Rethinking the Approach to Beauty in Medicine

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In 1907 a surgeon named Charles C. Miller described what he saw as a growing preoccupation with physical beauty in society. “For years,” he warned, “the newspapers and magazines have been devoting many pages to ‘Beauty Chats,’ . . . and the people have gradually developed a desire for knowledge of those means which will enable them to appear to the best advantage.”1 While his colleagues ridiculed patients seeking correction of cosmetic defects, Miller was anxious for them to be seen by responsible surgeons: “Every practitioner who laughs at the patient who questions him regarding an operation, takes the chance of seeing that patient return . . . disfigured for life.”

Nearly a century later, the American public is arguably just as concerned about physical attractiveness as it was in the early days of cosmetic surgery. In a recent survey asking whether “physical beauty” or “inner beauty” “counts more in the real world,” for example, more than a third of participants over the age of 18 said that they thought physical beauty “counts” more. Nearly a quarter of women said they considered maintaining an attractive physical appearance “essential,” and more than half of women said that they considered it at least “important.”2

At the same time, public demand for more diverse and sophisticated ways of enhancing appearance continues to arouse conflicting feelings in the medical profession. On the one hand, clinicians specializing in fields such as dermatology, plastic and reconstructive surgery, and cosmetic dentistry have seen an explosion in the demand for their services. According to the American Academy of Cosmetic Surgery, the number of cosmetic procedures performed annually in the United States has more than tripled in the past decade.3

On the other hand, clinicians from all medical fields may worry that patients’ concerns about their appearance may distract them from issues that are more critical to their health. While it is clear that a person’s appearance can affect his or her social and economic success, it is not obvious that beauty is “medically necessary” for well-being. Furthermore, psychiatric conditions associated with body image distress point to ways in which patients’ anxieties about their appearance can cause them to adopt behaviors damaging to their health.

This issue of MSJAMA examines themes surrounding cosmesis in medicine. Is it possible to distinguish between normative and pathological body image distress? Can clinicians use patients’ dissatisfaction with their appearance to motivate them to change their behavior? How has the medical profession helped to shape stereotypes about beauty? Can physicians, patients, and insurers agree on what distinguishes “cosmetic” and “therapeutic” procedures? Today, concerns about appearance and concerns about health continue to overlap.

REFERENCES

Body Image in the Balance

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You have been weighed in the balance and found wanting. Daniel 5:27

While 21st century Americans are more concerned about being found ample than wanting, the emotional impact of the scale’s judgment is as powerful today as it was in Biblical times. Across the weight spectrum, as many as 66% of women and 52% of men report feelings of dissatisfaction or inadequacy regarding their body weight.1 Once considered to be a mere side effect of weight gain, body image distress is increasingly being recognized as a medical and psychological problem in its own right.

Although body image distress among men appears to be on the rise, the problem still predominantly affects women.2 In part, this may be due to the perpetuation of idealized and unrealistic female body images by the mass media in the United States and other Western countries. For example, since 1922, the body mass index of Miss America winners has steadily decreased to a level that, for most winners in the past 3 decades, lies within the range of undernutrition.3 In a recent study, prolonged exposure to Western television was found to give rise to dramatically increased rates of weight concern and disordered eating in Fijian adolescent girls.4

Current research suggests that the prevalence of pathological weight loss behaviors is increasing as a result of increasing body weight dissatisfaction. Some 35% of dieters in the United States engage in pathological dieting, and one quarter of pathological dieters go on to develop subthreshold or full-syndrome eating disorders.5 Excessive dissatisfaction with body shape and weight may also cause patients to engage in self-destructive behavior such as abuse of diet pills, fast diets, or compulsive exercise.

Practitioners who treat patients with eating disorders are acquainted with the phenomenon of body image distress across the weight spectrum, including underweight patients with anorexia nervosa, normal-weight patients with bulimia nervosa, and obese patients with binge eating disorder. An individual’s belief that her weight and shape are central to her worth as a person, along with an assessment that her current weight as unsatisfactory, leads to the classic eating disorders mind set. The rigid and unforgiving nature of this belief system, combined with the fact that weight cannot be easily or quickly modified, creates a barrier to the positive self-regard that energizes healthful living.

