

## MEDICINE AND SOCIETY

### Historical Situatedness of Categories' Meanings in Medicine

Sander L. Gilman, PhD

#### Abstract

Dichotomies in medicine are real, and the boundaries that define them are constantly shifting. Radical antitheses such as healthy versus ill, reconstructive versus aesthetic, or medical dermatology versus cosmetic dermatology can be more clearly understood by considering the cultural context of medicine. This essay examines the latter two antitheses and asks whether medical dermatology should be a category limited to somatic illness. It also examines how the tendency to create and endorse dichotomies distorts the meaning and delivery of surgical procedures as well as reimbursement practices in contemporary medicine.

#### Shifting Boundaries Between Aesthetic and Reconstructive Surgery

In 1992, US Food and Drug Administration (FDA) Commissioner David Kessler, later a distinguished dean of the Yale Medical School, facilitated the FDA's decision to limit access to [silicone breast implants](#).<sup>1</sup> The implants had been allegedly silently leaking their contents and causing a wide range of autoimmune illnesses, including scleroderma, lupus, rheumatoid arthritis, and fibromyalgia, and, it was argued, increasing the risk of breast cancer.<sup>2</sup> Introduced in 1962 by Dow Corning,<sup>3</sup> but not subject to safety testing by the FDA until 1976,<sup>1</sup> the implants replaced a range of substances, from autogenous body fat to paraffin, which had been employed in breast enhancement from the mid-1890s.<sup>3</sup> Kessler, relying on a scientific committee report, halted their general use, but allowed—and here was a critical point of contention—“access to silicone breast implants for patients ... who undergo reconstructive surgery at the time of mastectomy.”<sup>1</sup>

A number of scholars studying reconstructive and aesthetic surgery pointed out the FDA's odd rationale: if silicone breast implants caused pathological reactions (a claim eventually disproven<sup>4</sup>), why would their use be permissible, even under close supervision, in patients who had been diagnosed with breast cancer?<sup>5</sup> Did this not exacerbate cancer recurrence risk among patients who had already survived a severe health crisis? The rationale seemed clear at the time: women—and indeed the word *patient* here meant only women, ignoring the consistent if low percentage of males who present with breast cancer<sup>6</sup>—needed these implants to help ameliorate the psychological trauma of mastectomies. This rationale ignored the simultaneous public appearance of articulate women who had had mastectomies, such as the poet Audre

Lorde, who saw their scars as signs of survival rather than badges of shame,<sup>7</sup> a view depicted on the *New York Times Magazine* cover in 1993 in a photograph titled *Beauty out of Damage*.<sup>8,9</sup> This is one historical example of how personal, social, and cultural meanings of mastectomies continue to be debated.<sup>10</sup>

Breast implants were quietly suggested as an intervention for a psychological side effect of breast cancer surgery, the loss of self-esteem.<sup>1</sup> It seemed that Kessler recognized psychic pain as a treatable symptom, although how to balance the potential benefits of implants in ameliorating psychological trauma against the potential health risks of silicone leakage was never articulated. Kessler noted that insurance companies' payments for implants following mastectomies signaled their social value, while mere augmentation could mask breast cancer during mammograms.<sup>1</sup> This all became moot by May 2000 when the FDA approved saline implants, which replaced silicone ones.<sup>11</sup> Silicone implants never actually vanished from the marketplace, however: implants employing more cohesive silicone gel were approved for broad use in spring 2013 after discussions of health risks posed by silicone leakage finally abated.<sup>12</sup>

