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Restoration and Enhancement: Is Cosmetic Dentistry Ethical?

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Abstract

The ethical ground for restoration (returning a patient to healthy form and function) differs from enhancement (using medical means to improve appearance). Physicians and dentists who argue that enhancements improve self-esteem must reconcile this claim with the fact that they are not licensed to practice psychology. The extreme views are that doctors either should provide cosmetic services as requested by patients or they should not. The middle position is that doctors must retain their fiduciary position of trust based on professional judgment and advocating for patients' health interests. Patient health always outweighs patients' cosmetic desires.

The rapid rise in demand for cosmetic procedures in both medicine and dentistry has had a dramatic effect on the practice of both professions. Both physicians and dentists educated in a tradition that emphasizes the use of surgical skills to help people with health needs are now routinely asked for procedures that have little or nothing to do with illness. The unmitigated proliferation of "extreme makeover" programs on television and in the print media would give the impression that the medical and dental communities are in full support of this new deployment of surgical skills. Yet, it is quite possible that the intense public demand has outpaced any thorough examination of the ethics that are relevant to this change. Perhaps it is time to take a collective breath and try to find a way to reconcile this change in popular opinion about what physicians and dentists should be expected to provide and the ethical traditions of these professions.

This paper will examine the ethical aspects of cosmetic procedures and try to provide an ethical basis from which dentists can make sound treatment decisions with their patients. I will argue that there are indeed times when the ethical dentist (and physician) ought to say no to requests for cosmetic procedures and I will attempt to provide some practical guidelines for determining such times.

There are several terms and concepts that if clearly defined would help this investigation greatly. Unfortunately, terms such as "health," "disease," "normal," "medically necessary," "treatment," "risk," "need," and "esthetics" all involve significant ambiguity and are often at risk of being defined however the user wishes. What counts as a "risk" for one person may not be the same for another, and what is considered a "need" may also vary greatly within a given population. Nonetheless, I think it is possible to work through the general outlines of the

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ethics of cosmetic procedures without a definitive consensus on these terms. I will ultimately reject the thesis that since subjectivity plays a role in doctor-patient treatment considerations, it is always the deciding factor in those cases.

Restoration and Enhancement

To begin, I will take "restoration" to mean the act of returning something (in this case a person) to normal form and/or function. Things in need of restoration have a defect of some sort and, with regards to people, these defects go by many names, such as malady, disease, deficit, etc. I will take it as uncontroversial that, whatever the precise definition of health may be, the traditional goal of medical and dental care has been to eliminate or manage defects and restore people to health (normal form and function), however broad the "normal" limits might be. This is commonly known as healing or curing or therapy. With regard to plastic surgery and dentistry, examples of restorative procedures include restoring a broken tooth with a porcelain crown, repairing a cleft lip, reconstructing a breast following a mastectomy, and reconstructing a nose following trauma.

"Enhancement," on the other hand, seeks to take an individual who has no defect and improve that person's form or function (according to some standard other than health) through medical or dental procedure. Examples of enhancement include prescribing steroids or beta-blockers to improve the performance of an athlete, surgically altering a body part to improve performance on a task, prescribing amphetamines to increase job productivity, or any number of cosmetic procedures (both medical and dental) that enhance esthetics.

Some will immediately argue that cosmetic procedures do not belong in the category of enhancement. Cosmetic surgeons and dentists are famous for claiming that patients do indeed have a deficit (unattractiveness, ugliness, etc.) and that cosmetic procedures "heal" the individual by increasing the individual's perception of themselves (Christiansen, 1989; Leibler et al. 2004). However, Jos Welie has convincingly made the case in his excellent 1999 article that "ugliness" is, on the contrary, not a medical condition at all and procedures that seek to "heal" this condition are outside of medicine and dentistry proper (Welie, 1999). Likewise, Eileen Ringel has argued that the effects of aging on skin are not a disease and therefore cosmetic skin enhancement is not a therapy or treatment in the proper sense (Ringel, 1998).

The problem here is that the advocates of cosmetic procedures confuse benefit with therapy. Just because something is of benefit to a patient does not necessarily place it within the proper domain of dentistry or medicine, which is the restoration of people to health (normal function and form), i.e., therapy. There is no doubt that people find great benefit in tattoos and other body art; but just because these involve the body it does not logically follow that physicians and dentists should be offering to do these procedures or that they should be considered examples of therapy. Many patients no doubt desire and are made happy by cosmetic procedures; but this is no argument for the ethical acceptance of these procedures as appropriate components of dental or medical practice.

