Aesthetic, cosmetic and reconstructive: why words matter

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Introduction

Plastic surgery discourse resolves into discussions about appearance-based procedures and those procedures that have a more functional outcome. In the case of appearance-based procedures, there is a general view that the terms ‘aesthetic’ and ‘cosmetic’ are interchangeable, and that expediency can determine which is used. Some consider that applying the label ‘cosmetic’ to the surgeon’s title allows patients to make better treatment provider choices. The term ‘aesthetic’ is thought to be excessively metaphysical and beyond the average patient’s comprehension.

There has also been a tendency among plastic surgeons to label surgery where appearance is not the major focus as being ‘reconstructive’. While plastic surgeons have an implicit grasp of what this means, others may not necessarily share this level of understanding. Irrespective of the terminology, the labels imply that appearance and function involve different surgical activities, are practised by distinct groups of treatment providers and fulfil different patient needs.

In this perspective I argue against these views. There is a distinction between the terms ‘cosmetic’ and ‘aesthetic’. Further, differentiation between appearance-based surgery and function-based surgery is in many cases arbitrary.1 These issues matter because terminology influences our surgical decision making and the perceptions of patients, regulators and insurance companies. These distinctions have far-reaching ethical, economic and health equity implications.

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Discussion

The Medical Board of Australia defines cosmetic medical and surgical procedures as:

‘... operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient’s self-esteem.’

The crucial issue in this definition are the words ‘what the patient perceives’. The patient has a view about his or her current appearance and this motivates a desire to seek change through medical or surgical intervention. Under this definition, ‘cosmetic’ becomes a therapeutic indication.

Aesthetics relate to issues of perceived attractiveness. Anthropological research proposes that facial attractiveness may have a strong evolutionary basis where traits such as symmetry, averageness (a trend towards normality) and perceived health confer tangible social and reproductive benefits. These benefits arise from observable physical attributes. An aesthetically desirable appearance therefore serves as one of several criteria on which to assess surgical outcomes. Under these conditions, ‘aesthetic’ becomes an output of intervention.

A consequence of this approach is that the concept of aesthetics is shifted from the metaphysical into the realm of everyday experience. Since an appreciation of anthropometric norms is a core plastic surgery competency, it follows that a positive aesthetic outcome becomes one of the goals of every plastic surgical intervention. On this basis, aesthetic sensitivity is foundational to plastic surgery.

Consider how the distinction between cosmetic and reconstructive operates in practice and how each has an aesthetic basis. Upper eyelid skin reduction may be motivated by a patient’s desire for improved appearance. Alternatively, the indication for surgery may be a demonstrable visual field defect. In the first instance, the procedure would be viewed as ‘cosmetic’, whereas in the second it would be deemed to have a functional indication. These alternative indications would be handled quite differently with respect to patient access, insurance coverage and resource allocation. Yet patients, the community and surgeons themselves still have an expectation that the aesthetic outcomes in each instance would be of a similarly high standard. This is as it should be. A good aesthetic outcome is as much a metric of a successful plastic surgical procedure as optimal wound healing and restoration of function.

Despite evidence that diastasis repair can improve lower back pain and urinary incontinence following pregnancy, abdominoplasty is currently considered to be ‘cosmetic’ by regulators and third-party funders. While it is a fact that a well-performed abdominoplasty will have a significant aesthetic benefit, this presupposes that patients will be motivated to undergo surgery based on a perceived improvement of appearance. Although that may be true in some cases, the improved appearance is a natural consequence of moving the abdominal anatomy towards its pre-pregnancy state and the consequential improvement in abdominal muscle function. In this case, the aesthetic benefit is an outcome of restoring anatomical normality.

When treating facial skin cancer, the patient will have two concerns: adequate tumour removal and an aesthetically optimal result. Frequently, patients will deliberately choose a plastic surgeon, not because of oncological concerns but because of sensitivity to aesthetics. In this case the aesthetic issue is not change, but preservation of appearance.

Ethical debate in the latter case would be better served by focusing on practitioner behaviour, particularly with respect to exploitative marketing and fostering unrealistic expectations. The distinction between cosmetic and functional motivation is significant to this discussion for three reasons. Firstly, designating a procedure
as cosmetic results in patients bearing the total cost themselves, including anaesthesia and hospitalisation. A non-cosmetic label enables the costs to be shared with third-party funders. There is ongoing negotiation between plastic surgeons, regulators and third-party funders as to which procedures should be deemed ‘cosmetic’ and which ‘functional’. Although imperfect in practice, this system at least has the merit of explicitly characterising various procedures.

Secondly, by making the distinction explicit (albeit changeable subject to future evidence), indemnity insurers have a basis to stratify risk and to accurately price that risk. This should allow premium costs to reflect a practitioner’s case load and practice profile more precisely.

The third significance of having an explicit distinction is to allow regulators to make rational resource allocation decisions, particularly at times of constraint. Conflating a cosmetic motivation with an aesthetic outcome risks negative discrimination towards plastic surgery procedures. The consequence of this is that patients may be denied beneficial treatment.

**Conclusion**

A positive aesthetic outcome equates to a need to achieve or maintain anatomical normality. This is an essential goal for any surgical treatment where the visible results have such profound social and psychological effects on patients. An appreciation of this should focus ethical discourse where it will have the greatest impact on patient welfare and will create an advocacy path to facilitate equitable resource allocation and access to treatment.

**About the author**

Dr Sheen completed his medical degree at the University of Melbourne and specialist postgraduate training in plastic and reconstructive surgery at Emory University in Atlanta and the University of Virginia, USA. He is a Fellow of the Royal Australasian College of Surgeons and a member of the Australian Society of Plastic Surgeons, the Australian Society of Aesthetic Plastic Surgery and the American Society of Plastic Surgeons.

**References**