At the same time, some degree of body image dissatisfaction is normative and perhaps even useful for those who could benefit from weight loss. Researchers have suggested that the distinction between pathological distress and normative discontent with one’s appearance is largely one of degree. Heinberg and colleagues propose an “inverted U” model for determining the amount of body image distress that is optimal for producing significant, but not pathological, behavioral change.6 Obese patients who have too little body image distress may not be sufficiently motivated to practice the taxing dietary and exercise routines necessary for weight loss. Conversely, those with too much distress are at risk of engaging in self-destructive measures or may be “paralyzed” by the seeming impossibility of the task.

For the individual whose self-definition is overly dependent on weight and shape, the amelioration of body image distress may be a prerequisite to ongoing healthy lifestyle change.7 Cognitive behavioral therapy has been shown to improve body image even in the absence of weight loss and can complement behavioral and dietary strategies in weight management.8 Self-acceptance and healthy change are not contradictory ideals; rather they are mutually reinforcing principles in the journey toward health.9

The physician’s challenge, then, is to assess the patient’s attitudes toward her body and to assist her in negotiating the delicate balance between acceptance and change. A heightened awareness of media influences and their impact on the target audience may increase the clinician’s ability to empathize with his or her patients’ concerns.

While less precisely measurable than blood pressure, lipid profile, or fasting glucose, the patient’s self-regard is a key component of her overall health and well-being. When excessive or pathological, body image distress is a problem in its own right, and the intentional or unwitting reinforcement of this distress, even in the service of a laudable goal, can have serious consequences for the patient.

REFERENCES
Appearance vs Health as Motivators for Weight Loss

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Obesity is a major cause of morbidity and mortality in the United States, and its prevalence has been steadily increasing the last 20 years. At the same time, the frequency of dieting and other weight control practices may also be increasing. Among people with a body mass index greater than 27, almost two thirds of women and nearly half of men have tried to lose weight. Unfortunately, many adults who initially succeed regain most or all of their weight within 5 years.

Given that many patients are unsuccessful in adhering to weight loss plans, it is important to understand the factors contributing to adherence. One factor may be patients' motivation for attempting to lose weight. In general, concerns about health appear to be the most common motivators, followed by concerns about appearance. However, women who desire to lose weight are more likely to do so in the hopes of improving their appearance, whereas men who wish to lose weight are more likely to be concerned about their future health and fitness.

Research has been inconclusive about whether patients' motivations for losing weight affect their adherence to dieting and exercise regimens. One study found that overweight women who desired to change their appearance were more likely to adhere to an exercise regimen. However, in another study of adults of varying body weight, exercise adherence was associated with enjoyment, competence, and social interaction, but not with a desire to improve fitness or appearance.

Furthermore, for both men and women, exercising and dieting to enhance attractiveness have been associated with body image dissatisfaction. Negative body image may deter obese individuals from exercising in public settings, such as a health club; such individuals may also be less willing to seek medical or preventive health care services. Perhaps for these reasons, patients with an initially positive body image have been found to be more successful in losing weight.

If a patient is motivated to change his or her behavior or lifestyle to lose weight, does it matter what drives this? The research suggests that the answer may be both yes and no. If the desire to lose weight is based on unhealthy or unrealistic goals, it may be medically and psychologically hazardous. Because there are risks associated with cosmetic procedures and various weight loss methods, the clinician should review these risks and discourage unrealistic expectations regarding their use.

Based on our experience in treating obese individuals and on these research findings, we suggest that the process of building obese patients' motivation should begin by emphasizing the health and fitness benefits of weight loss and maintenance. We find that we are more likely to persuade patients to change their attitude if there has been a recent event, such as a family health problem, that reinforces our message. We have also found that patients may be less motivated by relatively abstract medical constructs, such as blood pressure and lipid levels, than they are by physical symptoms, such as fatigue or exertional dyspnea.

As for sociocultural, appearance-based motivators for weight loss, we cannot close our eyes to their potency, but must use them cautiously. Patients who remain unconcerned about the health risks of their obesity may benefit from special emphasis on the other benefits of weight loss, such as increasing fitness and energy level. Failing this, motivation derived from extrinsic societal pressures may be better than no motivation at all. If our attempts to direct the patient's attention to the health, fitness, and energy-related benefits of weight loss have been ineffective, and the patient remains motivated primarily by appearance, this source of motivation should be encouraged, as to discourage it may squelch the patient's only motivation for weight loss.

Incidental social benefits of weight loss are often very powerful short-term motivators. However, these tend to be less effective at sustaining long-term lifestyle change because they often are geared toward transient events, such as losing weight for a wedding or some other social function. Positive changes in lifestyle that are not externally imposed, on the other hand, may be more likely to sustain themselves over time.

