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# **Body Modification Practices and the Medical Monopoly**

Joseph Tarquin Foulkes Roberts

(Forthcoming in *Social Theory and Practice*)

## **Abstract**

The state currently grants the medical profession a monopolistic entitlement on the legal use of medical technology. As physicians are duty bound to not expose people to medically unnecessary harm, individuals who wish to engage in Body Modification Practices are effectively precluded from doing so as only physicians are legally entitled to use medical technology. In this paper I argue this is incompatible with respect for persons. Abolishing the medical monopoly allows us to meet the demands of respect for persons by granting access to technology, whilst still upholding physicians' right to refuse to provide requested services and thereby determine the boundaries of their profession according to what they consider to be the internal morality of medicine.

Keywords: Body Modification Practices, Respect for Persons, Medical Monopoly, Conscientious Refusal, Controversial Medical Services

## **I. Introduction**

In this paper I argue in favour of liberalising access to medical technology so as to enable those individuals who wish to pursue Body Modification Practices (BMPs) to do so. Under current UK statutory Law, the defence of consent does not apply to the pursuit of BMPs, although it does apply to conventional surgery.<sup>i</sup> This, I argue, is a consequence of the medical monopoly (i.e. the web of legal entitlements that grant exclusive licences to use medical technology to physicians). This state backed control by physicians over appropriate uses of bio-medical technology precludes those who wish to pursue BMPs from living their lives in accordance with their own values.

Drawing on an account of respect as non-interference I argue that although physicians are entitled to refuse to perform BMPs if they consider they fall outside the realm of medicine (for example by being incompatible with the physician's professional duty to benefit people in health-related ways or to promote their 'best interests'), the profession should not

be granted a monopoly on the use of medical technology. Individuals who wish to engage in BMPs as a form of self-expression, resistance to dominant social codes or as an aesthetic pursuit should be entitled to do so irrespective of whether these activities expose them to health risks for no countervailing health benefit.

The argument of the paper proceeds as follows. In section II I provide a definition of Body Modification Practices and argue that the fact physicians are under a professional duty to provide health-benefits precludes them from participating in the pursuit of many BMPs. Section III grounds the claim that physician's currently have monopolistic entitlements to use medical technology. Section IV briefly presents an account of respect for persons which, in section V, is used to argue that physician refusal to participate, when coupled with monopolistic control over medical technology, is incompatible with respecting people. This, I argue in section VI, gives us reason to liberalise access to medical technology by abolishing the medical monopoly. In section VII I argue that although extending access to medical technology to non-medics may raise safety concerns, these do not constitute a reason to uphold the medical monopoly; before turning, in Section VIII, to dismissing the claim that we have a duty to uphold our health strong enough to ground prohibiting access to medical technology. Finally, section IX considers and rejects the possibility that using the person's 'best interests' to determine physicians' professional obligations could solve the problem of lack of access to medical technology created by the existence of the medical monopoly.

## **II. Body Modification Practices and Physician Refusal**

Body modification is a term which has been used to denote a somewhat heterogeneous group of practices such as: tattooing, scarification, piercing, branding, cosmetic surgery, body building, hair styling, body painting and make-up, the insertion of implants and hardware under the skin, tanning, skin whitening, the use of prosthetics, voluntary amputations, gender reassignment surgery, circumcision, sub incision of the penis, neck and skull elongation, stretching of various body parts, the sharpening of teeth, and the sustained use of corsetry or other constricting devices.<sup>ii</sup>

What, if anything, unifies these practices? Firstly the practices all involve the non-trivial alteration of the physical size, shape, appearance and/or functionality of the body even if they do so with varying degrees of permanence and using different methods. The second unifying feature of this group of practices is the way in which the body is modified. Body

Modification Practices (BMPs) involve deliberate and purposeful alterations of the flesh, as opposed to mere passive acceptance of bodily changes. Defining BMPs as purposeful and deliberate allows us to distinguish between progressively losing one's pigmentation as a consequence of working night shifts, which would not be a form of BMP, from engaging in skin whitening, which would be.

The pursuit of BMPs has often been pathologised in the psychological and psychiatric literature. In particular, the pursuit of BMPs is often taken to be a reason to question the quality of the person's agency and the voluntariness of the decision.<sup>iii</sup> The suggestion is that, although individuals claim they want to engage in BMPs, the desire to engage in these practices is likely to be the kind of desire that people aren't autonomous with respect to. If the pursuit of BMPs is generally non-autonomous, the objection proceeds, the fact people are precluded from engaging in them is not a cause for concern.

This attempt to downplay the importance of BMPs in virtue of them being non-autonomous, however, ought to be resisted. As Thomas Schramme argues, we have little reason to believe that all instances of BMPs are pathological as there are plenty of cases which it would be a stretch to consider involuntary or the product of a form of disordered agency.<sup>iv</sup> Individuals who engage in BMPs report doing so in order to achieve a myriad of goals. Some people engage in BMPs as a means of creating personal narratives, pursuing beauty or expressing themselves as individuals; others as a way of connecting with spiritual and cultural traditions, expressing group affiliations or as a means of resisting dominant social trends. Still others modify their body to test their physical endurance and explore their sexuality.<sup>v</sup>

Those who engage in BMPs seem to take their activities seriously and engage in them as a way of achieving a variety of goals. Although it is possible that some individuals engage in BMPs non-autonomously, this is not always the case. If say, someone engaging in BMPs couldn't endorse their desire, reflect on their motivations or control their impulses; they may be non-autonomous. Whether or not a particular individual is non-autonomous with respect to their BMPs, hence, will depend on the particulars of the case. The important point is that establishing that the pursuit of BMPs is non-autonomous cannot be done in general terms. Absent strong empirical evidence that demonstrates participants have faulty understandings of their own motivations and behaviour, are non-autonomous with respect to their desires, or

have diminished agency; we ought to take participants reports of their own activities seriously.