### **A Lesson**

What should we glean from the FDA's approach to implants? Be careful when assuming that categories of pathology are universally accepted and unchanging; the categories are, indeed, socially, culturally, and historically contingent and must be contextualized as such. The patients that the FDA imagined having mastectomies were women, who, by World War I, were labeled by society as vain for undertaking aesthetic procedures—even when those procedures, developed by and for men, such as nasal reduction, had been earlier understood as reconstructive.<sup>9</sup> Some religious organizations that had opposed many aesthetic alterations of the body from the early modern period came to advocate, in the 20th century, for procedures such as the “nose job” when men's employability was at stake.<sup>9</sup> This debate pitted those who saw the psychological impact of bodily appearance as trivial against those who saw it as essential for human functioning. Aesthetic surgery became “vanity” surgery and was thus distinguished from “real” surgery—now labeled reconstructive—even when identical procedures were done, as with breast implant procedures. Women trying to look younger or more attractive, Jews trying to pass as gentiles, and blacks trying to pass as white were seen by some as vain or duplicitous if they underwent such procedures. White World War I veterans who underwent procedures to reconstruct their appearance because of their need to be employed or to have a more socially acceptable visage were, however, not viewed in the same light.<sup>9,13</sup>

There are similarly shifting boundaries in the realm of dermatology, where some program directors have questioned whether dermatology residents should use their limited training time to learn cosmetic dermatology,<sup>14</sup> with its implied contrast to the diagnosis and treatment of real dermatological diseases. In other words, there is a

perceived dichotomy between treating real illnesses, such as acne, and pandering to the vanity of members of the upper middle class through Botox® skin tightening. Should funding and training time be devoted to such frivolity? A response to this ethical question, based on what we learn from the FDA's response to silicone breast implants, would do well to emphasize the importance of resisting the temptation to distinguish among categories of treatment based on assumptions about patients' motives for undergoing clinical procedures (surgical, dermatological, or other). Historically contextualizing ethical questions about funding of and training in such procedures enables us to discern that the boundaries between reconstructive and cosmetic procedures are contingent and always shifting.

### **The Contingency of Distinctions Between “Medical” and “Nonmedical” Procedures**

Should we be uncomfortable with aesthetic interventions and applaud reconstructive ones? Why are aesthetic procedures always self-pay and rarely seen as necessary, especially by programs such as Medicare? Should aesthetic surgeons volunteer in programs that provide free cleft lip and palate surgeries to children in resource poor areas but not offer free blepharoplasties to their parents? How can physicians address the dichotomy between treatment of real diseases and treatment that merely satisfies human vanity—that is, between medical and cosmetic dermatology?

Responses to these questions might well come from a considering what a physician's calling is: Is it to “help the sick according to my ability and judgment,”<sup>15</sup> according to the ancients who saw themselves as bound by the religious and moral practices of their age? Let me stress the role of *judgment*, for learning professional judgment is a goal of training. Should amelioration of pain and discomfort be limited to that which we define as somatic only? Should we deal with the body as if it is not intimately connected to and influenced by mind, psyche, and emotions? I suggest not, since physical pain is simultaneously psychic pain, and psychic pain is often experienced in the body. This duality is evident in dermatology, for the surface of the body is the immediate social space we occupy as persons and as patients.

There is, of course, the omnipresent problem of whether and to what extent physicians should be held responsible for responding to patients' psychological as well physical reasons for requesting clinical interventions to modify a stigmatized bodily feature, regardless of whether the source of stigma is breast cancer, deformity from war, or social and cultural privileging of youthful skin texture. Since any stigmatized bodily feature can cause psychic pain, I suggest that it's ethically questionable to perform an intervention that reifies problematic views of the body. If a physician refuses to undertake requested interventions, such as a nose job or liposuction, because doing those procedures does not confront the underlying cause of stigma in unfounded prejudice against nonconforming bodies, should we applaud that physician? Perhaps we should, particularly if such interventions exacerbate stigma and contribute to a kind of

moral damage called *infiltrated consciousness*.<sup>16</sup> Given that a physician's immediate duty is to the patient, not to general society, a physician should try to ameliorate the patient's psychic pain while being aware of its sources—in the social, cultural, and historically entrenched practices and messages in greater society—and while also being aware that [providing an intervention can exacerbate stigma](#) from those sources though it might ameliorate the suffering of an individual patient. Physicians can play important roles in helping to shift meanings associated with being different; this can be good for society (by undermining stigmatizing messages) and good for patients (by strengthening clinician-patient relationships).

