Skin Bleaching as a Dermatologic Intervention

Complicity or Service?

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Case Scenario
A 21-year-old African American college student has disliked her dark complexion for years. She believes that black women with light complexions have a better life—better grades, better boyfriends, better job opportunities. In her view, these women are treated better by society in every way. She believes her chances of being successful in life would be appreciably improved if her skin were a few shades lighter. She tries some creams available at a beauty supply store that claim to lighten complexion, and she notices a very slight lightening of her skin. She is encouraged by this change, but wants something stronger. She has heard from a friend that dermatologists can give prescriptions for stronger products, so she makes an appointment to see a dermatologist for further assistance in lightening the color of her skin.

There is strong evidence suggesting that lighter skin correlates with a range of social, professional, and even health care advantages over individuals who have darker skin tones. While skin-lightening treatment appears to be reasonably safe and efficacious, it raises a weighty ethical dilemma for dermatologists asked to prescribe them to lighten one's complexion. On the one hand, skin-bleaching treatment can be understood as a valuable service to the patient, who may very well improve her life prospects owing to the treatment the dermatologist provides. On the other hand, skin-bleaching treatment may be understood as reinforcing the societal racism that advantages lighter skin, possibly making the dermatologist complicit in the continuation of the social ill that generates the patient's request and the positive impact on the patient's life chances from the treatment in the first place. Here we lay out the ethical arguments speaking both in favor of and against dermatologic interventions intended to lighten one's natural complexion with the intention of sparking a dialogue within the field.

The First Prong of the Ethical Dilemma: The Argument for Service

The patient in our case requests the skin-lightening interventions based on her observations that lighter skin confers many benefits in our society. She believes that people will respond more favorably to her, leading to better job prospects and higher income. And there is empirical evidence to support her anecdotal observations. Research shows that lighter complexions are also associated with better socioeconomic opportunities. Lighter skin color is correlated with preferential outcomes in education, higher personal and family incomes, and occupational prestige, even when controlled for confounding factors like English-language proficiency, education, occupation, ethnicity, and race. Lighter skin tone is even associated with better health outcomes: for example, darker skin color has been linked to higher blood pressure among African Americans.

The preference for and privileging of lighter skin and the discrimination against those with darker skin has been referred to as “colorism.” This preference for lighter skin is a phenomenon that occurs both within and across racial categories, and it is thought to be very much tied to our country's long history of slavery and racism. The claim is not that colorism is deliberate or premeditated, but that the widespread preference for lighter skin is subconscious and largely internalized. If a dermatologist believes that her patient is a victim of colorism, does she have a duty to use her medical expertise and training to remediate this wrong, aiding the patient in accessing better life prospects? This intervention could offer the patient a means to improve her life chances, from receiving higher wages to accessing better health outcomes. There is a compelling argument that dermatologists have an obligation to agree to provide the intervention on grounds of the physician's duty of beneficence. Although this clinical duty has traditionally been focused on the prevention and treatment of physical maladies, perhaps this duty should be extended to achieve broader patient self-determination and flourishing. Perhaps the physician's obligation to beneficence should be expanded to include social, interpersonal, or even economic goals. Given that the evidence suggests that lightening the patient's skin is in her best interest, the physician may not only be permitted, but might even be duty-bound, to aid the patient with this request.

The Second Prong of the Ethical Dilemma: The Argument for Complicity

To find the counter-argument that opposes a physician's assistance in skin-bleaching, one must merely look to the long history of both racism and skin color consciousness in the United States. The preference for light complexions over dark incontrovertibly grows out of, and is buttressed by, racism. Our skin color consciousness was both created during the institution of slavery, and it remains one of its lasting legacies. Skin bleaching is part of that long sordid history. References to skin bleaching in the black press go back as early as the 1850s. A French soap advertisement from the 1930s provides an example of the association of blackness with pollution and dirt. The poster shows a dark African man washing his hands with soap, turning them white. Such images of black people lightening their skin with use of cleansing products occur frequently in turn-of-the-century product advertising. The skin-bleaching products currently available over the counter are merely a more subtle form of an intractable racism that still exists today.

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While “enhancement” is the category of medicine that prescription skin-bleaching interventions fall into because it is a nontherapeutic medical intervention on normal, healthy structures, this categorization of skin lightening is an unfortunate one. The implication of the term “enhancement” is that skin made lighter is enhanced, and thereby superior to one’s original darker skin, playing into the racist motivations behind the request in the first place. That raises the question of whether, in acquiescing to the patient’s request, the dermatologist becomes complicit in that racism, further validating it, with the medical profession’s stamp of approval.

The relevant moral principle that would lead the clinician to refuse to perform skin-lightening is the duty to “do no harm,” *primum non nocere*, what is often referred to as the principle of nonmalevolence. In this case, the principle would refer to the macro-level harm of perpetuating a societal ill. Many have argued that skin bleaching can exacerbate racial bias and disparities by further entrenching racist appearance standards. The medical profession’s participation in skin bleaching might reinforce the society’s racist preference of light skin over dark.

But even if skin bleaching by dermatologists had these unintended negative consequences, would that constitute a strong enough ethical argument to prohibit it? Are physicians obligated to cure the society’s ills through their clinical practice? And even if there is a moral obligation for physicians to be agents of needed social change, is refusal to prescribe skin-lightening treatment for patients the best means to that noble end?

**Conclusion**

The complex ethical dilemmas related to skin bleaching do not lend themselves to easy answers, but our intention herein is to prompt the profession into a thoughtful debate long neglected in the field.

**ARTICLE INFORMATION**

**Conflict of Interest Disclosures:** None reported.

**REFERENCES**


