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Reframing Ethics in Aesthetic Medicine: Foundations of Patient-Centered Care

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Abstract

This paper explores several important dimensions of the interplay between aesthetic medicine (AM) and ethical considerations, and outlines a potential deontological framework to guide practice in line with prevailing standards. The status of AM has long remained contentious. It continues to lack well-defined practical and moral boundaries, including within scholarly environments, given that its primary goal is to refine personal appearance rather than treat illness. In the current landscape, addressing these questions has become both necessary and timely, particularly as AM professionals serve an expanding and more discerning clientele that has shifted considerably in recent years. Present-day issues in AM involve the absence of international standardization in specialist training, the growing presence of practitioners from varied educational pathways, the proliferation of services delivered outside conventional clinical or hospital environments, and the powerful sway of social media, where ideals of success are shaped by the pursuit of youthful features. As the discipline expands through innovative technologies aimed not merely at modification but also at tissue maintenance and restoration, it is imperative to foster a robust cross-disciplinary conversation to delineate commonly accepted ethical boundaries. This exchange would help AM fully establish itself as a field committed to advancing patient well-being, while preserving regard for individual aesthetic balance, the specialized skills of AM practitioners, the critical priority of safety, and the significance of a trusting, confidential doctor–patient bond.

Keywords: Aesthetic medicine, Ethics, Patient-centricity, Care

Introduction

Aesthetic medicine (AM) is a broad designation for various specialties dedicated to enhancing outward appearance through both invasive and non-invasive interventions (largely elective) that address cosmetic concerns, unattractive outcomes of disease or trauma, and the prevention of aging to fulfill patient expectations [1]. Techniques for improving bodily appearance have existed since early civilizations and have adapted to shifting cultural preferences and ideals of attractiveness. Yet, AM activities have generally been considered apart from disciplines focused on curing disease and delivering healthcare [2]. A closer look at the linguistic origins of AM reveals that “medicine” derives from the Latin medeor, meaning to mend or heal, whereas “aesthetics” comes from the ancient Greek aìsthesis, referring to

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sensory perception and the awareness of all that can be felt, including both beauty and its absence [3].

Ethics represents a core element inherent to the very notion of medicine, extending beyond any specific method, location, or historical period in which physicians work, and it defines appropriate conduct as the cornerstone of every clinical encounter [3]. These foundational ideas trace back to 400 B.C. in ancient Greece, with Hippocrates of Kos; the associated oath compels doctors to care for patients according to their competence and insight, to apply sound judgment, to uphold confidentiality in relationships, to avoid causing harm, and to act in ways that benefit those under their care [4]. This pledge created the groundwork for Western medical deontology (derived from the Greek deonloghìa, denoting the study of duty) [3, 4].

Over time, these principles have evolved in response to developments in medicine and societal norms, culminating in the formulation of the "four principles plus scope" model in the 1980s. Under this framework, ethical challenges in healthcare revolve around four core duties: (1) respect for patient autonomy; (2) the Hippocratic ideals of beneficence and non-maleficence; (3) justice, understood as fairness or equality; and (4) careful attention to the proper scope of application. Within AM, this scope centers on achieving a more appealing appearance, which patients may desire for diverse personal motives (such as resolving relational difficulties or improving employment prospects), thereby demanding a nuanced appreciation of the patient's inner world, drawn from the ancient Greek concept of psykhé (soul) [4]. Autonomy entails the individual's ability for self-governance, encompassing agency (the conscious recognition of one's own desires and intentions and the capacity to act on them), independence (freedom from controlling external pressures), and reasoned, deliberate decision-making [5]. A patient's freedom to make independent treatment choices is intimately connected to the Hippocratic emphasis on confidentiality, rooted in the Latin cum fides (with trust), which obliges those entrusted with private information to withhold it without explicit consent and to honor the patient's autonomy along with their right to privacy [6].