Individuals who wish to pursue BMPs will find it hard to find a sympathetic physician. The reason physicians are likely to refuse to participate in BMPs is that their pursuit is often incompatible with the goals of medicine. Physicians have a professional duty to provide health-benefits,<sup>vi</sup> an important corollary of which is the duty to not expose people to medically-unnecessary harm.<sup>vii</sup> Edmund Pellegrino, for example, argues that clinical medicine centres around a healing relationship between the person afflicted by an ailment and the individual who professes to heal.<sup>viii</sup> As the medic offers themselves as a healer of a vulnerable ill person, physicians are duty bound to further the health of the people they care for. Leon Kass also takes the view that medicine is, first and foremost, about health and that uses of medical skill and knowhow in the pursuit of other projects is incompatible with the internal morality of medicine.<sup>ix</sup>

Although BMPs are pursued for a number of reasons, they are not normally pursued as a means of restoring or maintaining the person's health. Moreover, the pursuit of BMPs often involves exposing oneself to health risks (e.x. tissue damage, infection...) for no countervailing health benefit. This distinguishes BMPs from conventional surgery, which exposes individuals to similar risks in order to reverse, avert, control or mitigate other more serious medical harms. The lack of a countervailing health benefit makes physician involvement in BMPs problematic in a way that their involvement with conventional surgery is not. As physicians have a duty to refuse to provide services which are incompatible with the goals of medicine, a category into which many BMPs fall, people who wish to engage in BMPs will find it difficult to find a sympathetic physician to perform these procedures and, if they do, it is likely that their attempts will be thwarted by the profession as a whole.

There are some notable exceptions to medicine's focus on health. Cosmetic surgeons perform a number of non-health based BMPs like rhinoplasties, breast implants and liposuctions with the goal of enhancing people's beauty (or at least helping them look like they want to look). As cosmetic surgery has been allowed to flourish, this could be seen as an indication that medicine as a whole isn't committed to the goal of health.

This, however, is not the case. The existence of non-health based BMPs within the boundaries of the profession is an inconsistency in current practice, one that clashes with the general obligation of physicians to promote people's health. The use of medical technology

by doctors to enhance people's beauty has been continually subject to dispute in the medical profession at large.<sup>x</sup> Cosmetic medicine as a field has struggled to gain recognition since the facial reconstruction techniques developed following WWI were applied to alter the faces of individuals who had not suffered battle wounds. Whilst restoring normal functionality to wounded soldiers was the proper domain of medicine, the beautification of individuals without severe facial deformities was considered an illegitimate use of medical technology.

Non-health based BMPs are marginal practices within the wider profession even when they are practiced. The marginal status of cosmetic surgery has led to a proliferation of attempts to justify it as a means of promoting people's 'best interests' or a more holistic notion of health. For example, it is often claimed that rhinoplasties and breast enlargements can be justified in virtue of their psychological benefits, such as increased self-confidence and decreased anxiety.<sup>xi</sup> On this interpretation of cosmetic surgery, the aesthetic goal is merely a means to the goal of alleviating psychological burdens. This way of viewing cosmetic surgery is an attempt to legitimise the practice in the eyes of the wider medical community by linking it to the wider goals of the profession (which include promoting and maintaining people's mental health).

These justifications for cosmetic surgery imply a wider view of the boundaries of the profession which does not fit well with how we ordinarily understand medical practice. I will return to the question of whether we ought to reinterpret the role of medicine and adopt a best interest standard in section IX. There I will argue that adopting a best interest standard only serves to perpetuate the problem posed by the medical monopoly: the fact professions have undue influence over what people are allowed to do with their bodies. For now it is important to note that, although cosmetic surgeons perform some non-health based BMPs (such as rhinoplasty), there are other forms of BMP they do not provide (such as scarification or branding). As a consequence, some people will be precluded from pursuing their plans.

To summarise, Body Modification Practices (BMPs) are practices in which one purposefully and non-trivially alters the shape, size, appearance and/or functionality of the body. As engaging in some forms of BMPs exposes individuals to health-risks, physicians are likely to object to providing some of these procedures. In the next section I ground the claim that the medical profession has monopolistic legal entitlements to use medical technology. In

sections IV and V I show how the existence of the medical monopoly, when coupled with physician refusal to participate in BMPs, is incompatible with respect for persons. This, I argue in section VI, gives us reason to abolish the medical monopoly.

### **III. The Medical Monopoly**

By medical monopoly I mean the web of legal entitlements that grant exclusive licences to use medical technology to physicians. The state grants physician's monopolistic control over the uses of medical technology in a number of ways.<sup>xii</sup> Firstly, the medical profession has a monopoly over technology like surgery in virtue of the fact possessing a medical licence is necessary to perform it legally. Without a licence to practice, any form of cutting another person opens the 'cutter' up to charges of wounding, Actual Bodily Harm and Grievous Bodily Harm regardless of whether or not the activity was consensual as it would not constitute 'reasonable surgical interference'.<sup>xiii</sup> Under current UK statutory law an individual cannot give valid consent to another to perform surgery on them unless that other person is a licensed medical professional.<sup>xiv</sup> By granting physicians (and not all moral agents) this power to insulate themselves from criminal charges when consent has been sought, the state erects barriers to entry around the entitlement to use certain technologies (surgical techniques and prescription only medications for example). Physicians, hence, benefit from a state backed monopoly over licences to practice which enables their professional societies to exercise control over who can use medical technology without facing charges of Wounding, Actual Bodily Harm and Grievous Bodily Harm.<sup>xv</sup>