As Ringel states: "When happiness replaces healing as the goal of medicine, the practice of medicine becomes a commodity and the medical profession just another way to make a living" (Ringel, 1998). Traditionally, the goal of medical and dental therapy has been to provide a benefit that addresses a deficit, restoring a patient as much as possible to normal form and function. The suggestion that physicians and dentists may provide services that are outside of the traditional goals of both professions should at least be ethically suspect. Just because a physician or dentist has the capability to provide a procedure does not make it ethically acceptable to do so. "Therapy" and "treatment" are terms to be used only when discussing procedures that have some dental or medical benefit by restoring the patient to health or maintaining a patient's health in the face of some threat to it.

Have medicine and dentistry evolved to the point that this tradition no longer applies? Perhaps they have. And yet, I doubt if the subject has had sufficient formal discussion to create a consensus among practitioners and ethicists. One thing is clear, the sheer prevalence of cosmetic procedures performed in contemporary medicine and dentistry is

not a sufficient argument for the inclusion of cosmetics within the professions. Moreover, opinion surveys showing that providers and patients are "comfortable" with these procedures is a poor argument as well (Christiansen, 1994). Many may feel that in regards to cosmetics "the horse is already out of the barn." But my sense is that there is a sufficient level of uneasiness (at least within the dental community) that a reasoned ethical investigation may still recover what is rapidly being lost everyday.

There is one way in which it may seem that cosmetic surgeons and dentists really do have a good point in saying that they are actually providing therapy to their patients. They claim that the cosmetic procedures they perform are "psychotherapeutic." Poor self-esteem and other psychological maladies are often "cured" or at least the patient's situation is significantly improved by giving someone a better "look."

There are many problems with this thesis and Eileen Ringel has done an excellent job identifying them (Ringel, 1998). Briefly summarized: There is no strong evidence that cosmetic procedures improve self-esteem. In fact, cosmetic procedures, by focusing on superficial attributes of the person, may only deflect and defer real progress toward an authentic acceptance of the person from which a true increase of self-esteem will result. Moreover, physicians and dentists who perform cosmetic procedures are not trained to evaluate psychological and psychiatric disorders, so if this is their rationale for doing cosmetic procedures, they are offering therapy without a proper diagnosis or, in the case of dentists, practicing outside the scope of practice. In fact, as far as outcomes are concerned, the evidence that surgical therapy is an effective treatment for psychiatric disorders (with the exceptions of body dysmorphic syndrome and sex reassignment surgery) is thin or nonexistent. Lastly, it is reasonably argued that any patient with a serious psychological deficit requiring treatment may not be in a position to give an informed consent, and treating such a patient simply on the basis of his or her request for treatment would be unethical for this reason alone.

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The Continuum

With these arguments in mind, I think it is reasonable to draw a distinction between medical and dental procedures and cosmetic procedures. Now we must ask ourselves whether dentists and physicians ought to be providing cosmetic procedures at all. And if the answer to this question is yes, what are the circumstances under which a physician or dentist is ethically justified in performing such services?

We can look at the possible answers to the first question as lying somewhere along a continuum. At one extreme, we have the position that dentists and physicians should not perform any cosmetic procedures. At the other extreme, we have the position that physicians and dentists should provide any cosmetic procedure that the patient asks for as long as the physician or dentist is competent to provide such services. Somewhere in between these is the position that physicians and dentists may provide cosmetic procedures, but must not be merely an agent of the patient; they will sometimes decline to treat based on their judgment of the situation.

Let's consider the first extreme. Welie has made the case that cosmetic procedures are outside of medicine and dentistry proper and thus outside the ethics of those professions. People (patients) who decide to allow physicians or dentists to perform these procedures

ought to know that the ethics of the profession do not apply and they can be no more assured of professional care than they would be at a tattoo parlor. The ethics of the marketplace that any muffler shop or hair salon follows is the only ethical standard constraining the relationship at that point. Now if this were indeed the case, it is reasonable to say that there is nothing special about having a physician or dentist provide these services. Just as with tattoos and hair styling, anyone talented enough and creative enough should be able to obtain a license to provide cosmetic surgery. (In that case, of course, the costs of these procedures would undoubtedly drop and the benefits of cosmetic procedures would be obtainable by a larger segment of the community.) From the standpoint of the principle of justice, this would necessarily be a good thing.

Doctors and Cosmetologists

However, most members of society want more than justice, low prices, and good training; they demand a certain level of professional judgment and want to know that, when it comes to surgery on their bodies, someone is looking out for them. Society's implicit contract with physicians and dentists expects a security that can only come from something beyond skill and training, namely professional judgment in the best interest of the patient. It is this fiduciary responsibility that distinguishes medicine and dentistry as professions; they are not just businesses. Without this fiduciary responsibility there is no such thing as professional ethics.

