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ETHICS AND APPEARANCE

Workshop organized by the Department* of *Medical Ethics at the Erasmus University Rotterdam and the Department of Medical Philosophy and Clinical Theory at University of Copenhagen, endorsed by the European Committee on Bioethics of the European Union.

Short Letter
Adapted for the EASAPS

1. INTRODUCTION - ETHICAL CONSIDERATIONS

From an ethical point of view, the main question is **who** should perform Surgery of Appearance**, why** and **where**.

The question of **who** should perform Aesthetic Surgery has to be based on who is better prepared and therefore morally entitled to perform Aesthetic Surgery.

To better appreciate the problems, it seems essential to define both branches of Plastic Surgery, **Reconstructive and Aesthetic**, to discuss training and its prospective future evolution, the relationship with other Surgical Specialties and its ethical implications, as well as those problems due to untrained physicians performing surgery of appearance. - *IPRAS Newsletter November 1995 – 25*

Specialty boards have no authority to regulate manpower to prevent unemployment. Most Health Ministries fail to do this for political reasons. Neither do they prevent clinics, employing non-surgically trained physicians performing “Cosmetic Medicine”, from frequently also performing Aesthetic operations. These clinics fall under mercantile law and restrictions would represent a restraint of trade, leaving them open to anti-trust action. Ethically this should not be tolerated!

In Spain and other countries, the graduation “Licensed for Medicine and Surgery” in principle allows, even the next day, to perform any major surgery. Although the untrained physician is not allowed to use the title
‘Specialist’, nor theoretically to practice a specialty, which is considered an intrusion and constitutes disloyal
competence, any clinic employing untrained physicians may advertise the type of medical and surgical treatments performed therein, including aesthetic operations!

Is it possible to perform and teach Aesthetic Surgery in institutions, universities or hospitals of the national health systems other than in private clinics?

And, last but not least, the minimum conditions required for performing this type of surgery in private clinics should also be established.

However, we should not close our eyes ignoring the present evolution as our teachers in General Surgery did.

Those who are in a leading position must foresee the future evolution and must act to guide this in the right direction. Otherwise the specialty will be overrun by the events, with a negative effect for both the public and the specialty.

At present other specialities are also interested in performing "Regional Aesthetic Surgery", whether of the head and neck area or the trunk.

2. RECONSTRUCTIVE AND AESTHETIC PLASTIC SURGERY: DEVELOPMENT, DEFINITION, TRAINING AND PRESENT STATE.

2.1. Development

Although reconstructive operations have been performed for more than two millenniums for treatment of injuries or ritual purposes and, occasionally to repair defects caused by punishments (origin of the so-called "Indian method" of nose reconstruction), it was not until the last century that the term "Plastic Surgery" first started to be used by German Surgeons predominantly dedicated to the replacement and repair of facial tissues. The first book, titled "Die Plastische Chirurgie nach ihren bisherigen Leistungen" (I), by F.A. von Ammon and M. Baumgarten, was published in 1842. Plastic Surgery became an official specialty after World War II due to the large demand of reconstruction of war injuries.

2.2. Definition of Plastic Surgery

As ratified on May 5, 1990, by the Specialist Section of Plastic Surgery in the UEMS, "Plastic or Reconstructive and Aesthetic Surgery is that specialty concerned with acute and nonacute conditions which may be congenital or acquired as a result of trauma, disease, degeneration or ageing in patients of both sexes and all ages. Its aim is the restoration or improvement of function and the normalization of appearance and well-being".

2.3. Training in Plastic Surgery

It is foreseen that the training of a Plastic Surgeon in the EU should consist of three years of basic "common trunk" and three years of specialty training, with a transition period up to 1998. For the time being, five years is the minimum required.

The European Board of Plastic, Reconstructive and Aesthetic Surgery, EBOPRAS, has established a log-book with a minimum number of operations which the trainee should prove to have performed during the years of training in the complete spectrum of Plastic Surgery, (Burns, Surgery of Extremities and Hand Surgery, Reconstructive Microsurgery, Cranio-maxillofacial Surgery, Oncologic Plastic Surgery, Genito-urinary Plastic Surgery, Aesthetic Surgery, etc...), either personally or as an assistant.

The specialty "Plastic, Reconstructive and Aesthetic Surgery" is the only one in the EU providing a complete basic training in Aesthetic Surgery.

After Board certification, most Plastic Surgeons concentrate their interest on specific areas of Plastic Surgery, with a tendency to superspecialization which also takes place in other surgical specialties.

Basic training should remain within Plastic Surgery as the most creative Specialty, which developed the principles and techniques for Reconstructive Surgery based on high standards of research, surgical skill and artistic sense.