Today's professional environment for physicians bears little resemblance to the world of Hippocrates or even the 1980s. AM experts now use approaches unavailable even two decades ago, while the frequency of procedures continues to surge, driven by declining costs that make them more attainable. However, this rapid progress in AM has not been accompanied by clear criteria regarding who is qualified to perform such interventions, the appropriate venues for delivery, or the standards that must be observed. Consequently, this situation has fostered confusion, including among colleagues in other medical fields, who sometimes perceive AM merely as a means to enlarge their practice and supplement income (as if any medical qualification—or occasionally none at all—paired with short-term training would qualify someone to offer these services) [2].

Earning a reasonable profit is understandable, since AM contributes positively to patient quality of life (QoL) without the responsibility of preserving life itself; still, this commercial dimension has frequently reduced AM to the perception of a superficial, profit-oriented subspecialty [2].

AM likewise operates within the fluid realm of adornment and rejuvenation, commonly termed "cosmetics," originating from the ancient Greek kosmetikòs (adorned). This domain is heavily shaped by prevailing beauty ideals, which in earlier eras were established by artistic works (particularly paintings and sculptures), by political leaders (from the Pharaohs to Marie Antoinette), by film and music celebrities through the close of the twentieth century, and presently by the most influential medium in history: the internet. Etymology once again offers insight: the word "beauty" stems from the Latin bellus, a diminutive form of bonum (good). This linkage already appeared in ancient Greece through the phrase kalòs kai agathòs (beautiful and good), highlighting the fusion of moral and physical excellence as a marker of ideal wholeness. Consequently, beauty can be reinterpreted beyond mere visual appeal to incorporate ethical dimensions of health and virtue, meaning that AM strives for outcomes that satisfy the senses while also supporting overall well-being [7].

Regardless of how beauty is conceptualized, it remains transient, as Ovid observed with the phrase forma bonum fragile est (beauty is a fragile good). This impermanence drives the ongoing effort to sustain it through AM, effectively attempting to outwit time and nature—an apparent paradox, since physicians in ancient Greece approached physis (nature) by aligning with rather than opposing it.

This article aims to investigate the relationship between AM and ethics, with particular attention to the influence of social media, matters of safety and accountability, the intricacies of the doctor–patient dynamic, the pursuit of harmonization, the standing of AM physicians among

professional peers, and the development of a patient-centered ethical approach in AM. This is undertaken with the understanding that, despite its distinctive character, AM has always constituted an essential component of the broader medical field.

