prevent the harm of the patient becomes inexorably connected with critical questions applied to society as a whole. It is no longer enough to ascertain the individual's wishes and wants and assure that they are fully informed and not obviously coerced. Rather, it becomes imperative to consider as well the situation from a social context. One must not only consider what the individual states he or she wants, but also question where and why these wants and wishes emerged. We must ask if the context from which they have emerged is conducive to full human flourishing and ameliorations for all, and we must attempt to mitigate against those situations and those norms that limit opportunities and expectations based on power-related dichotomies (e.g., men over women, citizen over noncitizen, Anglo appearance over other, etc.).¹⁵

In addition, the dermatologist must also consider his or her role in society and in the context of the norms that motivate individuals and society to see cosmetic enhancements as empowerment, as a way to express individual choice rather than for what it is, which is a profit-driven institution that is, through the use of sophisticated advertisement campaigns, manipulating the public's internalized need to conform to the unrealistic cultural codes of beauty and youth.

The physician who understands the implications of a social understanding of the self will fully expect that the thoughts and choices of the patient are already and necessarily deeply informed and influenced by context, and that context includes any information, advertisements, or similar provided by the physician. The question then becomes not whether others have influenced the individual but how this influence is manifest and whether or not the influence is conducive to meaningful self and societal actualization, with the cultivation of active and intelligently engaged social participation rather than routine or unthinking absorption and repetition of what is passively experienced.¹⁶ In other words, it becomes a question of whether the individual is critically and thoughtfully engaged in his or her own construction and the construction of others and of society as a whole.

Thus, when considering the central question of this paper from the perspective of a social understanding of the self, the physician must seek to understand the patient's stated wishes and connected choices from a wider social justice perspective, asking whether the norms, expectations, and values of the social circles from which this individual emerged are constructed so that all individuals in that social context can participate fully and live flourishing lives. In these cases, socialization certainly occurs but occurs with intelligent and critical engagement rather than being passive and routine. With this understanding, we must evaluate the practice of advertising and offering cosmetic procedures with a critical awareness of how that practice is situated within a culture that is problematically gendered (as discussed above) and that values physical perfection over other conceptions of actualization connected with meaningful community engagement.

As noted above, our culture cultivates in individuals a sense that they have a duty to avail themselves of all possible technologies in order to better meet the established norms. Failing to meet these results in a sense of shame and even guilt¹⁷ and can further result in negative social consequences such as, for example, lower pay, missed promotions, and social castigation for those individuals who have not met the standards of beauty embraced by society. These consequences or the possibility of these consequences serve as strong motivation to continue to do all that one can to get closer to the impossible. When we include within the realm of possible "fixes" products and procedures offered by physicians, what is possible continues to expand and what is required in the mind of the individual becomes nearly limitless.

With this more nuanced and interconnected consideration of this issue, we see that advertisements for cosmetic or enhancement procedures by dermatologists can no longer be viewed as an empowering service to the patient, informing them of additional tools available to them in their quest toward the perfection they desire. Rather, the ads must be viewed as part and parcel to the larger context of society in which the culture of perfection has had and continues to have nefarious effects.

Interestingly, while one might assume that the accrediting bodies of dermatology would have addressed this particular issue directly, this is not the case. Instead, organizations such as the American Academy of Dermatology (AAD) and the American Society for Dermatological Surgery (ASDS) have only made gestures toward acknowledging the ethical issues involved and have not addressed it head on, offering no definitive statement on the practice.¹⁸ In addition, the American Medical Association (AMA), while offering opinions on an expansive array of medical related practices in a variety of medical areas of specialty, is silent on the practice of cosmetic dermatology.¹⁹ This should change. The AAD, the ASDS, and the AMA should be more explicit about the regulation of advertising cosmetic procedures and products and should offer guidelines, as it does for other controversial medical topics, for the use of biotechnologies. Further, this essay has, in part, been an argument that any guidelines offered by the governing bodies of medicine and dermatological medicine should be available and, as are other medical guidelines, should be framed by principles of biomedical ethics. Further, how the issue is critically considered should be within a framework of the self as a social being and not atomistic in order to avoid the narrow conception of bioethics that an atomistic conception of the self may yield.

Further, regardless of what the various medical boards and institutions choose to do, individual physicians should, at least until the advisory institutions offer explicit opinions to guide their decisions, refrain from advertising or otherwise promoting cosmetic products and procedures, cease the use of biotechnologies for primarily cosmetic reasons, and lobby their governing medical bodies to state more explicitly positions consistent with these ethical practices related to this topic. Once a physician becomes aware of his or her influence on the norms of society, then the physician has responsibility to act accordingly. One purpose of this work has been to enhance awareness. To the extent that this has occurred, continuing with practice as normal is to neglect one's ethical responsibility.