This is justified as it is for the benefit of the public.

2.4. Training in Plastic and Aesthetic Plastic Surgery

After being selected from the most suitable medical students and on graduation, the Resident should be trained from the beginning in the Plastic Surgical Department of a Teaching Hospital. The advantage is that the Resident is exposed, right from the initiation period, to the principles and basic techniques of delicate tissue handling and replacement.

The Program Director should also coordinate the most suitable rotation to other specialties for different periods of time, such as General Surgery, ENT, Ophthalmology, Orthopaedics, Primary Care, Urology, etc., i.e. the most suitable disciplines of the "common trunk'. This guarantees a better control of the total training program including clinical work, research and academic activities.

If the department does not cover the main areas of Reconstructive Surgery, an agreement should be reached with other Plastic Surgery departments to guarantee a broad based training, including in Aesthetic Surgery in accredited private clinics.

3. AESTHETIC PLASTIC SURGERY

3.1. Development

In this century, Aesthetic Surgery was first developed by Surgeons such as Lexer, Joseph, Passot, Bourguet, Noel, Esser and many others. With specialization in Plastic Surgery it became an important and increasing part of our specialty.

Five *of the 12 Founding Members* of *the ISAPS, Drs. David Serson Neto, Salvador Castaliares, the* late Mario Gontilez Ulloa, the late JosC *Virias, and UIrich Hinderer, signing the "Act of* Organization" at *the UN in New York, also on* behalf of the absent *Founding Members (Drs. Perseu Castro de Lemos, John R. Lewis, Hktor Marino, Rodolphe Meyer, John C. Mustard&, the late Guillemo Nieto Cane and the late Ernesto F. Malbec), witnessed by different accredited Diplomatic Representations, on February 12,1970.*

As a result, we, Plastic Surgeons, founded on February 12, 1970, the "International Society of Aesthetic Plastic Surgery". The "Act of Organization" was signed at the United Nations, in the presence of various diplomatic representatives.

The 12 Founders decided to call this branch of Plastic Surgery "Aesthetic Plastic Surgery" and not "Cosmetic Surgery", term used more in Great Britain and the U.S.

The science of "Aesthetics" was developed in 1750, on old concepts, by Alexander Baumgarten, as the science of beauty.

Aesthetic Surgery would therefore be surgery which creates beauty and thus visual pleasure through achieving harmony of proportions and symmetry of the components of a unit and also by correcting the signs of ageing of appearance.

On the contrary "cosmetic" derives from *"cosmein"* or adorn, and *"kosmed"* from decoration. "Kosmetike techne" would thus be the art of decorating or adornment. It is therefore more appropriate for everything related to external skin care, make-up and cosmetica.

The patient seeking Aesthetic Surgery wishes to regain self-confidence, security and a better adjustment to life when the image of his vitality or the grace of his appearance, whether in his family, professional or social environment are fundamentally in doubt.

Aesthetic Surgery is therefore not only a technical specialty but moreover a science, closely related to psychotherapy and art as well". In the end it is "surgical psychotherapy", the main ethical justification for Aesthetic operations (8,9).

"The training in Aesthetic Surgery should be included as an important part within the training in Reconstructive Plastic Surgery as both are and should always be inseparable.

The advancements in both fields have had a mutual influence in the development, and the aesthetic aims and psychological benefits are common to both branches" (5,8,9).

"Aesthetic Surgery is also the final step of the overall rehabilitation of patients undergoing longstanding and tedious reconstructive surgery for the repair of congenital, acquired, accidental and neoplastic defects".

3.2. Training in Aesthetic Surgery

An important question is: do we adequately train our Plastic Surgery Residents in Aesthetic Surgery? Without any doubt "we offer our young trainees adequate basic theory with a profusion of Courses, Symposia, Meetings and live video-sessions and also access to the abundant literature on the subject"

What are the possibilities for a practical training?

Aesthetic surgery procedures have gradually been removed from teaching hospitals and confined to private clinics or out-patient office facilities.

Actually, National Health Services cannot afford the expenses for elective aesthetic procedures, other than by indication of a psychiatrist, taking into account that there is usually a waiting list even for life-threatening reconstructive procedures and that it would represent an important additional burden to the national or municipal budgets.

Attempts to obtain official recognition of adequate private clinics for training programs have mostly failed.

Residents as well as young Plastic Surgeons may attend operations or may obtain a post within the team of a private clinic. They will only then act as an assistant or be allowed to perform operations assisted by the Senior Plastic Surgeon, as the patient demands to be operated by an experienced Plastic Surgeon, or by the head of the Plastic Surgery clinic, who due to medico-legal considerations will have to assume the responsibility of the results.