The key aspect of the doctor-patient relationship is that the doctor is ethically bound to decline to "treat" a patient requesting treatment if the risks and costs of the procedure outweigh the benefits. It is a generally accepted ethical tenet that patients cannot ask doctors to hurt them (Ozar & Sokol, 2002; Beauchamp & Childress, 1983). Because of this, it is safe to say that people are not ready to turn over cosmetic surgery to tattoo artists and others in the esthetics business, however gifted they may be. So, either we license anyone with the ability to provide cosmetic procedures, or we bring these procedures into the domain of medicine and dentistry along with the professional ethics that apply to them.

Now let's look at the other end of the continuum. If all cosmetic procedures are fully within the domains of medicine and dentistry, then patients clearly may request any cosmetic procedure they wish and physicians and dentists who value the business may ethically provide these services if they are capable of doing so.

Gary Chiodo and Susan Tolle have addressed the issue of cosmetics procedures in some detail (Chiodo & Tolle, 1993). They argue first that there are indeed limits to a patient's right to demand cosmetic dental services. Briefly summarized: Dentists have the ethical duty to weigh the risks, costs, and benefits of a given procedure and decline to treat if the risks and costs outweigh the benefits. The ethical principles of beneficence and non-maleficence both support this conclusion. But Chiodo and Tolle propose that, if the risks and costs do not outweigh the benefits, the patient has the right to expect the treatment because it passes the benefit/harm test that the dentist is professionally obligated to apply. Chiodo and Tolle rightly emphasize the subjective nature of this type of deliberation and point out that the personal values of the patients, and thus the rationale for their treatment requests, are often different from the values of the dentist. The significance of risks, costs, or benefits varies from patient to patient. Chiodo and Tolle argue that a dentist should not impose his or her values on the patient unless a clear case can be made that the proposed treatment has unacceptable risks or will, in fact, result in harm to the patient. They go on to say, however, that dentists always have the right to refer to another practitioner if they are "uncomfortable" doing a procedure they would not choose for themselves.

There are two points to be made here regarding Chiodo and Tolle's position. First, the word "treatment" is used to describe cosmetic procedures. "Treatment" suggests that there is some dental health benefit received as a result of the procedure. We have already established that there is no health-related dental benefit (no goal of restoration) in enhancement procedures, so this use of the word "treatment" stretches its meaning significantly. When no health-related dental benefit is to be had, normal considerations for balancing risks, costs, and benefits may not apply. More on this point below.

Second, as I have argued previously (Jenson, 2003), if a procedure's risks and costs do not outweigh the benefits, the dentist must ordinarily provide the treatment if he or she is capable. Otherwise there is no real ethical weight to patient autonomy.

Chiodo and Tolle are in alignment with this; and other bioethicists would agree that the normative picture of the doctor-patient relationship as a paternalistic or guild-based cannot be accurate (Ozar & Sokol, 2002; Kirkland & Tong, 1996). But the fact that the doctor-patient relationship should not be paternalistic does not require us to accept the other extreme of our continuum where the doctor is merely an agent of the patient and must do whatever the patient asks.

With just a little reflection and a few examples, the case can be made that this extreme position does not accurately describe the ethics of enhancement procedures. Consider the case of a person who would like to have his front teeth filed down to sharp points for either esthetic or cultural reasons. While we might make the case that the patient values this procedure highly, we would be hardpressed to find a practicing dentist who would agree to this procedure. Similarly, we would be hardpressed to find a physician who thinks it is a wise choice to give an otherwise healthy athlete a prescription for steroids. In both cases, the harm or potential harm to the patient seems to conflict with some deeply held sense of what it means to be a dentist or physician. It simply does not make sense to create an ethical parameter for the doctor-patient relationship that has implications that no doctor could support. We need to seek some sort of reflective equilibrium that is both rational and realistic.

Having looked at the extremes, let's now consider a middle position. This position states that cosmetic procedures may be done by dentists and physicians, yet it also holds that there are times when the physician or dentist must say "no" to an enhancement request. How are we to define this position and locate it along the continuum? While it may be difficult to delineate this point in specific instances, I think we can at least establish some general guidelines.

The first point to stress is open communication between doctor and patient. Weighing risks, costs, and benefits to determine a course of treatment in the proper sense is, by anyone's assessment, not a mathematical process. The process always involves the judgment and values of both doctor and patient. A different outcome from these deliberations is almost to be expected with different doctors and different patients. However, the fact that these deliberations involve some aspect of subjective values does not mean that they are inherently irrational; reasonable people can come to different conclusions and parties who disagree on what is best may still agree precisely on what is unacceptable. A judicious consideration of clinical experience, research studies, and patient preferences is ethically demanded of the doctor and can lead him or her to a reasonably good and ethical treatment plan for a specific patient.