As licences to practice are granted through professional societies on the condition that those who acquire them practice medicine according to certain standards, monopolistic control over *who* can get a licence means that professional societies effectively determine *how* the technology is used.<sup>xvi</sup> An example of this control are the limitations set on Cochlea implants. Cochlea implants are electronic medical devices that replace the function of the damaged inner ear. Unlike hearing aids (which make sounds louder), Cochlea implants bypass the damaged parts of the ear and transmit sound signals directly to the brain. By bypassing the normal hearing process, cochlea implants can theoretically enable individuals to hear sounds that people with organic hearing devices would not be able to, such as ultrasound. In virtue of physicians as a group having a monopoly over the terms of access to medical technology,

however, cochlea implants can only be adjusted to pre-determined settings by medical experts.<sup>xvii</sup>

#### **IV. Respect for Persons and Non-Interference**

A basic tenet of liberal political philosophy is that respect is the appropriate response to persons. To be called to respect something is to be called to take account of that thing in one's deliberations,<sup>xviii</sup> to be called to constrain our behaviour towards it in some appropriate way.<sup>xix</sup> As respect is a response to the value of a thing, the way in which we respect something depends on what we are being called to respect.<sup>xx</sup>

One characteristic of persons that is often considered worthy of respect is their ability to value things and choose in light of their values as a means to furthering their projects. An important way in which we demonstrate our respect for this capacity is by constraining our behaviour towards them by granting them a sphere of non-interference<sup>xxi</sup> in which they can live their life in accordance with their own values.<sup>xxii</sup> Constraining the behaviour of others by granting individuals spheres of non-interference allows us to ensure that their ability to pursue complex plans is not thwarted by the unwanted actions of others. Thwarting other people's plans by interfering is to treat them as unimportant, it is a failure to perceive the value inherent in people pursuing the projects that matter to them<sup>xxiii</sup> and, in virtue of this, a failure to respect them at people.

Importantly this is true even if we disapprove of the actions of a person. Respect for persons is a form of recognition respect and, hence, is owed regardless of whether we have pro-attitudes towards the choices the person we are called upon to respect makes. This means respect for persons is not a form of appraisal respect, which is a response to excellence.<sup>xxiv</sup> We neither can, nor should, have appraisal respect for the bad, foolish or sub-optimal. We must, however, have recognition respect for them as people regardless of whether we deem their pursuits to be excellent. Although respect for persons does not require we value what other people value, it does require that 'we let that person go his own way, whether we approve of it or not'.<sup>xxv</sup>

Some authors argue that respect requires more than this. Robert Noggle, for example, argues that respect for person's gives us at least *prima facie* reason to promote a person's aims.<sup>xxvi</sup> Sarah Buss conceives of respect for persons as being intimately connected to the sublime and takes it to involve recognition that our perspective on reality is necessarily par-



tial.<sup>xxvii</sup> Ian Carter argues that respect has an attitudinal component as well as a behavioural component which requires we treat other people as ‘opaque’.<sup>xxviii</sup> This, however, needn't concern us here, as whatever respect requires above and beyond granting people the space to live their own lives free from interference is for the purposes of the argument of this paper immaterial. The argument against the medical monopoly does not depend on demonstrating that its existence does not actively further people's projects or that it gives expression to non-respectful attitudes. It is conditional on respect involving non-interference, which is something virtually all conceptions of respect agree upon.<sup>xxix</sup>

In conclusion, one of the reasons people are entitled to respect is in virtue of possessing the capacity to value things and choose in light of their values. In order to exercise these capacities and pursue projects over time, individuals need to be free to act. It is for this reason that, whatever else respect requires, it requires non-interference with their choices. What remains to be shown is how the existence of the medical monopoly, when coupled with physician refusal to participate in BMPs, is incompatible with respect for people and their capacity to pursue projects. This is the task of the next section.

## **V. The Medical Monopoly and Non-Interference**

The existence of the medical monopoly is incompatible with respect for persons as current legal arrangements do not take adequate account of competent people's power of consent. Individuals who wish to engage in BMPs must, under current UK legal arrangements, find a practitioner who is not a physician to help. These practitioners, let us call them Body Modification Specialists (BMSs), are not entitled to perform surgery on people in light of them not being licensed medical practitioners. Not being covered by the defence of consent to charges of Wounding, Actual Bodily Harm or Grievous Bodily Harm, Body Modification Specialists (BMSs) work in a legal grey zone where they are vulnerable to prosecution regardless of whether or not the person undergoing the procedure consented. Not giving normative weight to an instance of morally transformative consent is incompatible with respect for persons as it is through the power of consent that we alter the normative landscape.

In consenting, we absolve particular others of some of the obligations our rights impose upon them; making an action which was impermissible, permissible. This is crucial if people are to live their lives in accordance with their own values as many (if not all) of our

plans and projects involve other individuals. The medical monopoly limits the group of people who can enter into morally valid transactions to perform BMPs to physicians. This is especially problematic in light of the fact that those who are entitled to use medical technology without fear of prosecution are entitled to do so only on the condition that they do not act against the goals of medicine as defined by their professional societies. As professional societies have a monopolistic entitlement to issue licences to use medical technology, individuals whose BMPs fall outside the realm of procedures professional societies allow their members to provide will be effectively precluded from pursuing their projects.