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Endnotes

1. In a study commissioned by *Dove*, a Unilever Beauty Brand, researchers found that only 2% of women worldwide see themselves as beautiful and, further, that women also see "... beauty and physical attractiveness as increasingly socially mandated and rewarded, with almost two-thirds strongly agreeing that: 'Women today are expected to be more physically attractive than their mother's generation was' (63%); and, 'Society expects women to enhance their physical attractiveness' (60%)." This same study found that "women tend to believe that the popular meanings of beauty and physical attractiveness have become increasingly **narrowed and unattainable**. [...] Further, more than] two-thirds (68%) of women strongly agree that 'the media and advertising set an unrealistic standard of beauty that most women can't ever achieve'" (Etcoff, Orbach, Scott and Agostino 2004, 1-25, esp. 9 and 25).
2. With a focus on children and advertising but arguably similarly applicable to all consumers, the Media Educational Foundation highlights how this is accomplished in their 2008 documentary *Consumer Kids: The Commercialization of Childhood*. The documentary demonstrates how corporations strive to secure "360 degree immersive marketing" in order "to insinuate brands into the fabrics of children's lives" and to do so from "cradle to grave," the goal being to turn the child into a life-long consumer. The focus in this documentary is on children because it finds this to be particularly problematic as it is children that are developmentally more vulnerable. However, the adults too experience this 360 degree marketing. Further, the children grow up to be adults who are now primed for targeting as an adult audience by the fashion & beauty (cosmetic) industry.
3. Drawing on, as one example, the Kantian ethical tradition, this involves treating these individuals "simply as a means" and not as "ends in themselves," thereby violating the principle of humanity, and is therefore unethical, violating their autonomous existence as rational, self-determining individuals. See especially Kant's second formulation of his categorical imperative, "Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means" (Kant 1785, 36-37).
4. Though the line is gray between the medical use of biotechnologies in dermatology and the cosmetic use of the same, the distinction is generally agreed to rest on one of using the technologies primarily for medical reasons, which may have secondary cosmetic benefits, and primarily for cosmetic reasons, which may yield secondary health benefits (but not enough to warrant the procedure or product alone). In general, and for the purpose of this essay, cosmetic dermatology falls under the umbrella of Enhancement Medicine, which, as Sotonye Imadojemu and Autumn M. Fiester highlight, "... intends not to restore appearance or function damaged by disease trauma, or congenital defect to age-appropriate levels, but to improve average appearance or function to some desired level beyond age-appropriate norms" (137). In contrast, plastic surgery, though involving the use of the same biotechnologies, is focused on performing surgery that is medically necessary, even while it may involve some secondary cosmetic benefits. Thus, though many laypersons refer to surgery done for cosmetic purposes as "plastic" surgery, this essay makes a distinction between plastic and cosmetic surgery and finds only the latter ethically problematic as the former, by definition, is medically necessary.
5. Particularly nefarious to the patient are the advertisements that occur in the practice (within the medical office) of a physician. On a recent visit to a dermatologist for a yearly skin check, I was bombarded with advertisements for cosmetic enhancing procedures and products at every turn (in the waiting room in the form of leaflets and posters, in the examining room in the form of a binder of procedures offered and more posters, and at checkout, on my appointment slip and with a coupon given to me as part of my exit materials. Two posters stick out to me most: the first had a picture of a healthy looking woman with arrows pointing at all the potentially problematic parts of her face that could be addressed with various enhancement procedures and the second, located at the checkout counter, had a male and a female cuddling on a couch. The caption above the woman said, "If I ever doubted my decision to have breast augmentation, I don't now." As a captive audience in this practice, and there for purely medical reasons, I find it problematic that I and the other patients are subject to these messages and the not so subtle message that I will be happier (and apparently cuddle more with my partner) if I consider the procedures being offered.