3.3. Aesthetic Surgery performed by other surgical specialists

Organ-bound or regional specialists, mainly stimulated by financial reasons, also became interested in Aesthetic Surgery. They may attend Courses and Symposia and travelling Fellowships primarily in Aesthetic Plastic Surgery private clinics.

In principle we have no right to prevent them from attending or from learning from us. In any case we will not prevent them from performing Aesthetic Surgery. We must always remember that our first obligation is to protect the public from inadequate treatment. Therefore I believe it is our duty to teach.

The fact that they try to superspecialize in regional Reconstructive and Aesthetic Surgery does not, however, justify that a gynecologist perform rhynoplasties or facelifts, an ENT surgeon breast surgery or moreover a dermatologist, without surgical training, perform any type of major oncologic or aesthetic surgery, claiming that when doing a face-lift he acts on the skin, which is untrue, as today facial rejuvenation means to act from bone to skin.

The insufficient preparation ethically condemns these practices, which are unjustified and immoral towards the patients.

3.4. Aesthetic Surgery performed by physicians untrained in Surgery.

This is the most serious problem. It is due to several factors:

3.4.1 Aesthetic Surgery is an elective surgery.

3.4.2 Governments do not do enough to prevent physicians without a Plastic Surgery or regional surgical specialty title, from performing Aesthetic Surgery procedures.

In almost all countries the rights of the qualified Plastic Surgery minority are insufficiently protected by administrations against those of the unqualified majority, which uses advertising as an instrument towards the credulous consumer, who is not aware of who is adequately trained.

Plastic Surgeons are bound by deontological rules established by their own Societies which restrict advertising.

Non-specialists are only restraint by Medical College regulations, that in many countries are not strictly adhered to, despite the fact that in many countries the practice of procedures pertaining to surgical specialties is illegal.

Melvin Westreich “I make no judgment of the surgical abilities or results that these surgeons achieve, but I believe that these advertising practices cross the border from legitimate to criminal”. “These surgeons should be stopped, but the laws concerning medical advertising are not as clear as those that cover cigarettes and toilet tissue”.

3.4.3 Private clinics fall under mercantile law and may therefore do as much publicity as they wish.

Frequently they even try to exploit unemployed young Plastic Surgeons for a salary or percentage of the fees. In some countries they also split income with referring doctors, hairdressers, beauty parlors or cosmeticians.

3.4.4 Due to political reasons Governments fail to prevent an excess of staffing in the medical professions.

In Spain almost 100% of the population has access to the National Health Service. However, only a part of medical professionals may work for the Health Service. Many doctors are unemployed and try to make a living as they can. After attending Courses, reading textbooks or viewing videos, they settle down and open their cosmetic clinics, luring the public into a false sense of security. They then join National or International Societies of Aesthetic or Cosmetic Medicine, or Medicine and Surgery, and exhibit certificates, attracting a beguiling public who feels assured to be in professional hands.

Occasionally these Societies even extend certificates of "Master in Aesthetic Surgery" which are unrecognized officially. In general these Societies have more members (and therefore more income from membership dues) and frequently ample additional financial resources, as they are related to the cosmetic business.

It is obvious that in soliciting and performing Aesthetic Plastic Surgery both the untrained physicians and the Clinics commit an immoral act which is by no means justified.

4. WHAT CAN WE DO TO PROTECT THE PUBLIC FROM INADEOUATELY PERFORMED AESTHETIC SURGERY?

4.1. Maintenance of high standards

Our first obligation is to increase knowledge and to maintain a high standard so that the Plastic Surgeon is always distinguished through excellence.

Also in Aesthetic Surgery, Continuous Medical Education (CME) credits should be established.

4.2. Accreditation of National Training Centres for Aesthetic Plastic Surgery

Both the UEMS and the National Boards should recommend to the National Ministries of Education and
Health the establishment and accreditation of adequate Training Centers for Aesthetic Plastic Surgery.

4.3. Isolation from "mala fide" competitor Societies

We must keep our home as clean as possible, isolating those who prefer to support "mala fide" competitor societies and commercial groups producing short-circuit pseudo specialists in Aesthetic Surgery. We should therefore not participate in Courses, Symposia and Congresses of these groups promoting short-circuit teaching.

4.4. Foundation of Aesthetic-Plastic Surgery Societies

National Aesthetic-Plastic Surgery Societies should be formed. They should be exclusively managed and integrated by full-member Plastic Surgeons predominantly dedicated to this branch, affiliated to the National Plastic, Reconstructive and Aesthetic Society and also recognized by the ISAPS.