As the medical profession has a monopoly over the legal terms of access to medical technology, it is difficult for individuals to engage in BMPs which fall outside the realm of medicine. The medical monopoly does this by limiting the group of people who are entitled to use medical technology without fear of prosecution through government backed licensing arrangements. The upshot of this is that those who wish to engage in BMPs cannot do so without being vulnerable to interference by others. Without the protected sphere of action respect requires we grant people, those who wish to engage in BMPs risk having their plans frustrated.

The medical monopoly grants the medical profession the power to enforce obligations which arise from their (voluntarily accepted) professional codes on people who may not subscribe to them. Although respect for persons requires allowing people to form voluntary associations which make membership conditional on following codes of practice, it counsels against allowing these groups to govern the actions of non-members. Although physicians as a group are entitled to collectively determine the goals they adhere to, and even if the *practice* of medicine is inherently teleological (aiming toward health), the telos of a practice cannot transfer to the technology itself.

Limiting the use of medical technology to physicians for the purposes of health is an expression of a particular ordering of values which gives health a special weight among the projects that could be pursued through the use of medical technology. While it makes sense to conceive of a practice being teleological, accepting the idea an object or a piece of technology used in that practice has an inherent goal requires buying into controversial metaphysical assumptions that individuals in liberal societies cannot be forced to live by. Technology often has multiple uses and the fact that one of those uses is medical in no way shows that that use ought to be prioritised. Superglue (2-Octyl cyanoacrylate) is used for a variety of purposes.

One of the uses of superglue is as a way of quickly sealing wounds, yet no one believes that using superglue for other purposes (e.x. model aircraft construction) is problematic. The same goes for the internet. Precursors to the internet such as ARPANET were first developed by the military for research use. The World Wide Web was created at CERN in Switzerland by Tim Berner's-Lee. Still, the internet has no telos; it is not *for* anything aside from what we use it for.

Decreeing that a particular piece of technology is to be used for one end and not another is beyond the scope of any profession in a liberal society even if determining their own goals as a collective association of people is. Whilst the profession is entitled to refuse to use particular forms of technology or skill for particular ends, professional societies shouldn't be granted exclusive rights to dictate what constitutes appropriate use of particular forms of technology. Respect for persons requires that it be within the individual's purview to decide what to value, how much to value it and, so long as they do not cause harm to others, to pursue their ends with the appropriate means. As much of the technology used by physicians can be put to other ends (such as beauty or self-expression), granting them monopolistic entitlements to use it precludes people from pursuing things they value by depriving them of the means they need to achieve their goals; which is incompatible with respecting them.

It could be objected at this point that the existence of the medical monopoly does not preclude people from modifying their own bodies (which respect requires we allow them to do), it merely precludes other people from helping them modify their bodies. This form of interference with our plans, called indirect paternalism, may not be as problematic as stopping a person from using their own means to pursue their own goals. This, Thomas Schramme argues, is true when an individual does not possess a right to another person's assistance or when the individual offering the service doesn't have a strong entitlement to do so (such as when the service is inherently harmful or morally dubious).<sup>xxx</sup>

Although there may be a difference between direct and indirect paternalism in some circumstances, in the case of BMPs the distinction breaks down. Even if it is true that people don't have a right to another person's assistance in the pursuit of BMPs, they do have the right to access the means through which to do so. The existence of the medical monopoly does not merely preclude individuals from offering and accepting assistance, it also precludes them from accessing the means to pursue their projects by themselves. The medical mo-

nopoly as it currently stands, hence, cannot be defended on merely indirect paternalistic grounds.<sup>xxxi</sup>

Finally, it is also not clear that offering to assist people in the pursuit of BMPs is an inherently morally dubious or harmful service. Unless one takes the view that a person's health is the only legitimate reason for altering one's body (i.e. the view that the medical monopoly promotes), it is far from clear that the pursuit of BMPs is inherently harmful. Many people achieve things they value through the pursuit of BMPs and willingly take health risks to achieve them in much the same way people trade off their health for success or gratification in others realms of life. The fact that engaging in BMPs involves the alteration of the individuals flesh is not in itself a reason to consider the activity harmful. Although it may be problematic for physicians to offer to help people undermine their own health in the pursuit of other goals, the problem lies in the fact it could be considered a violation of voluntarily accepted professional duties. Absent the professional commitment to prioritise health over other goals, providing assistance in the pursuit of BMPs seems no more morally dubious than a boxing coach assisting a professional boxer to lose water weight before a fight weigh-in (which can have adverse health consequences), or a rock climbing instructor assisting someone in negotiating a potentially dangerous ascent.

## **VI. Abolishing the Medical Monopoly**

Above I argued that it was the *combination* of physician refusal to participate in the pursuit of BMPs and the existence of the medical monopoly that precluded people from living their lives in accordance with their own values. In order to enable people to engage in BMPs: i) force those who possess licences to provide services or, ii) allow individuals who are willing to perform these services to do so. In this section I will argue for the latter option. The medical monopoly should be abolished in favour of a liberalised market for medical technology which does not fail to respect either those who wish to engage in BMPs, those who perform them (BMSs), or the physicians who want nothing to do with BMPs.

Michael Cholbi argues that the fact that physicians benefit from a medical monopoly implies that they do not possess a right to conscientious objection and, hence, can be compelled to provide controversial medical services. Failing to do so, Cholbi argues, allows physicians to violate the duties of reciprocity they have incurred in virtue of their privileged

position.<sup>xxxii</sup> What Cholbi considers inconsistent ‘is medicine enjoying a cartel status that provides it a monopoly on these technologies while also arrogating to itself the right to deny people access to these technologies’.<sup>xxxiii</sup> Cholbi’s argument for forcing physicians to provide controversial services proceeds on the assumption that physicians ought to have a monopoly over medical technology.<sup>xxxiv</sup> This is the assumption this paper challenges.