6. As stated by the American Society for Dermatological Surgery (ASDS), “Dermatologists have more influence on a decision to have cosmetic procedures than friends, physicians referral, or 11 other factors, according to respondents” (www.asds.net/about.aspx). Julie Cantor makes a similar point, arguing that while physicians do not carry the same prestige and power that they once had in society, the level of prestige and influence they still have remains significant and means that what he or she says or does carries with it the corresponding added influence (Cantor 2005, 155-160, esp. 156).
7. See Thomas L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics*. 4th ed. Oxford University Press, 1994 and, in reference to the command that we should, “. . . at least do no harm” see the *History of Epidemics* by Hippocrates. In contemporary bioethical terms, the command to “. . . make the habit of two things—to help, or at least to do no harm” is, in part, encompassed and furthered with the four commonly embraced principles of bioethics, which include the principle of respect for autonomy (assure understanding and informed consent, respecting the informed wishes of the patient), the principle of nonmaleficence (do no harm), the principle of beneficence (promote welfare and wellbeing of the patient), and the principle of justice (offer fair distribution of medical knowledge and medical practice).
8. Similarly but not directly addressing the issue of justice are Daniel Callahan’s four goals of medicine. These goals include the following: (i) to prevent disease and injury and to promote and maintain health; (ii) to relieve pain and suffering caused by maladies; (iii) to care for and cure those with a malady, and to care for those who cannot be cured; and (iv) to avoid premature death and to pursue a peaceful death (Callahan 1996, 21-27).
9. As Julie Cantor notes, the obligations of a dermatologist practicing cosmetic dermatology include to “act in the patient’s best interest, do no harm, serve the interests of justice, ensure informed consent” with an added obligation to “combat the influence of television on patient perceptions, and their informed consent dialogue should be detailed and exhaustive. A truly informed consent process is even more important of cosmetic procedures than it may be in other areas of medicine” (156, 159). In the end, however, she argues that the “ethical obligations posited here are quite simple. Be truthful in advertising, whether selling procedures or products. Be forthright about training credentials . . . Advocate for patients and maintain the integrity of the profession by demanding that companies deflate claims in their ads . . . Continue to have medical dermatology practice, and volunteer those services, if not also the cosmetic ones, to those who cannot afford them” (159). With this ending statement she fails to draw the insights she offers earlier about the influence of television on the patient and the possible effects this may have.
10. A distinction between wants and needs is helpful here. “Needs” include those things that are medically necessary and without which the health of the patient would be diminished in the present or future. “Needs” in relation to medical procedures include such things as plastic surgery in order to reconstruct the nose so proper breathing can be established. In contrast, a “want” is something that is not medically necessary for the health of the patient but instead is desired for cosmetic purposes. For example, a patient may want cosmetically motivated plastic surgery to reshape his or her nose because he or she does not like the current size or shape of his or her nose. The nose, in the case of the “want” without an accompanying “need,” works perfectly fine but does not look like what the patient would prefer. Of course, there may be needs that are also wants. For example, an individual who needs plastic surgery to reconstruct his or her nose in order to breathe more effectively and also “wants” this surgery for cosmetic purposes. For further discussion on the distinction between plastic and cosmetic surgery, as being used in this essay, see *Vide Supra*, endnote 7.
11. Given the current context of the field of dermatology, where the need for dermatologists that practice medical dermatology is high, this particular option would seem to be especially positive, filling a need in the field while also offering that service to those who otherwise may not be able to afford it. As Roubaix notes, “Restriction of aesthetic surgery to the rich may counteract notions of ‘distributive justice’, causing envy in the not so affluent . . . Prohibiting aesthetic surgery is unlikely to divert surgical expertise to more ‘deserving’ instances, and may cause translocation of medical expertise. Many aesthetic surgeons also perform non-aesthetic surgery (much needed in developing countries). Volandes suggests taxation on aesthetic surgery to subsidize surgery for the poor, which might also improve negative perceptions of the medical profession” (Roubaix 2011, 11-16, esp. 13).
12. This is similar to the argument against viewing the woman as somehow oppressed by the social norms around beauty and youth. Some argue that the availability of these technologies are empowering, allowing the woman to act as an agent in control of her destiny, giving her the ability to meet the criterion of success in her society. This enhances, it is thought, autonomy and rather than being oppressive is empowering. (See reference to this type of argument in Deborah Sullivan’s *Cosmetic Surgery: The Cutting Edge of Commercial Medicine in America*.) However, this assumes that we live best without questioning the status quo, but this would be a faulty assumption. If what we are empowering an individual to do or be is oppressive, even if this makes her happy or gives her advantages in society, it is wrong.
13. In Chapter 8 of the *Opinions of the Council on Ethical and Judicial Affairs* for 2016, the AMA augments and

updates the AMA Code of Bioethics with current opinions and guidance on contemporary bioethical issues. Here the AMA insists that “Although physicians’ primary ethical obligation is to individual patients, they also have a responsibility to protect and promote public health” (American Medical Association, <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics>). With this the AMA seems to be laying a foundation that supports an interpretation of the role of physicians in society that is not an atomistic interpretation but rather consistent with the arguments offered in this essay and soon to be developed as part of the social notion of the self and its application to this topic. While, within the opinion offered in this AMA Chapter on “Physicians and the Health of the Community,” a specific application to the use of biotechnologies for cosmetic and/or medically necessary purposes is not offered, such an opinion would be consistent with the overarching principle advocated by the AMA and, arguably, given how ubiquitous cosmetic procedures are in our society, seems to be a missing topic in this Chapter.