Although it is challenging for clinicians to uncover patients' motivators and determine how they will affect behavior, we believe that this is a professional obligation. As part of this process, we often share our opinions with patients about which motivators seem to work best, and those that other patients have found to be the most satisfying and sustainable. We encourage clinicians to dedicate time to discussing both health and appearance concerns with patients struggling to achieve and maintain a healthier weight. An empathic but frank approach will broaden the discussion and allow us to offer patients in their quest, not simply for the ideal body form, but for the ideal of the best health that each patient can achieve.

REFERENCES
The “Jewish Nose” and Plastic Surgery: Origins and Implications

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In 1914, a young woman who had always been self-conscious about the appearance of her nose decided to seek the advice of a surgeon. Her physician, Jerome Webster, made the following diagnosis: “Nose is fairly long, has a very slight hump, is somewhat broad near the tip and the tip bends down, giving somewhat the appearance of a Jewish nose.” Echoing the perspective of a generation of surgeons, Webster concluded, “I think that there is sufficient deformity to warrant changing the nose.”

For over a century, the term the “Jewish nose” has been used in Western scientific literature to describe a set of physical features thought to constitute a distinct, race-based deformity. As early as 1850, Robert Knox, a prominent anthropologist, described the physical features of the Jews as including “a large, massive, club-shaped, hooked nose, three or four times larger than suits the face.” Thus it is that the Jewish face never can [be], and never is, perfectly beautiful.” In the 1900s, the “Jew nose” became the subject of purportedly scientific studies of hereditary transmission; a 1928 text described a “Jew nose” that emerged in the offspring of mixed Jewish and non-Jewish marriages, for example.

By the early 20th century, physicians were arguing that surgical procedures to alter “racial characteristics” such as the “Jewish nose” could be a means of promoting patient well-being. In 1930, William Wesley Carter noted that “the modification of accentuated family or racial characteristics, such as arombic, observable especially in Semitic subjects . . . is frequently of great importance to the individual.” Another surgeon, Vilray Blair, argued in 1936 that, due to prejudice against Jews, “change in the shape of the pronounced Jewish nose may be sought for either social or business reasons.”

The persistence of this charged category in the medical literature raises some important questions about the medical profession’s role in perpetuating racial and aesthetic prejudices. By incorporating this term into their clinical vocabulary, early plastic surgeons unwittingly lent scientific credibility to popular stereotypes about beauty and ethnicity. In this way, the “Jewish nose” was transformed from a facial variation into a specific, pathological condition for which there existed a medical protocol for correction.

At the same time, however, plastic surgery’s appropriation of this term can be seen as a reflection of the fledgling field’s own need for professional and social credibility. Noting that many patients dismissed plastic surgeons as so-called beauty quacks, a professor of surgery at Johns Hopkins was driven to argue in 1927 that “a beauty surgeon works strictly on a commercial basis . . . while a plastic surgeon is . . . one who has the ideals and education of [the medical] profession.” Such surgeons were anxious to convince both patients and other physicians that they were not simply catering to the vanity of the public, but addressing “scientifically” defined deformities that could have great economic and emotional costs for their patients. The incorporation of terms such as “Jewish nose” into the medical lexicon was therefore consistent with the specialty’s struggle to solidify its professional status.

Today, some plastic surgery texts continue to describe the “Jewish nose” as if it were a standard physical deformity requiring surgical correction. A 1996 manual describing procedures for altering ethnic noses, for example, indicates that correction of the “Jewish nose” requires “a classic rhinoplasty with lowering of the dorsum, narrowing of the bony pyramid, refinement and elevation of the excessively long hanging tip.” Another recent manual, while refraining from explicitly using the Jewish nose as a diagnostic category, notes that patients who have “acute nasolabial angles, plunging tips, or foreshortened nasal tip pyramids” were “of Jewish ancestry” or of “Jewish descent.”

However, changes in attitudes toward ethnicity and beauty have caused many plastic surgeons to rethink earlier approaches to physical features associated with ethnicity. In the words of a recent rhinoplasty text, “it is neither feasible, desirable, or possible to transform totally an Asian into a Caucasian or vice versa. . . . Nor is it advisable to transform a Black nose . . . into an aquiline nose better befitting the classic British butler.” Furthermore, recent reports suggest that many patients who elect to have plastic surgery for aesthetic reasons are themselves expressing a specific desire to retain signs of their ethnic identity.