Physicians who object to engaging in BMPs have as much (and no more) of a right to live their own lives in accordance with their own values as all other individuals. Respect for persons requires we do not force them to provide their skills in the pursuit of goals they consider to be either wrong or counter to the way in which they view the goals of their profession. When physicians freely associate to constitute professional societies and collectively determine their professional obligations, respect for individual physicians generates an obligation to respect their collective determinations of their obligations. Forcing physicians (either individually or as a collective) to forgo their values and act against their professional obligations is a big price to pay for others being entitled to access medical technology. Moreover, it is an unnecessary price to pay. If, instead of forcing physicians to perform BMPs, we allow Body Modification Specialists (BMSs) to use the technology necessary to do so, we can ensure that people who wish to engage in BMPs (and access other controversial services) can do so without forcing any of the parties to act against their values. Abolishing the medical monopoly, hence, allows us to respect BMSs, physicians who wish to refuse to participate and the individuals who want to pursue BMPs. If the medical profession ceases to have monopolistic entitlements to use technology, physicians needn’t be forced to provide the services they object to. In the absence of a medical monopoly, physicians do not fail to fulfil duties of reciprocity by not providing their services. In a liberalised market for medical technology, physicians are free to refuse to participate because individuals who do not subscribe to the internal morality of medicine can access medical technology and use it to provide BMPs.

So, what would a liberalised market for medical technology look like? In the remainder of this section I will make a positive case for the abolition of the medical monopoly by looking at two examples of technology that non-medical practitioners are not currently entitled to use: local injectable anaesthetics and surgical skill.

Body Modification Specialists are not currently trained in evidence based surgical techniques. BMSs, like tattoo artists, undertake unregulated apprenticeships under more ex-

perienced practitioners.<sup>xxxv</sup> The lack of accredited training makes it hard for people to choose the practitioners they wish to visit and to ensure they receive safe body modifications. The lack of training is problematic for practitioners (and the industry as a whole) as there is little opportunity for robust standards of good practice to emerge. The lack of surgical training for Body Modification Specialists (BMSs) means those who wish to engage in BMPs have to make do with lower standards of competence than, say, those who wish to have conventional surgery (who can be helped by trained surgeons).

Body Modification Specialists (BMSs) are currently not allowed to use local injectable anaesthetics. This is due to the fact local anaesthetics are ‘prescription only medicines (POMs) therefore they can only be prescribed by a suitably qualified practitioner’.<sup>xxxvi</sup> Suitably qualified practitioner, in the context of this quote, does not include piercers, tattooists or BMSs. Local anaesthetic injections, hence, ‘are not licensed for local anaesthesia prior to tattoo or body piercing’<sup>xxxvii</sup>. Neither are they licensed for BMPs such as scarification, branding or the insertion of implants as these procedures are not carried out by medics. In practice, the prohibition on the use of local injectable anaesthetics in body modification means that people have to suffer pains not associated with conventional surgery since Dr William T G Morton and Dr John Collins Warren performed the first successful operation using anaesthesia in 1846.<sup>xxxviii</sup>

In a liberalised market for medical technology, Body Modification Specialists (BMSs) would have access to both surgical training and injectable local anaesthetics (among other pieces of technology). Allowing BMSs to use this technology without fear of prosecution would enable individuals who wish to engage in BMPs to have them performed with the tools necessary to do so.

Having provided a sketch of what a liberalised market for BMPs could look like, and shown it to be compatible with respect for persons, it is time to turn to look at reasons why we should not abolish the medical monopoly. This is important because respect for persons isn’t the only value at stake in the discussion over who should have access to medical technology. In the next section I will address objections based on the idea that liberalising access to medical technology raises safety concerns. Section VIII addresses objections to abolishing the medical monopoly based on the idea that we have a duty to uphold our health.

## VII. Safety First

One reason we could have to object to liberalising access to medical technology is that doing so is inherently dangerous. The reason it is permissible to limit access to medical technology to physicians is that they, and only they, possess the knowledge to use medical technology safely.

That the medical technology we use in the 21st century has the potential to cause severe harms to the people it is used upon is undeniable. What is not clear is that concerns about ensuring the safety of individuals participating in BMPs justify the current legal prohibition on non-physicians using medical technology. Prohibitionist approaches rarely make activities safer. It is difficult for robust standards of good practice to emerge when people cannot do their business in the light of day. If we want to stop those who pursue BMPs from coming to harm, allowing BMSs to access training and medical technology legally is a step toward greater competence and higher safety standards.

One question this solution raises concerns *how much* training BMSs would need to undergo to perform their procedures safely. In the extreme, it may be that individuals need all the skills of a general surgeon to perform BMPs safely. Although we may have reason to ensure that BMSs receive adequate training to ensure the safety of those who engage in BMPs with their assistance, this is not the same as requiring that BMSs possess medical degrees. Although it is true that some of the procedures that BMSs carry out require access to similar training and techniques as those required by surgeons, the set of skills and procedures required are not identical.