14. This particular reference to the self as social and co-constitutively always “in-process” is reference to John Dewey’s work and, more broadly, the work of many in the American pragmatist tradition, such as George Herbert Mead and, with a more contemporary reference, Shannon Sullivan. As John Dewey explains, “[L]ife goes on in an environment; not merely in it but because of it, through interaction with it. No creature lives merely under its skin; its subcutaneous organs are means of connection with what lies beyond its body frame, and to which, in order to live, it must adjust itself. . . . The career and destiny of a living being are bound up with its interchanges with its environment, not externally but in the most intimate way” (*LW* 10: 13). This is also consistent with many feminist conceptions of the self and is echoed in traditions such as the ethics of care tradition (Noddings, Held, Card, etc.) and in critical theory traditions, with theorists such as Maria Lugones and her conception of the self as being selves who are “mapped” into and within social contexts and social norms.
15. This is similar to what Maria Lugones calls us to consider, which is the nature of our social existence as “mapped.” Lugones argues that even those who benefit from the mapping are “spatially mapped by power.” Our paths are “. . . marked as places you may, must, or cannot occupy” (Lugones 2003, 8). In these cases, it may be “empowering” to offer individuals tools to better conform to one’s expected location and function within the map; however, taking a larger, global view allows one to see that this misses that the map itself may be in need of revision. In this case, empowering the individual to continue to maintain her location within the map is really disempowering that individual and other individuals who are similarly mapped.
16. I borrow this distinction from John Dewey and his distinction between routine and intelligent habits. Dewey, as noted above, embraces a social conception of the self, what he calls a transactional self and integral to this social self are habits and the role habits play in the formation of society and the defining and influence these societal habits (customs) have on individuals. Habits are absolutely necessary for self-formation but they can be more or less conducive to individual and community amelioration. Habits that are intelligent, are, as Dewey says, “sensitively percipient, more informed with foresight, more aware what they are about, more direct, and sincere, more flexibly responsive than those now current” (*LW* 14: 88-90).
17. This all leads to, Roubaix points out, shame. . . shame that no matter what one does or doesn’t do, one cannot meet the norms. “The underlying dynamic is a culture that shames any divergence from ‘an unrealistic aesthetic idea.’ The question is whether women really make free choices in favour of aesthetic surgery under these circumstances” (Roubaix 13, quote from Allison A. “Plastic Surgery. . . When is Too Much not Enough? Celebrating Women, Diversity and Achievement.” Online 14, January, 2010. <http://amelialisoun.worldpres.com>.)
18. Surprisingly, there is little direct attention to this question in the relevant academies of medicine or the bioethical societies. For example, *The American Academy of Dermatology (AAD)*, though offering a booklet addressing ethical issues (*Ethics in Medical Practice: With Special Reference to Dermatology*), does not in this booklet speak directly to the nefarious contribution dermatologists makes when promoting cosmetic procedures toward greater physical perfection. The references to ethics are general in nature, arguing that dermatologists should “participate in activities contributing to the improvement of the community and the betterment of public health” but does not specify a position on the most obvious issues related to promoting this culture of perfection. While “unnecessary procedures” are to be avoided, there does not seem to be a willingness to make a connection between cosmetic procedures and “unnecessary procedures.” It is curiously silent on this issue. The same is true for the *American Society for Dermatological Surgery (ASAS)*. While this society offers an account of the rise in interest in cosmetic procedures, it does not call into question the role that dermatologists are playing in the normalization in these practices or the ethics of doing so. And this while noting that “Dermatologists have more influence on a decision to have cosmetic procedures than friends, physician’s referral or 11 other factors.”
19. As mentioned above (*Vide supra*, endnote 13), the AMA, in their Code of Medical Ethics, provides not only their principles of medical ethics but also a series of opinions that, though not laws, are “standards of conduct”

or, in other words, guidelines that identify “. . . essentials of ethical behavior for physicians” in relation to particular medical practices (Preface and Preamble to Opinions of the Council on Ethical and Judicial Affairs). Herein the AMA offer guidelines for a large variety of medical topics including, to name just a few, “Assisted Reproductive Technology,” “Torture,” “Physician Participation in Interrogation,” “Genetic Testing and Counseling,” and “Cloning for Reproduction.” Absent, however, is any guidelines of considerations for the use of biotechnologies for cosmetic purposes.