Medical Necessity Reimagined: Cosmetic Surgery through the Lens of Capabilitarianism and Resourcism

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Abstract: This project seeks to investigate the circumstances in which cosmetic surgery can be deemed medically necessary based on competing political theories of justice. The literature review is focused on outlining various approaches to conceptualizing health, medical ethics, and medical necessity, and I explain the differences in resourcist and capabilitarian interpretations of medical necessity and their application to cosmetic surgery. At its conclusion, I hope this project advances the study of bioethics and readers contemplate implications for clinical practice, health care delivery, health financing, and health policy initiatives.

Introduction

The practice of cosmetic surgery is ethically complicated and fraught with moral concerns. While there are many complicated ethical issues concerning cosmetic surgery, this project will investigate how capabilitarian and resourcist approaches to justice and human welfare might argue that certain cosmetic procedures should be considered medically necessary. These two approaches were chosen because they are closely related, and both attempt to define a just society and determine how to support human thriving.

There is a variety of literature to look at when considering the topic of medical necessity. In the review below, I draw first from literature concerning how we define health, and then address standard approaches to medical ethics and why they are insufficient when applied to cosmetic surgery. The next section considers current debates about enhancement versus therapy and what alternatives to cosmetic surgery already exist. Medical necessity is then defined and related to current practices in the US regarding insurance coverage. Lastly, I outline resourcism and capabilitarianism, explain the differences in their interpretations of medical necessity, and discuss how these approaches can be applied to cosmetic surgery.

I will argue that medical necessity can be reimagined to include all services and procedures that individual physicians and the medical community at large believe to be clinically indicated for physical and mental health. In my larger project, I determine whether certain circumstances make cosmetic procedures medically necessary by constructing scenarios in which theoretical patients desire certain procedures. I evaluate the medical necessity of each procedure in these scenarios by considering and answering questions specific to both resourcist and capabilitarian theories of justice. By the end of my completed project, the reader should be able to develop their own framework through which cosmetic surgery procedures can be evaluated for medical necessity.

Literature Review

Health

Much of the debate surrounding the ethics of cosmetic surgery is based on one's conception of health. Medical practice is guided by the goal of maintaining optimal health; thus, health informs all medical decision making. The World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO Constitution2020). The expansive WHO definition is not fully accepted by many stakeholders, yet it has remained unaltered since the organization's founding in 1946. As it relates to cosmetic surgery, the WHO definition appears to lend its full support to enabling people to feel their best via surgical means. However, it is unclear whether the WHO would truly encourage the use of cosmetic surgery to alleviate mental health issues and emotional distress. Many take issue with the inclusion of social well-

being as a matter of health, believing it places too great a burden on the medical profession to solve social ills (Callahan 1973). Some believe the WHO defines a state of happiness, not a state of health. Others believe the WHO's conception of health is simply aspirational since health services could never be effectively distributed and used to treat all potential "medical" problems that arise from this definition. Moreover, it seems quixotic to expect medical science to eliminate unhappiness. Critics cite the importance of first establishing physical health equity rather than focusing on social and psychological issues (Saracci 1997). Detractors of the WHO definition contend that one's personal desire for cosmetic surgery represents a way for them to attain happiness, not health.

Following the first publication of the WHO definition of health, authors have continually critiqued, reworked, and fashioned their own definitions, adding in qualifiers and limitations in an attempt to create more realistic objectives for medicine since many scholars have criticized the WHO definition of health as idealistic and unobtainable (Callahan 1973; Saracci 1997; Bircher 2005). One such example is Johannes Bircher, who writes, "Health is a dynamic state of wellbeing characterized by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility" (Bircher 2005). Bircher's definition eliminates more recent critiques that the WHO idea of health cannot take into account the rise of chronic illness. Most physicians in the US operate under the idea that restoring health equates to preventing and managing disease with less emphasis on the patient as a unique individual with complex concerns and wants. While the WHO espouses a very holistic approach to health, that is far from the reality of American health care delivery. Physicians in the US spend little face-to-face time with patients and encounters are focused on the treatment of disease, management of chronic illness, and restoration of physical health.