Results and Discussion

AM: past and present

Procedures designed to alter the human form have existed for hundreds of years. Ancient Egyptians practiced skull elongation, nasal, ear, and oral reconstructions were documented in India during the 6th century B.C., and accounts of operations for drooping eyelids and gynecomastia appear in 11th-century Turkish writings [8]. During the 19th century, facelifts were performed using solutions containing arsenic and lead, while the development of the syringe enabled the injection of various substances under the skin for cosmetic goals, including less-than-optimal materials such as paraffin [9]. In the 20th century, invasive surgical techniques gained wider acceptance thanks to advances in anesthesia, pain management, and antibiotics, which made possible the facial reconstruction of soldiers disfigured during World War I [10]. In 1921, surgeon Jacek Maliniak established the first plastic surgery clinic in the United States (US) [8]. Certain Hollywood actresses underwent rib removal to create an extremely narrow "wasp" waist, and it has been reported that Marilyn Monroe received a chin sponge implant to achieve a more refined facial contour [11]. The 1960s marked the golden era of breast implants, highlighted by the first breast augmentation using silicone implants in 1962 [11]. The early years of the new millennium witnessed the broader application of botulinum toxin for wrinkle reduction, along with more biocompatible injectable agents for rejuvenation and regeneration—such as hyaluronic acid (HA) and platelet-rich plasma for hair restoration—as well as emerging methods utilizing adipose-derived stem cells that show encouraging outcomes in both regenerative medicine and AM [12-16]. According to 2020 statistics from the International Society of Aesthetic Plastic Surgery, there was a 1.8% decline in all AM procedures globally, largely attributable to safety issues and economic pressures caused by the coronavirus disease 2019 (COVID-19) pandemic [17]. Aesthetic plastic surgery procedures specifically dropped by 10.9%, whereas nonsurgical treatments continued to rise, although at a slower rate than in prior years [17]. The leading surgical procedures worldwide remained breast augmentation (16% of all procedures), liposuction (15.1%), eyelid surgery (12.1%), rhinoplasty (8.4%), and abdominoplasty (7.6%) [17]. The five most frequent nonsurgical procedures stayed consistent: botulinum toxin (43.2% of the total), HA (28.1%), hair removal (12.8%), nonsurgical fat reduction (3.9%), and photo rejuvenation (3.6%) [17]. Notably, even though overall surgical volumes decreased, rhinoplasty, brow lift procedures, and nonsurgical facial rejuvenation rose in 2020 after having declined in both 2018 and 2019 [17]. Regarding age distribution, the majority of rhinoplasty cases involved patients aged 19–34 years (67.9%), while individuals aged 35–50 years represented the largest group receiving botulinum toxin treatments (50.2%) [17]. Dermal fillers may offer therapeutic benefits for children suffering from atrophic conditions such as lipoatrophy and morphea; however, safety and efficacy data in pediatric populations remain limited, and a multidisciplinary evaluation is advised [17]. Although still a minority, the proportion of male patients seeking AM is growing steadily; the American Society of Plastic Surgery documented a 99% increase in cosmetic procedures among men between 2001 and 2021 [17]. Men typically begin with noninvasive options (botulinum toxin injections and HA fillers) and hair removal, later progressing to eyelid surgery and liposuction [17]. Geographically, the US maintained its leading position for surgical procedures (14.7%), followed by Brazil, Germany, Japan, Turkey, Mexico, Argentina, Italy, Russia, India, Spain, Greece, Colombia, and Thailand [17]. Worldwide, hospitals remained the main setting for surgical interventions (43.8%), except in the US, where office-based facilities and ambulatory surgical centers were more frequently utilized [17].

By its very nature, AM does not encompass life-saving measures; therefore, performing a rhinoplasty does not raise the same ethical questions faced by an obstetrician or gynecologist deciding on a late-term pregnancy termination, or by an oncologist managing advanced cancer [17]. In 2020 alone, 10,129,528 surgical and 14,400,347 nonsurgical procedures were recorded globally. As the volume of AM interventions continues to grow, several important aspects of practice require careful examination, particularly as the patient population evolves and places new demands on practitioners in the absence of universally accepted ethical standards [17]. Traditionally viewed as healers,

physicians now face the fundamental question of whether AM functions primarily as a commercial enterprise or as a legitimate component of healthcare intended to serve patients [18].

The World Wide Web: a monster or an opportunity?

While historical beauty ideals—embodied in the athletic figures of ancient Greek Kouroi, Raphael's graceful portrayals of the Madonna, or Renaissance images of full-figured women—emerged from careful anatomical study, today's digital platforms often promote standards that contradict realistic human anatomy. Modern beauty norms are largely dictated by social media, with Western prototypes spreading worldwide and gradually overshadowing traditional concepts held by diverse cultures and ethnic groups, resulting in a concerning homogenization [19].

Although Facebook remains the dominant platform, used by 68% of adults in the US [20], the photo-sharing app Instagram has experienced swift growth, increasing from 28% in 2016 to 35% in 2018 [20]. Created to accelerate interpersonal communication, social media now includes built-in tools for image alteration. The most popular filters are those that simulate youthfulness by smoothing skin, brightening complexion, lightening eyes, and slimming the silhouette. In 2017, the American Academy of Facial Plastic and Reconstructive Surgery noted that 55% of surgeons had encountered patients requesting surgery to improve their appearance in selfies—an increase of 13% from the year before [20]. Even more telling, procedures above the shoulders rose markedly compared with those below the shoulders after February 2020, most likely driven by the widespread adoption of video calls that heighten the desire to look better on camera—often perceived as more critical than real-life appearance (the so-called "Zoom effect") [21].