However, the possibility should be left open to incorporate in the future, as **Associate Members**, colleagues of Regional Surgical Specialties interested in Aesthetic Surgery, and to create in a more distant future, sub-specialty Chapters. I believe this is the only way to prevent the foundation of Regional Aesthetic Surgical Societies by other Specialists, and to keep Aesthetic Surgery controlled by Plastic Surgeons, who are entitled to do so, due to their complete training in Aesthetic Surgery**.**

4.5. Adequate information to the public

The public must be informed by the National Societies, through the media, as to who should do what, where and also why. Our silence would show lack of responsibility towards the public and also to our young colleagues, who have dedicated many years and efforts to be adequately trained.

In any contact with the public, we must stick to our ethical rules. We should always remember that, besides exposing our personal image, we also represent our Plastic Surgery community. Reports should never be deceptive or misleading.

A "Specialist" logo to be used on personal stationeries by the members of National Societies will help the public to identify the Plastic Surgeon from advertising insufficiently trained physicians. It will serve as a distinction concerning training and thus basic condition of scientific quality and ethical behavior. The National Societies should also inform the media.

Proposed draft for a Specialist Logo in Plastic, Reconstructive and Aesthetic Surgery, of the European Section.

4.6. Information to Health Ministries and Judiciary Powers

The National Boards and National Societies of Plastic, Reconstructive and Aesthetic Surgery, and also the UEMS, should whenever possible, inform the corresponding National Authorities that the only Specialty providing full training in Aesthetic Surgery in the EU is "Plastic, Reconstructive and Aesthetic Surgery".

4.7. Information to Insurance Companies

Insurance companies should be contacted by the National Society to establish, in their own interest, differential premiums for Plastic Surgery specialists against nonspecialists for the cover of Aesthetic Surgery.

5. PRIVATE CLINICS: PROBLEM OR SOLUTION?

5.1. Teaching Hospitals vs. Private Clinics

Aesthetic Surgery as elective surgery should be performed either in accredited private clinics (surgical centers or office surgery-suites for outpatient surgery), or in teaching hospitals with independent areas for admission of private patients or with attached outpatient facilities.

The advantages of Private Clinics over Teaching Hospitals are:

- rising hospital costs
- delayed or uncertain admission in hospitals for elective surgery
- reduced possibilities of infection by hospital strains
- specialized nursing staff, also trained in psychological care of the patient
- greater privacy.

5.2. Requirements for private clinics

- Certification by the municipal Health Authorities with authorization as a private clinic or outpatient clinic, after control, mainly of the surgical, anaesthetic and recovery room facilities.
- Agreement with a nearby hospital for additional care in the event of an emergency.

5.3. The Staff

The Director, responsible for the Aesthetic-Plastic Surgery Clinic, should be a Specialist in Plastic, Reconstructive and Aesthetic Surgery, certified by the corresponding National Board, as should also be the Anesthesiologist.

- Adequate staff (assistants, nurses, etc,)

5.4. Optional requirements

5.4.1 Accreditation for training in Aesthetic Surgery by an University or Teaching Hospital, by the National Board and by EBOPRAS.

5.4.2 Quality Assurance of the clinic by the Committee of the “International Plastic, Reconstructive and Aesthetic Foundation“ and its European and National representatives.

The purpose of this Committee is to periodically examine the facilities of Plastic Surgery Departments and also of Private Clinics on a voluntary basis with the aim to improve the quality of care, to confer accreditation and to establish a worldwide register of accredited Plastic Surgery centers.

5.4.3 It is recommended that the UEMS Section of Plastic, Reconstructive and Aesthetic Surgery, in close cooperation with the National Committee for Quality Assurance, develop recommendations concerning “Private clinics for Aesthetic Surgery“, to be presented to the corresponding European and national bodies of the member and associate countries of the EU.

5.4.4 The responsible Plastic Surgeon should obtain CME credits on a voluntary basis.

5.4.5 The National Boards of Plastic, Reconstructive and Aesthetic' Surgery, with the endorsement of the UEMS, at the request of the Section on Plastic, Reconstructive and Aesthetic Surgery, should recommend the corresponding National Authorities to prevent inadequate Private Clinics with non or insufficiently surgically trained professionals from performing Aesthetic Plastic Surgery procedures.

This suggestion has already been taken over by Dr. Jean- Philippe Nicolai as President of the UEMS Section of Plastic, Reconstructive and Aesthetic Surgeons, sending the corresponding request to the Secretary General of the UEMS, Dr. R. Peiffer.

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