Basic Medical Ethics

One's conception of health informs their application of medical ethics. Since the 1979 publication of Beauchamp and Childress' four principles of biomedical ethics, physicians have made medical decisions based on respect for patient autonomy, nonmaleficence, beneficence, and justice. Respect for autonomy describes a patient's right to make their own well-informed medical decisions. Nonmaleficence refers to a physician's duty to do no harm, and beneficence is achieved when physicians both improve their patient's welfare and weigh the benefits and risks of medical intervention. The principle of justice refers to the need for equal distribution of access, costs, risks, and benefits to patients. Though Beauchamp and Childress' principlism has long been accepted in all aspects of health care delivery, it has sparked much debate when applied to cosmetic surgery. Much of the literature concerning the basic ethics of cosmetic surgery focuses primarily on difficulties respecting patient autonomy and a duty to do no harm, and on establishing a balance between nonmaleficence and beneficence (Chung et al. 2010). One way to frame the concerns surrounding maleficence and cosmetic surgery is to consider whether the procedures performed are considered enhancement or therapy. Those who oppose widespread enhancement of society often assert that cosmetic procedures constitute a form of harmful enhancement and are thus unethical extensions of medical practice (Pellegrino 2004; Maio 2007).

Enhancement versus Therapy

Cosmetic surgery has been hotly contested by those who view it as a complete and total departure from medicine, arguing that the practice caters to consumer-driven desires generated by a beauty-obsessed culture. According to ethicist Edmund Pellegrino, cosmetic surgery constitutes "patient-desired abuse." Pellegrino warns about medicalizing all facets of society by extending the term patient to those who consider themselves unhappy in any way, whether it be with their mind, body, or soul (Pellegrino 2004). Others argue that cosmetic surgery fits within the larger framework of biomedical advancement and enhancement, and thus should be pursued and further explored in an effort to push humankind to perfection (Caplan and Elliott 2004). The goals of medicine have long been focused on alleviating diagnostically recognized problems within the mind or body. With the advent and rapid proliferation of the cosmetic surgery industry, more traditional theorists take issue with what they view as an inappropriately

broad application of medical practice. Those in Pellegrino's camp are expressly opposed to Caplan's support of extensive developments in biotechnology and medicine, which they worry will bastardize the medical profession. Maio (2007) takes Pellegrino's argument further, asserting that cosmetic surgery cannot be classified as medicine since cosmetic surgeons are not performing any type of "healing," rather, they are acting purely on the desire of their patients to alter their appearance in order to fit in with perceived social norms. Therefore, Maio concludes that cosmetic surgery does not solve a medical problem, it only attempts to fix a social problem. However, in attempting to alleviate socially felt physical inadequacies, cosmetic surgery only serves to worsen that same problem by increasing the number of people who appear "normal" through artificial means (Maio 2007).

In the enhancement versus therapy debate, much of the public remains convinced that cosmetic surgery is solely a method of anatomical enhancement, spurred on by a desire to look younger, fitter, and more conventionally attractive. There appears to be no consensus among theorists on whether or not cosmetic surgery constitutes a form of therapy for emotional and social suffering related to body image and self-esteem. Cosmetic surgery is a gray area lying in between services universally regarded as outside the medical profession, such as tattooing or piercing, and procedures that are fully within the scope of medicine, like treating severe burns or cancer. Body modification has a long history and includes a range of practices, from foot-binding in China to nose piercings in Hinduism. While cosmetic surgery is fairly accepted within American culture, many continue to hold negative opinions of those who seek out the service, considering them to be vain, shallow, or narcissistic (Bonell et al. 2021; Saxena 2013; Tam et al. 2012). Though other forms of body modification are now considered expressions of self-identity, cosmetic surgery has not been similarly embraced. However, scholarship devoted to measuring cosmetic surgery patient motivations has found that most patients are seeking cosmetic surgery in order to improve their mental, emotional, and social well-being. A study surveying recipients of cosmetic procedures found that increasing self-confidence, feeling happier or improving quality of life, and looking good professionally were common motives behind patients' desires to undergo cosmetic surgery (Maisel et al. 2018). Those seeking cosmetic surgery are not merely attempting to become more beautiful. Rather, through attaining beauty they believe they will improve their mental, emotional, and social health. Some theorists keep these motivations in mind when choosing to support or oppose the practice of cosmetic surgery, considering the profound suffering that can result from dissatisfaction and unhappiness with one's appearance.

