Journal of Plastic, Reconstructive & Aesthetic Surgery (2011) 64, 11–16

JPRAS
An International Journal of Surgical Reconstruction
www.JPRASurg.com

Beneficence, non-maleficence, distributive justice and respect for patient autonomy – reconcilable ends in aesthetic surgery?

J.A.M. De Roubaix*

Center for Applied Ethics, Department of Philosophy, University of Stellenbosch, South Africa

Received 26 January 2010; accepted 11 March 2010

KEYWORDS
Autonomy;
Informed consent;
Cosmetic surgery;
Moral responsibility

Summary Respect for patient autonomy, as a fundamental principle in contemporary bioethics, guides the process of informed consent through which, it is hoped, patients' wishes are determined and executed. However, when procedures are exclusively cosmetic, questions as to the ethical legitimacy of such requests and enhancements arise. The purpose of this article is a thorough evaluation of the notions of and tensions inherent to the practice of autonomy and informed consent as they apply in aesthetic surgery. The question of motivation to undergo enhancement will be discussed, as well as the significance of risk and competence in determining the legitimacy of choice.

The final conclusion is that the complexity of the moral issues involved requires conceptualisation of an expanded notion of responsibility, which recognises that we need to progress beyond a 'legal' to a 'moral' conception. The implications of this expanded notion of responsibility are discussed.[142]

Respect for patient autonomy[1] guides practitioners' professional relations through the practice of informed consent; surgical disciplines generally practise a high standard of informed consent.[2]

My concern is with the ethical aspects of requests for elective aesthetic surgery; it may be problematic to reconcile the ethical principles of beneficence, non-maleficence and distributive justice, with respect for patient autonomy and professional duty.

Historical perspective of patient autonomy

The 1847 American Medical Association 'Code of Medical Ethics', exhibited frank paternalism, perpetuated until quite recently,[2] with 'assent' rather than 'consent' to treatment:

> ''The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them.''[3]

* 16, Diaz Avenue, Monte Vista, 7460, PO Box 12040, N1 City 7463, South Africa. Tel.: +27 21 558 1 030; fax: +27 21 558 6186.
E-mail address: malcolmderoubaix@gmail.com

1748-6815/$ - see front matter © 2010 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.
doi:10.1016/j.bjps.2010.03.034

Societal revaluation of personal autonomy has lead to a revision of this relation. Isaiah Berlin summarised an account of personal autonomy, applicable to current notions of informed, consent as follows:

> ''I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not other men's act of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody — a doer, deciding, not being decided for, self-directed and not acted upon by external nature or by other men.''[4]

Respect for personal autonomy is central to most current theories of morality, for example, Beauchamp and Childress' notion of four principles as basis for ethical practice.[1] Information empowers patients to make informed choices.[5] The professional relation becomes more symmetrical, limiting, but not eradicating paternalism because of scepticism of authenticity in decision making and limited ability to comprehend complex issues. Patient decisions are not invariably 'wise' or 'correct' but may be 'appropriate' within particular world views.[3]

Without adequate informed consent, therapeutic invasion may result in civil, even criminal proceedings.[6]

Requirements, nature of informed consent

Informed choices are rational decisions: evaluation and acceptance of reasons upon which one acts,[2] presupposing possession of all relevant information (explanation of surgical techniques, success and complication rates, risks, alternatives, the relative risks and complications of alternatives, costs and the role of each team-member in the procedure).[7] 'Being informed' is therefore the cornerstone of autonomous decision making; this posits the actual agreement between patient and professional as contractual.

Patients do not require equal levels of information,[8] but may have a moral obligation to accept appropriate information. Waiving the 'right' to information undermines rational choice, re-introduces paternalism, thus opposing the possibility of personal autonomy.[9] Forcing unwanted information upon patients may imply psychological harm (this may have been overemphasised[10]; information increases knowledge, not anxiety).[11] Refusal of information by competent patients may be acceptable acts of reasoned choice.

Competence (capacity) — the ability to grasp the essentials of an explanation, rationally deliberate and choose — is the central determinant of autonomy.[12] Requirements for competency should not be unnecessarily high. Competence is limited by circumstances intrinsic (mental competence and comprehension) or extrinsic (legally imposed relating to age or institutionalisation).[8]

The final step is un-coerced choice to undergo/defer particular treatment.

Inherent tensions regarding informed consent

For Berlin, autonomy is a good unto itself, serving no other purpose.[4] Choices and consequences require respect as free expressions of preference, but it is difficult to reconcile 'bad' and 'wrong' treatment choices with best practice and professional duty. Berlin's formal notion of autonomy is value-neutral, reducing autonomy to authenticity.[13] An alternative view is that autonomy is valuable 'if exercised in the pursuit of the good' without prescribing particular conceptions of the good[14]; 'being autonomous (is) a desirable state of affairs' since/if it promotes a worthwhile life.[15]

Autonomy and agency converge in non-aesthetic therapeutic choice, supported by substantial medical knowledge and opinion. Decisions reflect personal views, but underlying reasoning and logic are apparent. In aesthetic surgery, this convergence diminishes, depending on the motivation to undergo a procedure. Consider, for example, breast augmentations performed on American teens.[16] In almost 50%, the indication was aesthetic preference. American teenagers may be informed, understand the bodily implications, complications and side effects of, and request surgery, but their choices are not necessarily reasoned, balanced and mature.

Motivation in aesthetic surgery

'Improvement' by transcending the given is a fundamental human trait but may lead to excess. Human history is one of 'tinkering' with ourselves in many varied respects.[17]

The quest for 'eternal youth', contrasting the depredations of ageing, is as old as humankind. In Greek mythology, Eos kidnapped the Trojan Tithonus as lover, begging Zeus to grant him immortality — but not eternal youth, with dire consequences.[18] Oscar Wilde's Dorian Gray remains young and beautiful, although his painted image ages and shows the ravages of debauchery. Billie, in Jeanette Winterton's *The Stone God*, refuses eternal youth through genetic remodelling, and ages while everyone else remains youthful. Medical science is making advances in its quest to find the key to ageing. Billions are spent annually on beauty products (UK; £16 billion) and the 'anti-ageing industry' (USA; $20 billion).[19] The words 'eternal youth' produce more than 1.25 billion Google responses; for example, a 'youth clinic' in Beijing producing personalised facial lotion from abdominal fat stem cells[20] and the Strategies for Engineered Negligible Senescence (SENS) foundation, which aims 'to develop, promote and ensure widespread access to regenerative medicine solutions to the disabilities and diseases of aging'.[21]

The 'ugly obsession' of eternal youth ensures that billboard models are beautiful, young and vivacious; on TV, 'older people' rarely look their age.[19]

Influenced by peers, personal experience, the media and marketing, the subject, an unhappy member of an 'undesirable group', defines a category of persons desirable to 'pass' into (join).[22] The driving force is a quest for acceptance and happiness, with reference to John Stuart Mill, who wrote 'happiness is desirable, and the only thing desirable, as an end; all other things being only desirable as means to that end.'[23] But Mill's oft-disputed[24] notion denotes 'aggregate happiness' in terms of numbers and duration. Gilman might have done better with the arguments of Mill's conceptual antithesis, Emmanual Kant, for whom it was a prime duty to respect the rights of others.[25]