To see why, consider the case of branding. Branding involves the infliction of 1<sup>st</sup> or 2<sup>nd</sup> degree burns to the skin in order to get the skin to generate scar tissue.<sup>xxxix</sup> Judging how long to expose the skin to heat requires anatomical knowledge of how skin reacts to trauma. The success of a brand depends on the skin being burnt enough to scar visibly whilst ensuring that the person undergoing the procedure doesn't end up with 3<sup>rd</sup> degree burns. Achieving a good and safe brand requires damaging the skin just enough, delaying the healing process by adding irritants to the wound, whilst still ensuring it eventually heals without becoming infected. The ability to monitor the healing process to ensure the right aesthetic results are achieved in a safe way requires a good knowledge of the healing process of burns which is distinct from the knowledge physicians possess. As the aim of the physician is to ensure

burns and wounds heal as quickly as possible with minimal scarring, they lack knowledge on how to aggravate wounds in a controlled manner.

Although performing BMPs may require detailed knowledge about certain bodily processes and a set of skills surgeons don't necessarily cultivate, for the most part it will require much less knowledge and skill than performing complex surgical procedures (such as those that require entering the abdominal cavity or the use of general anaesthetics). In light of this, solving safety concerns through training is not merely a recreation of the medical monopoly.

Safety concerns can also be mitigated in a legalised market by enabling BMSs to rely on the assistance of qualified medical professionals if the individual undergoing the procedure suffers an adverse reaction. Making it easier for BMSs to direct people to more qualified professionals can reduce the extent to which BMSs have to be trained. As occurs in conventional medical settings, people are transferred from one practitioner or specialist to others depending on the nature of the problem and the skill set required. What is crucial in maintaining the safety of these arrangements is people being able to identify when more help is needed and transferring patients on. Ensuring people know when to transfer patients to other practitioners (such as emergency room doctors) is not as demanding as knowing how to resolve the complications (which may require the knowledge commensurate with a medical degree). Many studios that perform BMPs on people already provide advice on how to monitor complications and on when to send patients to the emergency room or their family physician.

One objection to this solution is that liberalising access to medical technology may lead to individuals requiring extra medical assistance from the health service than would otherwise be the case. In countries with socialised healthcare, liberalising access to medical technology requires diverting healthcare resources into dealing with the consequences of BMPs and away from other more important areas of care. If this is so, the objection proceeds, we have reason to limit access to medical technology to ensure a just distribution of medical services. In as far as respecting people does not require tolerating people violating their duties towards either society in general or to particular others, limiting access to medical technology to ensure a just distribution of resources may be compatible with the demand that people are entitled to respect.



The use of scarce medical resources is indeed problematic; especially when doing so deprives other (potentially more worthy) candidates of appropriate care. It is not, however, a reason to limit access to medical technology to physicians. This isn't, after all, how we deal with people pursuing all sorts of other dangerous activities such as skiing or rock climbing. If the problem with extending access to bio-medical technology to BMSs is the potential increased burden on nationalised systems such as the NHS, people who wish to engage in BMPs could be forced to purchase private insurance or offset the costs incurred by the NHS in some other way. Limiting access to bio-medical technology, thereby precluding people from pursuing their projects, isn't necessary to achieve the goal of preserving fairness in the allocation of scarce medical resources. Individuals, hence, should be free to pursue BMPs with the use of medical technology so long as they offset the costs incurred by socialised systems such as the NHS.

### **VIII. A Duty to Uphold our Health?**

If potential distributive concerns cannot ground a prohibition on accessing medical technology when doing so has potentially adverse health consequences, another possibility could be that all individuals have a self-regarding duty to uphold their own health.<sup>xi</sup> Limiting access to medical technology to physicians could be seen as a way of ensuring that we all satisfy our duty to maintain our health. As respect for persons does not require we abstain from interfering with them when they violate their duties, precluding people from accessing medical technology would be compatible with respect for persons.

The idea that people possess self-regarding duties to maintain their own health has initial intuitive appeal and appears to be relatively widespread in as far as people who act in ways incompatible with their health are often scorned, reprimanded and/or encouraged to do otherwise. Following Kant, we may think we have a duty to uphold our health in virtue of the fact that minimum health is a precondition for exercising our moral personhood.<sup>xii</sup> If this is the basis for our obligation to uphold our own health, however, our duty to maintain our health only kicks in at the bottom end of the spectrum of health. This is due to the fact that moral personhood and successful agency in the world are compatible with high levels of morbidity. Denying this is tantamount to denying that the ill and/or disabled are capable of moral personhood which, except in the most extreme circumstances, is not true. If moral personhood is the basis of our duty to maintain our health, most (if not all) BMPs would be

compatible with fulfilling this duty. This duty to preserve our health, hence, cannot ground the conclusion that access to medical technology ought to be restricted.

If, on the other hand, we take our obligations to maintain our health to have a more perfectionistic character, little is left of our freedom to live our own lives. This argument threatens to prove too much. Not only would people not be entitled to use medical technology to pursue other goals, individuals would also have to be precluded from engaging in a whole range of other activities (such as mountaineering, working with dangerous substances, being a professional athlete or refusing medical treatment) for the sake of their health. Although a life devoted to the maintenance of health to the detriment of other goals may be the end of life for some, most of us achieve valuable ends by risking our health. Ultimately lots of people want to be healthy to live, not live to be healthy.

## **IX. Best interests**

It could be objected that the case against the medical monopoly has been overstated. If, instead of understanding their duties as being strictly centred around health promotion and maintenance, physicians used a ‘best interest’ standard to determine whether an individual should be entitled to engage in BMPs, the fact that physicians have a monopoly over the use of medical technology would be less problematic. If physicians took into account the cultural and idiosyncratic values of the person who they are intending to help when making decisions about whether to provide their services, people would not be precluded from pursuing non-health based BMPs.