Sandman and Hansson (2020) evaluate how the differences in suffering among those with "functional" and "nonfunctional" conditions should inform the distribution of publicly subsidized plastic surgery. Functional conditions are commonly treated with reconstructive plastic surgery and include trauma after burns or cancer. Nonfunctional conditions would typically be treated by cosmetic plastic surgery and include dissatisfaction with the appearance of one's nose or breasts. Sandman and Hansson argue that nonfunctional conditions would warrant publicly subsidized plastic surgery if the patient experienced some form of suffering which the medical system could validate, though they are unsure what form that validation would take. Additionally, the authors define suffering as a person's experienced quality of life. There does not exist a clear and absolute hierarchy with regard to funding procedures for functional versus nonfunctional conditions since patients with functional conditions can experience less suffering than patients with nonfunctional conditions. Researchers found that patients requesting surgery for purely aesthetic reasons, as compared against those with both functional and aesthetic reasons, scored worse on multiple diagnostic scales for mental health (Cordeiro et al. 2010). However, those requesting reconstructive surgery are typically prioritized in the health care system though they experience less emotional distress than those who desire cosmetic surgery. Sandman and Hansson argue for statistical normality to be used as a tool to decide what procedures should and should not qualify for public funding. With regard to nonfunctional conditions, statistical normality of emotional, mental, and social suffering would be medically evaluated to determine if someone was experiencing higher levels of emotional distress due to their condition than what

was considered statistically normal. Unfortunately, the authors do not provide details about which diagnostic approaches might be used to quantify levels of suffering. Additionally, the authors assert that physical abnormality takes precedence over perceived suffering. Unlike Pellegrino's or Caplan's approaches, Sandman and Hansson do not speak in absolutes. Rather, they devise a strategy to help rationally differentiate between what procedures should and should not be considered a form of therapy and thus be granted public funding.

Alternatives to Surgery

Given financial concerns and the scarcity of medical resources, when a simpler and cheaper treatment alternative exists for remedying an ailment, a physician will prescribe that method rather than the more costly and invasive option. When individuals experience mental and emotional struggles, they are typically encouraged to see a psychologist or psychiatrist to help them learn to cope with their feelings and progress to a state of acceptance and emotional stability. Unless diagnosed with body dysmorphic disorder (BDD), patients seeking cosmetic surgery are routinely granted their requests with little pushback from surgeons. Much of this phenomenon may be attributed to the fact that cosmetic surgery is currently regarded as medically unnecessary in the US, and thus, private practices are comfortable supplying these procedures because they are not covered by insurance and are paid out-of-pocket by patients. Private practices therefore have no financial incentive to direct a paying patient elsewhere, even though counseling may be a cost effective and less risky treatment for their body image issues.

Medical Necessity

Though the ethical opinions surrounding cosmetic surgery discourse are wide-ranging, most authors are usually answering the question of whether cosmetic surgery is medically necessary. If the author's response is no, their arguments adopt similar positions found in Pellegrino and Maio's writing. If ethicists believe cosmetic surgery is medically necessary, they put forth arguments akin to those of Caplan and Sandman and Hansson.

Scholarship on medical necessity in the United States focuses primarily on the vast and variable landscape of health insurance. Janet Dolgin (2015) discusses the history of the term medical necessity in the US and implications of the ever-evolving definitions on health care delivery. In the US today, individual insurance agencies determine medical necessity, often frustrating physicians who feel their medical experience and opinions are being ignored in favor of cutting costs. According to physicians, medical necessity refers to all actions which are clinically indicated. Conversely, insurance agencies create complex coverage plans that are often at odds with what medical professionals would prescribe given that they prioritize financial gain over the utilization of medical services. In 2016, the American Medical Association stated that medical necessity consists of:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider (AMA 2016).

In 2010, after the passage of the Affordable Care Act, the Institute of Medicine considered developing national guidelines for making determinations of medical necessity. However, this idea was never realized due to significant pushback from private insurers, and medical necessity remains a variable and confounding principle in American health care delivery (Dolgin 2015). With the current boom in cosmetic surgery, it would be prudent to establish a position on the medical necessity of cosmetic surgery procedures.