The profile of the typical AM patient has evolved from affluent women to individuals from varied socioeconomic, ethnic, and cultural backgrounds, who are frequently younger and more knowledgeable. Because social media constantly showcases eternally youthful models, requests for rejuvenation treatments are increasingly common at younger ages [17], giving rise to the paradox of a long-living society that refuses to show its age [22].

Conversely, social media also serves as a valuable channel for AM practitioners to market their expertise, showcase services, and engage directly with prospective clients through live procedure broadcasts. This practice, however, raises ethical questions about whether such content prioritizes entertainment over authentic medical care [23]. On the positive side, social media can encourage patients to pursue realistic aesthetic objectives and promote awareness that AM represents a meaningful way to enhance quality of life (QoL) rather than a short-term cosmetic fix. In the word "ETHICS," the letter "C" should signify care, since AM is fundamentally a medical discipline whose core purpose is to provide genuine care and deliver benefit, meaning it must support the patient throughout the complete treatment journey, from the initial consultation through to post-procedure monitoring.

Physician–patient alchemy

The cornerstone of a successful cosmetic intervention is a strong, genuine relationship between physician and patient, which begins with careful patient selection. Practitioners must always prioritize ethical conduct, ensuring they perform procedures for the right reasons and on the appropriate individuals. Thorough assessment of patient personality traits is therefore essential. Individuals who have consulted multiple clinicians and consistently report unsatisfactory results may be experiencing body dysmorphic disorder, and carrying out treatment on such patients is very likely to result in further dissatisfaction. Similarly, those who display an excessively meticulous or perfectionist attitude may exhibit traits of obsessive-compulsive disorder [24]. Rather than reinforcing a desire that stems from an underlying mental health issue, the AM specialist should feel empowered to decline a procedure when a personality disorder is present [25].

Patients consulting AM specialists typically seek to modify their external appearance while remaining deeply concerned about their post-treatment look. For this reason, the concept of "cosmetic conservationism" must be clearly communicated: the objective of AM is to help patients appear improved yet still recognizably themselves. With the wide array of available modifications, it is theoretically possible to alter one's look so dramatically that even close acquaintances might fail to identify them—an outcome that must be prevented [24]. A physician–patient relationship (PPR) grounded in beneficence-in-trust also requires the doctor to be candid, explaining that the actual results may differ from the patient's original expectations given their starting point and desired goal [26]. In the acronym "ETHICS," the letter "T" stands for trust, because the connection

between physician and patient must rest on confidence and shared understanding. The patient needs to articulate their expectations clearly, while the physician applies clinical judgment to accept, modify, scale down, enhance, or refuse the requested intervention.

A recent worldwide survey conducted among both patients and physicians in the field of AM highlighted several mismatches in the physician–patient relationship (PPR). The findings showed notable differences concerning the ideal age to begin treatment, primary treatment objectives, priority anatomical areas, and obstacles to pursuing AM procedures. These gaps emphasize the need for physicians and patients to establish effective common ground in communication to prevent disappointment and clearly define the boundary between what is wished for and what can realistically be delivered [27].

A clear generational divide exists within the AM patient population. "Baby Boomers" (born between 1946 and 1964) tend to be more affluent, less cost-conscious, and more inclined to pursue durable, long-term outcomes. In contrast, younger individuals in the Millennial generation (born between 1981 and 1994/6) are more likely to "shopping around," often trying a single treatment first to evaluate results before committing to additional procedures. AM specialists must be aware of these differences to build appropriate relationships and tailor recommendations to each patient's personal needs and financial capacity.

The quest for harmony

The word harmony derives from the ancient Greek armonìa, meaning "connection." In aesthetic medicine, achieving a harmonious face or body involves introducing new shapes and proportions that integrate smoothly with the patient's existing features rather than conflicting with them. From our perspective, the letter "H" in "ETHICS" should represent harmony. Beyond any culturally or evolutionarily influenced anthropometric norms, the beauty search must always respect the individual's unique anatomical characteristics and their specific interrelationships, guided by a balanced aesthetic understanding of the whole person.