### **Implications for Meaning in Medicine**

Diseases of the skin took on social and ideological meanings in the mid-nineteenth century. *Plica polonica* was the dermatological disease ascribed to poor Jews that marked them as certainly as the convex shape of their nose and the prominent form of their ears (“Morris’ ears”).<sup>17</sup> The 19th-century dermatologist dealt with the former; the aesthetic surgeon dealt with the latter. That none of these were real “racial” markers made no difference. Their treatment was seen as nonmedical, allowing Jews to “pass” in gentile society, and was therefore merely aesthetic and sufficiently culturally situated to qualify as vain.<sup>9</sup> Perhaps the trickiest diseases to diagnose in the 19th century, as dermatology developed into a medical specialty, were sexually transmitted infections (STIs). That they are infectious diseases no one doubted, even well before Noguchi and Moore isolated the *syphilis* spirochaete in 1913.<sup>18</sup> But the treatment of STIs, like ear tucks and nose jobs, also treats the serious social stigma that accompanies them. The orthopedic surgeon Jacques Joseph, who helped develop modern *cosmetic* rhinoplasty and breast surgery, recognized as early as 1898 that social stigma caused psychic pain that inhibited normal (healthy) human interaction.<sup>19</sup> He operated on the psyche, not on the body. Ever since, however, aesthetic surgeons bear the stigma of treating vanity diseases, just as early dermatologists were seen as treating STIs and therefore abetting immorality even though they were treating stigma.

What, then, is treated and [who pays for it](#)? Today, we tend to separate out medical interventions based on idiosyncratic decisions of funding agencies, as indeed Kessler did. In a health care system that is heavily reliant on private insurance, the question of what should be reimbursed rests on the profit motive. The rationale for these decisions relies on social conventions of what is medical and what is not at any given moment. In the Weimar republic, the government funded a wide range of free clinics—including one for cosmetic interventions—as many people in prison desired such interventions, which were seen to ameliorate recidivism.<sup>20</sup> (This view has also been espoused more recently.<sup>21,22</sup>) That people would better be able to function in society without the stigma and resulting psychic pain was a given. Now it is also clear that what causes psychic pain differs from time to time and place to place. In societies that are oriented around a culture of youth, Botox interventions have a higher demand than in those that praise

“aging gracefully” (France, for example).<sup>23</sup> These trends reflect ever-changing boundaries between the healthy and the ill that are part of all clinical practice and training.

Thus, to put less curricular emphasis on medical dermatology and more on cosmetic dermatology is to make a real but momentary distinction between the two that will shift over time as social changes shift the boundary between the medical and the cosmetic and, indeed, as this distinction is shown to be only socially defined. I am not arguing that residents should have more freedom to determine what constitutes medical interventions but rather that the shifts in what is considered medical are frequent and often contradictory. Resident physicians do not make those determinations, but they are bound by their seeming inflexibility. One of the central demands on training physicians is to be aware that while the training they are providing is the best possible at any given moment, it might well quickly turn out to be the worst possible as the boundary between the medical and the aesthetic changes. Treating each patient means examining the disjuncture between that patient’s sense of discomfort and the means available to constitute or reconstitute his or her sense of health and wholeness within the parameters of what is considered to be best practice at any given moment. Indeed, that could well be a working definition of medicine in our time.