Thinking about medical necessity can be colored by social and cultural understandings of various procedures, such as abortion, transgender health care, and cosmetic surgery. Some scholars draw a distinction between those who receive plastic surgery due to a currently medically defined need, such as gender dysphoria, breast cancer, or severe burns, and those who desire plastic surgery because of personal perceptions of need or desire (Dubov and

Fraenkel 2018). However, individuals in both camps experience similar suffering no matter the cause. In the same way that exposure to popular media has long been regarded as a potential risk factor in developing an eating disorder (Morris and Katzman 2003; Spettigue and Henderson 2004), perhaps exposure to media may also instill in people a false sense of physical inadequacy that they feel can be rectified via cosmetic surgery. The key issue at play is whether perceived social acceptance and personal psychosocial well-being are valid justifications for determination of medical necessity. While some believe that personal dissatisfaction is not a strong enough reason for requiring surgical intervention, others disagree.

In the US, the idea of medical necessity has been conceptualized to mean whatever services the insurance industry believes it should cover. I posit that medical necessity can be reimagined to include all services and procedures that individual physicians and the medical community at large believe to be clinically indicated for physical and mental health. Additionally, though the current principlist approach to medical ethics reigns supreme, it only provides vague guidelines for when cosmetic surgeons should and should not operate. Principlism does not adequately address the unique complexities surrounding cosmetic procedures. Beauchamp and Childress' ethical guidelines emphasize the importance of autonomy and nonmaleficence, but cosmetic surgery directly challenges the primacy of patient autonomy concerning invasive and permanent surgical alterations and blurs the line between harm and healing. When standard medical ethics are applied to the practice of cosmetic plastic surgery, physicians are left with unanswered questions. As a result, many scholars have written about the ethical dilemmas facing the modern cosmetic surgery industry. With this understanding of the current ethical landscape surrounding cosmetic surgery, I will now pivot to frame those ethical concerns within the context of the resourcism and capabilities approaches to justice in order to determine how cosmetic surgery could be deemed medically necessary and distributed as such under a resourcist or capabilitarian society.

Resourcism

The resourcist approach to justice centers on the rights that individuals have to goods that will enable them to achieve well-being. Resourcism is a means-focused theory of justice, asserting that with fair access to goods, people can live in a just world no matter what they are ultimately able to transform those goods into. However, resourcists do not believe that justice demands total equality of distribution; some goods may be distributed unequally. The resourcist approach has been defined by philosopher John Rawls' seminal work, *A Theory of Justice* (1971). Rawls argues for justice as fairness and contends that when people are put in the original position behind a veil of ignorance, they will desire for all people to have an equal right to basic liberties, and that social and economic goods are attached to positions open to all and are distributed so that socioeconomic inequalities benefit the worst off in society (Rawls 1971). Resourcists assert that with fair distribution of goods, people will then be able to pursue their own unique goals and interests in society. Rawls believed that humans are sufficiently rational beings who, when acting on rational desires, can determine what is good and right for themselves. In summary, resourcists are primarily concerned with how to distribute goods in an equitable way so as to ultimately bring about equality or fairness of opportunity.

One common critique of resourcism is that it does not take into account circumstances such as disability or prevailing social norms that impact how individuals are able to live their lives (Sen 1979). Some resourcists disagree, arguing that resourcism does take individual differences in body and mind into account, as well as how those differences influence one's ability to convert resources into outcomes. One such resourcist, Thomas Pogge, also explains that in order to address the ways in which standard human needs do not align with all human diversity, resourcists might compensate those individuals by giving them more resources in other aspects of life (Pogge 2002).

Capabilitarianism

In response to Rawls' distributive approach to justice, a new movement emerged spearheaded by Amartya Sen and Martha Nussbaum. Sen and Nussbaum articulated an alternative to Rawlsian resourcism, arguing instead for what they termed the capabilities approach. In contrast to resourcism, the capabilities approach is ends-focused. The capabilities

approach is expressly focused on the capacity and capability of individuals to secure their own well-being. Additionally, the capabilities approach intrinsically considers the diverse nature of human need across different populations. Rather than asking what should be given to people in order for them to survive and flourish, capabilitarians consider what people can realistically do and how they can function as their own change agents. Capabilities represent the freedoms and true opportunities people have to achieve different states of being and doing. States of being and doing are thought of as an individual's "functionings." Capabilitarians remark that resourcism places importance on the possession of goods as advantageous rather than on how advantage is determined by the relationship between people and goods (Sen 1979). Within the capabilities camp, there is disagreement about whether these theories should include a comprehensive list of human capabilities that must be achieved. Some scholars, like Sen, elect not to include a list and believe each group or society adopting capabilitarianism should decide among themselves what capabilities they value. Others, most notably Nussbaum, fashion a fairly exhaustive list. A brief description of Nussbaum's ten capabilities is as follows:

1. Life: Living out a life absent of premature death or suicide.

2. Bodily Health: The ability to maintain good health via sufficient food, water, and shelter.

3. Bodily Integrity: The ability to exist and travel without fear of harassment, abuse, or violence, as well as the ability to achieve sexual satisfaction and reproductive choice.

4. Senses, Imagination, and Thought: The ability to use one's senses and mind in a whole and meaningful way, free from infringement or persecution; the ability to produce creative and artistic works; the ability to avoid unnecessary pain and experience pleasure.

5. Emotions: The ability to undergo healthy emotional development free from trauma, fear, and anxiety; the ability to form attachments and feel a full range of emotions towards things and people.

6. Practical Reason: The ability to plan one's own life according to their conception of the good.

7. Affiliation: The ability to perform social interactions, form relationships with others, identify and relate with others; the ability to attain the social bases of self-respect and be treated as equal.

8. Other Species: The ability to feel and express concern for the natural world.

9. Play: The ability to take part in and enjoy recreational activities.

10. Control over One's Environment: The ability to participate in the body politic, hold property and goods, and find employment, as well as being guaranteed freedom of speech and association and freedom from unwarranted search and seizure (Nussbaum 2013).

Regardless of differences within the literature, at its core, capabilitarianism is best summarized by the following statement: By serving each individual's capabilities, people are enabled and encouraged to fully function in society.

Table 1 summarizes the resourcist and capabilitarian ethical frameworks.

Table 1: Proposed framework of resourcist and capabilitarian ethical approaches. The categories on the left of the table were adapted from researchers at Brown University (Bonde et al. 2013)

	Resourcism	**Capabilitarianism**
Deliberative Process	What rights and goods relating to health would people need in order to establish fairness/equality of opportunity?	What capabilities contribute to health and well-being?
Focus	Directs attention to the means by which people are able to achieve well-being, rather than on their utilization of means or the outcomes of utilization.	Directs attention to the ends people are able to achieve with access to necessary capabilities.
Definition of Ethical Conduct	That which protects people's fair access to rights and goods.	That which results in increasing one's capacity to fulfill their capabilities and measurable improvements to one's well-being.
Motivation	Give people the resources necessary to establish fairness in society.	Ensure people are able to transform their capabilities into functionings in order to maximize well-being.

Application to Health and Cosmetic Surgery

In Rawls' initial publication, he explicitly stated that health was a natural good and was granted through an uncontrollable lottery, and thus, it was outside the scope of fair distribution. Rawls' theory of justice posits that only social goods should be distributed in order to enable individuals to realize and fulfill their life plans. Rawls did however include freedom of the person in his basic liberties, which includes freedom from "psychological oppression" Additionally, Rawls also included a right to the social

bases of self-respect and argues that this right is one of the most important primary goods at stake (Rawls 1971). The social bases of self-respect are defined by the social institutions which enable individuals to realize their own worth, gain the confidence to pursue their life plan, and fully engage in society. Perhaps health could qualify as part of fulfilling the social bases of self-respect. As such, beauty standards and social expectations about appearance could be considered a form of psychological oppression and thus be protected against via plastic surgery.

Some resourcist scholars have pushed back against Rawls' notion that individuals would not desire a right to health in the original position and have since argued that health is entirely within the scope of resourcist conceptions of social goods and rights, and that access to health care is paramount to a fully realized conception of justice (Daniels 2008). Scholarly discussion about the inclusion of health into resourcism typically defines health in more basic terms than the WHO, focusing on social determinants of health that would enable normal functioning (Ekmekci and Arda 2015). Norman Daniels' (2008) "normal functioning" approach is one of the most prominent examples of using resourcism as a theory to support the distribution of health. According to Rawls, all people should possess fair and equal opportunities for work based on their natal talents and skills, which is usually referred to as his equality of opportunity principle. Daniels effectively broadens Rawls' original principle to include health care institutions as one of the players responsible for establishing equality of opportunity. Rather than add health to the list of social goods, Daniels maintains that opportunity is the good at stake. Daniels asserts that opportunities can only be realized when individuals experience a baseline level of health according to normal human functioning, and he thus seeks to make health a precondition of equality of opportunity.