The Golden Ratio (approximately 1.618) describes the mathematical proportions that the human eye perceives as most aesthetically pleasing. These ratios appear throughout nature, have been employed in art for centuries, and have been the subject of numerous studies exploring whether they hold the key to human beauty [28-30]. Nevertheless, efforts to demonstrate that facial attractiveness can be reduced to a strict mathematical formula have produced inconclusive findings [31]. Furthermore, each patient's natural anatomy imposes practical limits on the rigid application of the Golden Ratio. Strict adherence to mathematical and anthropometric rules would often require multiple interventions to attain overall geometric "perfection." Instead, true respect for beauty begins with respect for biology and the distinctive proportions of a face shaped by an individual's unique, millennia-long genetic heritage, rather than by algebraic calculations [31].

In this sense, AM aligns seamlessly with other medical specialties and with the broader principle of precision medicine, which tailors approaches according to the unique interplay between a person's environment, lifestyle, genetic makeup, and treatment decisions [32].

When a patient wishes to retain a youthful appearance, the AM physician must address wrinkles and skin laxity while anticipating how the individual's features will naturally evolve with age. This creates a confidential, ongoing partnership between doctor and patient that extends beyond a single visit and includes continuous follow-up care. The goal of sustaining a youthful yet authentic look over time calls for repeated interventions that transform the unavoidable effects of aging into something graceful and genuine (from the Greek aùtentikòs, meaning 'author' or 'original').

Today, AM benefits from increasingly sophisticated, less invasive technologies that honor the natural character of the face. A prime example is hyaluronic acid (HA) fillers, where HA is a substance naturally present in the skin's dermis. Depending on the specific formulation, treatment zone, and injection strategy, HA fillers can achieve a range of objectives—from softening superficial and deep wrinkles to performing bioremodeling. In younger patients, they serve as a preventive tool against wrinkle formation. At the same time, in older individuals, they provide conservative, regenerative benefits through their well-documented moisturizing, elasticizing, and antioxidant effects, which accumulate with successive treatments and are supported by a growing body of clinical research [15, 16, 33]. It is therefore unsurprising that HA fillers rank among the most sought-after procedures: they offer a versatile, beautifying option with genuine regenerative and restorative qualities, restoring both aesthetic appeal and tissue function rather than serving mere vanity.

Moreover, the principle of aging prevention is central to AM. While harmonious results following treatment are attainable, they cannot be achieved to the same degree in every case, as outcomes depend heavily on each patient's genetic background, age, and lifestyle.

Safety and responsibility

"Safety" derives from the Latin securus, meaning without worry. When applied to medicine, this implies that the patient, the procedure itself, the setting in which it is performed, and the individual performing it must all be free of unnecessary risk. "Responsibility" stems from the Latin responsa, meaning "response" or "accountability," and requires the physician to answer for their decisions and actions. An intriguing etymological suggestion links the term to the Latin phrase res-rem ponderare, meaning to carefully weigh all relevant factors before taking action. From our perspective, the letter "E" in "ETHICS" should represent education, because AM practitioners cannot rely on improvisation. Their professional development must include continuous learning and active collaboration with colleagues to guarantee that every patient receives care from the most qualified hands possible.

AM procedures carried out by doctors lacking proper specialized training remain a persistent and serious concern. This problem has become even more pressing with the surge in popularity of non-invasive treatments, which has encouraged a growing number of non-medical professionals—such as cosmetologists, aestheticians, and electrologists—to offer these services without adequate medical background, formal instruction in skin science, cosmetic surgical methods, related clinical knowledge, or strategies for patient support after treatment [31]. Combined with differing regulatory frameworks across countries, this situation has created a troubling gray area between genuine medical interventions and simple beauty services. As a result, hybrid medical spas and retail clinics have proliferated; these venues often fail to adequately address potential safety risks while promoting access to cutting-edge technology at low cost, guaranteeing dramatic outcomes without complications, and promising rapid recovery [34].