The conflict over the use of the term “Jewish nose” can be seen to reflect a broader controversy about the role of medicine in either altering or preserving ethnic uniqueness. Both in the past and in the present day, cosmetic surgeons have been sought by patients wishing to alter features thought to separate them from the mainstream. By developing medical vocabulary and procedures to respond to these concerns, physicians may not be able to avoid complicity with the social and aesthetic prejudices they reflect.

REFERENCES

Nathan is a 13-year-old boy who was born with cleft palate and underwent reconstructive surgery on the palate and lip as a young child. Although the functional result was satisfactory, the scar on his lip was unsightly. His parents took him to a plastic surgeon who requested preauthorization from the health plan for a scar revision to create a more normal appearance. Would the family’s health plan consider the surgery to be medically necessary?

Medical necessity is a legal term used in most commercial health plan contracts to establish which interventions a health plan will cover for its members. At the same time, physicians think of medical necessity as the criterion by which they judge an intervention to be appropriate.

When used in a contract, the medical necessity standard may exclude some interventions that a physician may consider appropriate for a patient, such as treatments intended primarily to improve appearance. This is frustrating for physicians who feel obligated to do everything possible to help their patients, including correcting cosmetic defects.

The definitions and applications of medical necessity may vary considerably among health plans. While one plan might consider an intervention medically necessary if it is effective in improving health outcomes as determined by scientific evidence, another might require only that an intervention be in accordance with prevailing community standards. Contracts may further limit the range of “medically necessary” services by excluding from coverage certain interventions or entire categories of service, such as cosmetic surgery.

Health plans further specify medical necessity parameters by issuing detailed coverage policies about particular conditions. These may provide for exceptions to excluded services, based on the severity and morbidity of the condition. Even when contracts and guidelines are consistent, they can result in different interpretations for different patients, due to the subjective nature of clinical decision making.

Cleft lip and cleft palate are some of the most common structural birth defects, with an incidence of approximately 1 in 700 live births.1 Like other conditions that have both functional and cosmetic dimensions, its treatment often falls into the gray area between reconstructive and cosmetic surgery. As a result, medical necessity determinations involving this condition have proven to be especially problematic.

Given the particular circumstances described in the case above, a health plan might deny authorization for this intervention because there is no functional defect involved. Alternatively, the plan could consider the scar to be a complication of the earlier operation, in which case additional surgery would be considered to be medically necessary. Ultimately, the decision might depend on the specifics of the plan’s coverage policy and on the degree of the deformity.

Suppose that the unsightly scar resulted in frequent teasing by the child’s schoolmates, leading to problems with learning and socialization. Many medical directors might consider the intervention to be medically necessary under these circumstances, due to the potential psychological damage associated with the condition.2 In addition, a medical director might foresee the ability to avoid future and possibly expensive mental health services, and would authorize the intervention on economic more than medical grounds.

Now suppose that Nathan has already had several procedures to repair the scarring, but that the appearance of his lip is still not normal. At this point his plastic surgeon doubts the benefit of additional surgery. While many medical directors would deny coverage for further intervention under these circumstances, the patient’s family might continue to believe that another intervention is medically necessary. These situations, in which different perceptions of medical necessity are pitted against each other, are uncomfortable for physicians and patients, yet are quite common in practice.

Recently, many plans have made efforts to draw clearer distinctions between cosmetic and therapeutic procedures by addressing, in contract language, the issue of what constitutes restoration to “normal appearance.” In addition, at least 8 states now require health plans to provide coverage for the treatment and correction of cleft lip and cleft palate, although generally only “if medically necessary.”3

The example of medically necessary treatment for cleft palate suggests several important points. First, medical necessity can mean different things to different people and organizations. Second, by contract, most health plans agree to pay for those interventions that its medical directors, not the treating physician, determine to be medically necessary.4

When a case falls in a gray area, knowledge of the particular definition used in a plan, as well as the process used to make the decision, can be important for a physician who wishes to provide the patient with the best possible care. While the language of medical necessity will always allow room for interpretation, physicians can best serve their patients by providing clear information to the health plan.