Daniels explicitly states that his conception of health stands in stark contrast to the notion that health includes all facets of well-being and happiness. Rather, normal human functioning is based on measurable and quantifiable ranges of species-specific variation. Daniels does not specifically write about cosmetic surgery, so it is unclear whether he views psychosocial decline due to beauty and social norms as a departure from normal human mental functioning, whether that psychosocial decline meaningfully decreases one's equality of opportunity, and whether society has an obligation to remedy reductions in opportunity due to psychosocial decline as it relates to beauty norms. However, Daniels does comment that:

> The relative moral importance of treating different diseases and disabilities can in part be judged by reference to their impact on the range of opportunities open to us. Because this range of opportunities is itself socially relative, being affected by technology, education, wealth, and other cultural factors, judgments about the relative importance of treating different diseases and disabilities will have some social variability… (Daniels 2000).

Ultimately, Daniels' approach obligates health care providers to facilitate and promote the typical functioning of individuals in order to produce "normal competitors" for opportunities, rather than fully equal competitors.

As noted earlier, Thomas Pogge explains that resourcism can take into account how social factors and norms impact one's ability to transform resources into outcomes if those differences are due to past inequalities in access to resources (Pogge 2002). Pogge claims that resourcism can compensate individuals who, by virtue of human diversity, have been placed in a worse position in society. Pogge's line of logic could then be used to argue that those whose mental health and body image are worse than others could be given special access to cosmetic surgery to mitigate the way societal norms have put them at a disadvantage.

The capabilities approach has also been directly applied to the ethics of health and health promotion. Jennifer Prah Ruger (2010) addresses how people want access to good health as well the ability to achieve it, and that health is a required element of human flourishing as the end of justice. Within the capabilities approach to health, there is disagreement about which conception of health should be used to determine what capabilities are relevant to health status. Some believe that a full health capability equates to the ability to achieve all other capabilities, such as those included in Nussbaum's list, while other theorists believe the simpler disease conception of

health is a more straightforward method to establish agreed upon metrics and limits of health capability (Venkatapuram 2015).

In contrast to other capabilitarian thinkers, Elizabeth Anderson (1999) explicitly explores how cosmetic surgery could play a role in a just society. Anderson argues that people have a right to all capabilities necessary to avoid interaction with oppressive social relationships and a right to all capabilities necessary to function as an equal citizen in a democratic state. Anderson further contends that functioning as an equal citizen requires one to be endowed with rights to the social conditions of being accepted by others, "such as the ability to appear in public without shame, and not being ascribed outcast status." Anderson (1999) later hypothesizes that if it is too difficult for social movements to influence more flexible beauty norms to account for the ugly, publicly subsidized plastic surgery could plausibly be awarded to those individuals. This conception of the capability approach inspires many questions about how and whether we should differentiate between those who experience actual social discrimination because they do not fit in with beauty norms, versus those who feel ugly but who have no noticeable "defects" to most people.

While most other capabilitarian thinkers do not comment directly on the relationship between their theories and cosmetic surgery, their ideas can still be readily applied to the practice. Under a general capabilitarian theory, human diversity, including various mental states, is taken into account. This is particularly relevant to cosmetic surgery since two people with similar physical appearances may feel vastly different about whether they are "healthy" and able to fully function in society as they currently exist. An individual desiring cosmetic surgery may experience distress such as embarrassment, depression, and anxiety related to their perceived deformity or imperfection, and they may feel disinclined to be social because they do not want to be seen around others. When resourcism and capabilitarianism are applied to the practice of cosmetic surgery, they could likely draw differing conclusions about the necessity of these medical procedures. The preceding literature review illustrates the diverse ethical considerations that factor into decisions regarding the medical necessity of cosmetic surgery.

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