On the positive side, office-based and outpatient surgical procedures have grown in number thanks to refined surgical methods, safer anesthesia options, and more effective pain relief. Nevertheless, performing surgery outside hospital settings can introduce safety risks, since the qualifications of the AM physician, the quality of equipment, the types of procedures offered, and the availability of emergency support are not currently held to the same strict regulatory standards and oversight applied in hospitals [35]. In our view, the letter "S" in "ETHICS" should stand for safety, because the practice of aesthetic medicine must always prioritize the reduction of every possible risk before, during, and after any intervention. This commitment rests on the provider's expertise, the security of the clinical environment, and a thorough evaluation of the patient's medical background.

Informed consent must be obtained only after the physician has established realistic expectations by clearly describing the procedure and all associated risks. Furthermore, to reduce the likelihood of complications during or after treatment, it is a fundamental ethical duty to obtain a detailed patient history, including any existing medical conditions and allergies, as these factors may increase risk, render the procedure unsuitable, or lead to less-than-ideal results [36]. Should contraindications exist, the ethical principle of autonomy allows the patient to choose to proceed regardless; however, the AM physician retains the right to decline if the intervention would not provide meaningful improvement or benefit. A declaration of ethical principles issued by the World Medical Association states that "The patient cannot demand medical treatment that conflicts with legal requirements, professional ethics, or accepted clinical standards; in such cases, the physician has no professional duty to comply" [37].

Seven essential criteria underpin valid informed consent: the capacity to understand and decide; free and voluntary choice; full disclosure of relevant information; a recommended course of action; clear comprehension of the terms and agreement with the plan; and formal authorization of the plan [38]. Informed consent is considered valid only when all seven criteria are satisfied. A particularly sensitive situation arises when the patient is an adolescent. In such cases, consent must be provided by a parent or legal guardian. An important ethical and deontological challenge emerges when parents or guardians must approve or reject an adolescent's request for cosmetic enhancement—an often deeply personal desire that may be difficult for others to fully comprehend [39]. Consequently, the AM physician plays a crucial role in building trust with both the young patient and those legally responsible, guiding

the process toward a decision that benefits everyone involved [39].

Class action

Because aesthetic medicine is frequently misunderstood—even within academic circles—it becomes an ethical imperative for AM physicians to deliver care with skill, consistency, and careful reflection. To distinguish themselves from unqualified practitioners and earn full recognition as legitimate medical professionals, specialists must pursue ongoing education and accumulate substantial practical experience. In addition, exchanging knowledge with colleagues worldwide broadens clinical perspectives by connecting practitioners who care for patients with diverse aesthetic goals [24]. Regular discussion of clinical cases helps refine techniques and address shared ethical challenges related to the physician–patient relationship, expectation management, and the boundaries that must be respected—the most responsible course of action.

Collaboration and open knowledge-sharing among peers also facilitate deeper research in AM, engaging both pharmaceutical companies and patients. Scientific work in this field is increasingly guided by ethical considerations, focusing on aesthetic improvements that are paired with lasting enhancements in tissue quality. Since AM intersects with multiple disciplines—including plastic surgery, maxillofacial surgery, and dermatology—it is essential to act now to foster a clear professional identity rooted in a common ethical commitment that places the patient at the center of every decision. In our view, the letter "I" in "ETHICS" should represent identity, because in a world that rapidly standardizes beauty ideals, the AM physician must perform procedures in ways that safeguard each patient's individuality and authenticity over time.

Conclusion

In a culture saturated with constant visual imagery, the number of AM procedures has grown dramatically. This expansion raises important questions about how to uphold professional ethics and medical deontology amid the growing popularity and commercialization of aesthetic treatments. Because body image perception directly influences mental health, it raises broader concerns regarding the proper role, boundaries, and ethical foundations of medical specialties dedicated exclusively to the pursuit of "beauty." According to the World Health Organization (WHO), health is defined not merely as the absence of disease or infirmity but, more comprehensively, as "a state of complete physical, mental and social well-being" [40]. It is therefore clear that aesthetic medicine qualifies as a genuine medical discipline and must be practiced in close alignment with sound ethical standards.

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