Some medical associations such as the General Medical Council or the British Medical Association take cultural considerations into account when determining whether or not to assist an individual in the pursuit of non-health based BMPs. This line of reasoning can and has been applied to allow people to circumcise their children for cultural reasons and as a grounds for arguing that physicians ought to be allowed to help people to die on their own terms. Adopting a ‘best interest’ standard can also serve to justify cosmetic surgeons providing aesthetic services to their clients as it allows them to take into account the non-medical reasons for pursuing cosmetic enhancement such as the potential for increased sexual attractiveness or earning potential<sup>xlii</sup>.

This move, however, should be resisted. Having physician's use a 'best interest' standard inevitably involves a generalisation of expertise.<sup>xliii</sup> Although physicians may have a wealth of knowledge about the biochemical processes that constitute us and even what it means to be healthy, they are not experts on how to integrate cultural and idiosyncratic concerns into one's life or how to weigh any of one's personal values against that of health. All of these are value questions, not pure matters of fact. In a liberal society both what to value and how much to value it are not questions doctors are entitled to decide for others (absent the person's consent to delegate these concerns to their physician). Although it is laudable that some physicians are realising that people's idiosyncratic and cultural concerns merit consideration, they err if they consider themselves to have a special role in helping people balance these concerns against the other things they value.

The main problem with physicians using a 'best interest' standard is that it doesn't challenge the fundamental problem of the medical monopoly: physicians having undue power over our lives. There is no guarantee that, in moving to a 'best interest' standard disagreements between physicians and people who wish to use medical technology to further goals other than health will disappear. When a disagreement arises, we face a choice between two options. The first option is to defer to the person's own interpretation of their best interests and force physicians to provide the services the person requests, even if the physician considers these to be counter to the person's 'best interests'. Say an individual with an easily forgettable face visits their local cosmetic surgeon to have their tongue split, their nostrils reshaped into slits and their ears reduced in size with the express goal of looking more like a lizard. Imagine the individual thinks this is in their best interests because it makes them look very striking, unique and memorable; three qualities they currently lack. If adopting a 'best interest' standard involves deferring to the patient's interpretation of their best interests, the cosmetic surgeon can be forced to provide their services. This option is unacceptable in as far as it involves failing to respect physicians' right to abstain from providing services they may object to.<sup>xliv</sup>

The second option is no better. If we allow physicians to refuse to participate in BMPs when they consider these to go against the person's 'best interests', there is a risk that individuals who wish to take on highly unconventional aesthetic projects (such as looking more like a lizard), will be deprived of the means they need to pursue their projects.<sup>xlv</sup> The problem

caused by the medical monopoly will resurface regardless of what standard physicians use to determine whether or not treatment is appropriate. The objection to the medical monopoly isn't that physicians use the wrong principle to determine whether or not a particular intervention falls within the bounds of their profession. The problem with the medical monopoly lies in the fact it grants physicians the exclusive entitlement to use medical technology legally. So long as the medical profession has monopolistic legal entitlements to use medical technology and rules out some interventions as beyond the scope of their profession, some individuals will be precluded from living their own lives in accordance with their own values. This means it cannot be solved by modifying the criteria used by those who possess monopolistic legal entitlements; it can only be solved by abolishing the medical monopoly so that individuals other than physicians can access medical technology.

## **X. Conclusion**

Physicians currently determine the terms of access to medical technology by controlling *who* is entitled to use the technology legally and, by doing so, *how* medical technology is to be used. Physicians having a monopoly over the terms of access to medical technology is problematic as it precludes people who wish to engage in BMPs from accessing the technology they need to do so. Drawing on an account of respect as non-interference, I have argued that we ought to abolish the medical monopoly in order to respect individuals who wish to pursue BMPs as persons. Allowing physicians to have control over the terms of access to medical technology is incompatible with respect for persons as, without access to medical technology and the entitlement to use it legally, individuals who wish to engage in BMPs are vulnerable to interference by others and, as a consequence, risk having their plans frustrated.

Health needn't be the only goal medical technology is used to further. Although physicians have professional obligations to maintain and promote the health of the individuals they care for, these professional obligations do not ground a right to preclude others from using technology to promote their own idiosyncratic and cultural goals (even at the expense of their health). In a liberal society no profession ought to have such far reaching powers to determine the pursuits people are entitled to engage in.

So long as physicians retain monopolistic control over the use of medical technology, their refusals to participate in certain practices lead to individual's having their life plans

thwarted. This has led some authors to argue that physicians' right to conscientious objection should be curtailed to ensure access to technology. This solution to the problem comes at a cost, for it is incompatible with respecting physicians as persons and with upholding their right to use voluntary associations such as the General Medical Council or the American Medical Association to collectively determine the boundaries of the profession. Moreover, it is an unnecessary cost to pay as abolishing the medical monopoly allows us to respect both the people who wish to engage in BMPs and the physicians who do not.

Divesting physicians of their monopolistic control over medical technology is the only way of ensuring that access to the means necessary to pursue BMPs is not conditional on physicians approving of one's pursuits; for anything short of abolishing the medical monopoly still grants physicians powers to influence the course of peoples lives they shouldn't have.<sup>xlvi</sup>

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## **XI. Notes**

<sup>i</sup> This is due to the fact that the pursuit of BMPs is not considered an exemption to charges under the Offences against the Person Act of 1861. Unless an activity is a recognised exemption (which reasonable surgical interference is) assaults which occasion either actual bodily harm or grievous bodily harm are an offence irrespective of whether an individual consented. See: Attorney General's reference No 6 of 1980 [1981] QB 715 and The Law Commission, *Criminal Law: Consent and Offences against the Person*. Consultation Paper No. 134, 1993.