## References

1. Kessler DA. The basis of the FDA’s decision on breast implants. *N Engl J Med*. 1992;326(25):1713-1715.
2. Independent Advisory Committee on Silicone-Gel-Filled Breast Implants. Summary of the report on silicone-gel-filled breast implants. *CMAJ*. 1992;147(8):1141-1146.
3. Maxwell GP, Gabriel A. Breast implant design. *Gland Sur*. 2017;6(2):148-153.
4. Bondurant S, Ernster V, Herdman R, eds; Institute of Medicine. *Safety of Silicone Breast Implants*. Washington, DC: National Academy Press; 2000.
5. Angell M. *Science on Trial: The Clash of Evidence and the Law in the Breast Implant Case*. New York, NY: Norton; 1996.
6. Yalaza M, İnan A, Bozer M. Male breast cancer. *J Breast Health*. 2016;12(1):1-8.
7. Lorde A. *The Cancer Journals*. 2nd ed. San Francisco, CA: Spinsters Ink; 1980.
8. Matuschka. *Beauty out of Damage* [photograph]. <http://www.beautyoutofdamage.com/Aboutphoto.html>. Accessed October 6, 2018.
9. Gilman SL. *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*. Princeton, NJ: Princeton University Press; 1999.
10. Cromptvoets S. Comfort, control, or conformity: women who choose breast reconstruction following mastectomy. *Health Care Women Int*. 2006;27(1):75-93.
11. US Food and Drug Administration. Regulatory history of breast implants in the US.

<https://www.fda.gov/medicaldevices/productsandmedicalprocedures/implantsandprosthetics/breastimplants/ucm064461.htm>. Accessed September 11, 2018.

12. Calobrace MB, Capizzi PJ. The biology and evolution of cohesive gel and shaped implants. *Plast Reconstr Surg*. 2014;134(suppl 1):S6-S11.
13. Schweik SM. *The Ugly Laws: Disability in Public*. New York, NY: New York University Press; 2009.
14. Bauer B, Williams E, Stratman EJ. Cosmetic dermatologic surgical training in US dermatology residency programs: identifying and overcoming barriers. *JAMA Dermatol*. 2014;150(2):125-129.
15. Hippocrates. The oath. In: Jones WHS, trans. *Hippocrates*. Vol 1. Cambridge, MA: Harvard University Press; 1923:299.
16. Nelson HL. *Damaged Identities, Narrative Repair*. Ithaca, NY: Cornell University Press; 2001.
17. Gilman SL. *Creating Beauty to Cure the Soul: Race and Psychology in the Shaping of Aesthetic Surgery*. Durham, NC: Duke University Press; 1998.
18. Noguch H, Moore JW. Demonstration of treponema pallidum in the brain in cases of general paralysis. *J Exp Med*. 1913;17(2):232-238.
19. Joseph J, Aufricht G. Operative reduction of the size of a nose (rhinomiosis). *Plast Reconstr Surg*. 1970;46(2):178-181.
20. Ramsbrock A. *The Science of Beauty: Culture and Cosmetics in Modern Germany, 1750-1930*. New York, NY: Palgrave Macmillan; 2015.
21. Freedman AM, Warren MM, Cunningham LW, Blackwell SJ. Cosmetic surgery and criminal rehabilitation. *South Med J*. 1988;81(9):1113-1116.
22. Thompson KM. Refacing inmates: a critical appraisal of plastic surgery programs in prison. *Crim Justice Behav*. 1990;17(4):448-466.
23. Morrison AM. Aging gracefully, the French way. *New York Times*. July 14, 2010. <https://www.nytimes.com/2010/07/15/fashion/15French.html>. Accessed October 6, 2018.

**Sander L. Gilman, PhD** is a distinguished professor of the liberal arts and sciences as well as a professor of psychiatry at Emory University in Atlanta, Georgia. He is a cultural and medical historian who has written or edited more than 90 books. His most recent book is *Stand Up Straight! A History of Posture* (Reaktion, 2018).

**Citation**

*AMA J Ethics*. 2018;20(12):E1188-1194.

**DOI**

10.1001/amajethics.2018.1188.

**Conflict of Interest Disclosure**

The author(s) had no conflicts of interest to disclose.

*The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*