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REFERENCES
Breast Reconstruction: One Woman’s Choice

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Most women who undergo mastectomy are offered the opportunity to have breast reconstruction. Some women choose to have their reconstruction at the same time as their mastectomy. Others opt to wait. Some must wait, due to medical conditions that increase the risks of surgery. Nevertheless, more than 80,000 women undergo reconstruction after surgery every year. 

I decided not to undergo reconstruction with my mastectomy. When my breast surgeon asked me to schedule a visit with a plastic surgeon, I was reluctant to heed his suggestion. I had just endured a lumpectomy, followed within a week by a wide excision and axillary node dissection, plus a sentinel node biopsy as part of a clinical trial. I had been poked, prodded, and made to watch more vials of my blood collected than I thought humanly possible. I was also sporting drains, stitches, black and blue marks, and a numb left arm.

When I finally agreed to find out more about reconstruction, I found the plastic surgeon extremely thorough. He measured and examined my breasts from every angle. He determined the amount of skin available in my abdominal area, buttocks, and back. He took copious notes about my general health and previous medical history. Finally, he explained in great detail the options for reconstruction.

First, I could choose the least invasive reconstruction procedure, involving the use of saline-filled tissue expanders to stretch the skin over the chest wall, followed by insertion of a permanent breast implant and construction of a nipple on the surface. The second option was flap surgery, using tissue from either my stomach or shoulder to create a pocket for an implant or to create a new breast. Finally, I could select free flap surgery, the “gold standard” of breast reconstruction, in which a new breast would be created from my abdominal tissue, and the blood vessels feeding the tissue would be reconnected underneath my skin.

Along with his explanation of the procedures, the plastic surgeon showed me color photographs of post-mastectomy scars and reconstructed breasts. While it was clear that he considered these pictures to be mere tools of the trade, for me they were extremely graphic and unnerving. To this day, I think that seeing these photographs contributed to my reluctance to view my mastectomy scars.

I decided that I wanted to see some pictures of one of the alternatives to surgical reconstruction—breast prostheses. I found descriptions of both ready-made and custom-made options, and even one company that would make a mold of my breast and create a duplicate. The advantage of a prosthesis was that I would not have to have additional surgery—I could just pop it into a special mastectomy bra, which would have a pocket to keep it securely in place. The negative side, of course, would be that when I removed my bra, I would be reminded of my experience with cancer.

Weeks before my mastectomy would be performed, I stood in front of the bathroom mirror and looked at my naked breasts. They weren’t much, and I never paid too much attention to them. But now that one of them was about to be removed, I was agonizing over the loss. Would I feel disfigured every time I looked at my chest? Would my husband be repelled at the sight of me? Would my kids treat me differently? Would anyone notice?

I weighed all the choices in my mind, talked to my husband about his feelings, and even asked my children for their opinion. The bottom line from everyone was that it was my decision. They would all support whatever I wanted to do. As my husband put it, “I didn’t marry you for your breasts.” My children just wanted me to be healthy and alive.

After a lot of soul-searching, I decided to avoid reconstruction. Probably the biggest factor in my choice was the fact that I had gone through 3 surgeries in 6 weeks. I had been a faithful patient, but at some point in time, I just felt I had to throw up my hands and say, “I have had enough.”

If reconstruction could have enhanced the statistical chance of surviving longer or avoiding a recurrence, I would not have hesitated to go under the knife again. The fact that the surgery was cosmetic only made my decision easier for me personally. I decided that I was confident in my self, secure in my body image, and willing to tackle the world sans breast.

I really did not mourn the loss of my breast. When I awoke in the recovery room, I was so happy to be alive that it didn’t occur to me to feel any less than myself. After about 3 days at home, I finally looked at my chest in the mirror. The scar was long, neat, and very red. I knew that it would fade over time.

Some women choose to undergo reconstruction because they worry that they will not be able to feel feminine without normal-appearing breasts. Others do it to please their husbands or partners. In the end, I decided that I was comfortable in my own skin, and I needed to do what felt right for me.

It has now been 2½ years since my surgery, and when I occasionally think about reconstruction, I immediately dismiss the idea. My prosthesis is comfortable, looks great, and is undetectable. I have adjusted to the new shape and contours of my body. I am relaxed about my appearance and often forgo my bra in the house and have even ventured out in public without it.

I realized that my breasts do not define me as a woman. Perhaps my curves have changed a bit—I’m a little lopsided, but I maintain my warped sense of humor, competitive nature, a sharp tongue, and the need to help others. I’m still me, and I’m alive, happy, and better than before.

REFERENCE