<sup>ii</sup> Arnold Rubin 'General Introduction' in Arnold Rubin (Ed) *Marks of Civilisation*. (Los Angeles: Museum of Cultural History, University of California, 1988) pp. 13-17. Victoria Pitts, *In the Flesh*. (New York: Palsgrave Macmillan, 2003). James Myers 'Non-mainstream Body Modification- Genital Piercing, Branding, Burning, and Cutting', *Journal of Contemporary Ethnography*, 21, 3, (1992): 267-306. Mike Featherstone, 'Body Modification: An Introduction', *Body and Society*, 5, 2, (1999): 1-13. Sean Bray, 'Gender Dysphoria, Body Dysmorphia and the Problematic of Body Modification' *The Journal of Speculative Philosophy*, 29, 3, (2015): 424-436

<sup>iii</sup> See for example: Robert F. Raspa and John Cusack, 'Psychiatric Implications of Tattoos' *American Family Physician*, 41, 5, (1990): 1481-1486 and Williams, Kelwyn 'Tattoos, Scars, Body Adornment and Dishevelment in an Acute Psychiatric Population' *Psychiatric Bulletin*, 22, (1998): 94-96

<sup>iv</sup> Thomas Schramme 'Should we Prevent Non-Therapeutic Mutilation and Extreme Body Modification?' *Bioethics*, 22, 1, (2008): 8-15

<sup>v</sup> Silke Wolhrab, Jutta Stahl and Peter Kappeler, 'Modifying the Body: Motivations for Getting Tattooed and Pierced', *Body Image*, 4, (2007): 87-95

<sup>vi</sup> Julian Savulescu and Richard W Momeyer, 'Should Informed Consent be Based on Rational Beliefs?', *Journal of Medical Ethics*, 23, (1997): 282-288. J. L. A. Garcia, 'Health Versus Harm: Euthanasia and Physicians' Duties', *Journal of Medicine and Philosophy*, 29, 1, (2007): 7-24

<sup>vii</sup> Steve Clark, 'The Physician's Role, 'Sham Surgery' and Trust: A Conflict of Duties?', *American Journal of Bioethics*, 3, 4, (2003): 218-221

<sup>viii</sup> Edmund Pellegrino, 'Toward a Reconstruction of Medical Morality', *The Journal of Medical Humanities and Bioethics*, 8, 1, (1987): 7-18

<sup>ix</sup> Leon Kass, 'Regarding the End of Medicine and the Pursuit of Health', *Public Interest*, 40, (1975): 11-42 (p. 13)

<sup>x</sup> Franklin G Miller, Howard Brody and Kevin C Chung, 'Cosmetic Surgery and the Internal Morality of Medicine', *Cambridge Quarterly of Healthcare Ethics*, Vol. 9, (2000) pp. 353-364

<sup>xi</sup> Susanne Fraser, 'The Agent Within: Agency Repertoires in Medical Discourse on Cosmetic Surgery' *Australian Feminist Studies*, 18, 40, (2003): 27-44.

<sup>xii</sup> Julian Savulescu, 'The Proper Place of Values in the Delivery of Medicine', *American Journal of Bioethics*, 7, 12, (2007) :21-22. Julian Savulescu, and Udo Schuklenk, (2017) 'Doctors have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception', *Bioethics*, 31, 3, (2017):162-170. Michael Cholbi 'The Right to Die and the Medical Cartel' *Ethics, Medicine and Public Health*, 1, (2015): 486-493. Michael Cholbi 'Public Cartels, Private Conscience' *Politics, Philosophy and Economics* (2018): 1-22

<sup>xiii</sup> In *R v Brown*, Laskey, Lucas, Jaggard and Carter in 1993 16 homosexual sadomasochist men (known as the 'Spanner men') were prosecuted under sections 20 and 47 of the Offences Against the Person Act of 1861 with charges ranging from keeping a disorderly house to wounding, occasioning actual bodily harm and aiding and abetting occasioning actual bodily harm. See: Louis Bibbings and Peter Alldridge, 'Sexual expression, Body Alteration, and the Defence of Consent', *Journal of Law and Society*, 20, 3, (1993): 356-370. Victoria Pitts, *In the Flesh* (New York: Palsgrave Macmillan, 2003).

In *R v Wilson*, 1996, Wilson was charged with Actual Bodily Harm for branding his initials on his wife with her consent. In this case the Court of Appeals overturned the charges. See: Paul Lehan, 'Assault, Consent, and Body Art: A Review of the Law Relating to Assault and Consent in the UK and the Practice of Body Art' *Journal of Environmental Health Research*, 4, 1, (2005): 41-49

A more recent case is that involving Brendan 'Dr Evil' McCarthy, who was charged with three counts of causing grievous bodily harm with intent and three alternative counts of wounding without intent. McCarthy was charged with these crimes after having *consensually* split a person's tongue, removed another person's nipple and removed a third person's ear without having appropriate medical qualifications. On the 21st of March 2019, he was sentenced to 40 months in prison.

<sup>xiv</sup> The lawful exemption for medical treatment (i.e. 'reasonable surgical interference') requires that the procedure be done for medical purposes by a medical practitioner. See: The Law Commission op. cit. p. 37

<sup>xv</sup> Kass op. cit.

<sup>xvi</sup> David Gladstone, 'The British Medical Monopoly: How it was created, the harm it causes and what to do about it', *Political Notes*, 79, (1993).

<sup>xvii</sup> Enno Park, 'Ethical Issues in Cyborg Technology: Diversity and Inclusion', *Nanoethics*, 8, (2014): 303-306

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