This dynamic process, this interactive style of doctor-patient relationship is crucial to the ethical treatment of patients (Ozar & Sokol, 1994). And it must be part of the relationship between doctor and patient when cosmetic procedures are under consideration. Ultimately, both patient and doctor have rights; neither gets to dictate the treatment at all times and each has the right to decide not to participate in a procedure, the patient at anytime and the doctor under certain circumstances (Jenson, 2003).

Second, having already established that enhancement procedures are not "treatments" per se, it is fair to ask then if the same ethics apply to decisions between doctors and patients about cosmetic procedures as they apply to treatments proper. I propose that in the case of cosmetic procedures, it is simply not important to the dentist's ethical decision that the patient thinks the procedure would be beneficial. The values at work in patients' cosmetic decisions in the dental office do not differ from the values at work in other areas, far outside of the domain of dentistry and medicine proper, including tattoos and hair styling. People do, of course, place great benefit in some of these things; but what significant difference is there between people's valuing of cosmetic medical and dental procedures and their valuing of tattoos or hairstyles? The proposal here is that we have to say that all cosmetic procedures are simply a benefit to the patient with no hierarchy of value in relation to health, which is the focus of dental and medical decisions in the proper sense. As such, they are irrelevant to the doctor's deliberations as to whether or not he or she should agree to do the procedure. In practice this will mean that the threshold at which the doctor may say "yes" to a procedure rises significantly with a cosmetic procedure because it involves no health benefit to be weighed against the possible risks and harm of the procedure. What is important to the doctor's deliberation, then, is whether or not the procedure presents a significant harm or potential for harm to the patient's oral or general health.

For example, while it may be justifiable to expose a patient to the risk of death by general anesthesia (one in ten thousand cases) to obtain a medical benefit (e.g., removing a brain tumor), it is unjustifiable to expose them to the same risk in order to remove the fat from their thighs. For a dental example, a dentist who places a gold crown on a tooth that has no need for restoration, simply because the patient sees an esthetic benefit, would be practicing unethically given the fact that there is a

risk (one in one hundred) that the pulp of the tooth would be damaged in the process. Another common dental example would be the placement of porcelain veneers. If the veneers are intended to overcome some defect, (say, deteriorating restorations) the benefits of the procedure are more restorative in nature and may then be worth the relative risks and costs. Placing veneers to take a patient from a Vita shade B3 to B1 on the other hand, is clearly an enhancement procedure and may be difficult to justify given the attendant risks and costs. As an alternative, bleaching teeth has few if any risks and may therefore be ethically justified for the patient who has stained teeth.

The proposal here is that, if there is no health-related benefit to justify it, the dentist may not ethically perform a procedure with any significant risk of harm to the patient. If an enhancement procedure can be done without significant hazards, a dentist or doctor may agree to a patient's request. (At no time, of course, is the doctor justified in providing a procedure if it is beyond his or her capabilities.) Patient autonomy never outweighs the patient's health (Ozar & Sokol, 2002), and so the range of ethically acceptable procedures available for a patient to choose from will thus be significantly curtailed when it comes to cosmetic procedures.

Is it possible to maintain this distinction between these two ethics (patterns of valuing), one for regular dental procedures and one for cosmetic procedures? Can we really split professional ethics and say that some procedures demand one set of behaviors and another procedure some other? While it may seem counterintuitive initially, I propose that this is the case. Keep in mind that the only reason to include cosmetic procedures in the domain of medicine and dentistry is that the community thinks they ought to be there for its own protection. But the community cannot have it both ways: it cannot both demand that doctors make all of these procedures available and then not bring their professional judgment and professional duties to bear in specific cases—especially the duty not to harm, and to permit harm only in the interest of even greater health benefit. This would leave dental practitioners (at least the conscientious ones) in an impossible position. Distinguishing esthetic procedures from health related treatments in this way produces a workable compromise that is superior to either of the extreme positions.

In the future, physicians and dentists and the community will have to decide if enhancement procedures will eventually be part of medicine and dentistry proper and that health will mean more than restoring a person to normal function and form. (There are signs that we may be moving in this direction: see Carl Elliott's 2003 book, *Better than Well*). Until then, many of the cosmetic surgeries currently performed by physicians and dentistry simply cannot be supported ethically. This is not in any way a judgment on the values of the people who seek these procedures. People, ultimately, have the right to decide what they do with their bodies. They cannot, however, expect that a doctor should take part in that choice and contribute to the harm that these choices may bring. People must accept that there are limits to what their doctors can ethically provide; and if they desire more than this, they should seek those who are not bound by professional ethics. Caveat emptor. ■

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