

This response was submitted to the call for evidence issued by the Nuffield Council on Bioethics' Working Party on Cosmetic procedures. Responses were gathered from 11 January to 18 March 2017. The views expressed are solely those of the respondent(s) and not those of the Council.

Christian Medical Fellowship

Nuffield Council on Bioethics

Cosmetic Procedures – Call for Evidence

Council Terms of Reference¹

The Council has established a Working Party to explore the ethical issues that arise in connection with the increasing access to cosmetic procedures. The Working Party has called for evidence under five main headings:

- Definitions and aims;
- Increasing demand for cosmetic procedures;
- The supply and regulation of cosmetic procedures;
- Different parts of the body;
- Any other comments.

Christian Medical Fellowship

The Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 4,500 British doctor members in all branches of medicine. We are the UK's largest faith-based professional group. A registered charity, CMF is linked to about 80 similar bodies in other countries throughout the world.

CMF regularly makes submissions on ethical and professional matters to governments and official bodies. We have frequently responded to Nuffield consultations. One of CMF's aims is to promote Christian values, especially in bioethics and healthcare among doctors and medical students, in the church and in society.

Submission

A. Definitions and aims

Q 1. What counts as a cosmetic procedure?

¹ <http://nuffieldbioethics.org/project/cosmetic-procedures/open-call-for-evidence/>

We suggest that a helpful definition is found in Good Medical Practice in Cosmetic Surgery/ Procedures:²

‘Cosmetic Surgery comprises operations or other procedures that revise or change the appearance, colour, texture, structure or position of bodily features to achieve what patients perceive to be more desirable’.

This definition helpfully distinguishes cosmetic procedures from ‘plastic surgery’, which typically (although not always) describes *therapeutic* procedures, ranging from those used to cope with life threatening emergencies to the removal of skin cancers in a way that minimises disfigurement. Plastic surgery also includes restorative procedures following damage from, for example, trauma or accidents such as burns or battlefield injuries, or disfiguring surgery to remove cancers. In some cases, such as a breast implant following mastectomy for cancer, the plastic surgery operation may be the same as in breast augmenting cosmetic surgery, but the context and intention are different.

Q.2 The aim of cosmetic procedures

a) From the perspective of the service user

In cosmetic procedures, the focus is on appearance – the patient’s desire to alter their natural appearance in order to acquire certain preferable features. Concern about appearance is not new. Make up, clothing, footwear, tattooing and many other permanent and non-permanent interventions have been used for millennia to change and ‘improve’ appearance. Yet some seeking cosmetic surgery, are not trying to ‘improve’ or ‘enhance’ their appearance but to make themselves appear more ‘normal’. In any population, there will be those at the extremes of the normal distribution curve, whether in nose size or breast size. It is not unusual for patients with physical features at the extremes of normal, and who feel self-conscious or unhappy about their appearance, to seek cosmetic surgery to enable them to remain within, or move toward the ‘norm’ of the population of which they are a part. However, the definition of ‘normal’ can be very difficult and may be based on idealised perceptions, influenced by film and advertising media.

The aim of any cosmetic surgical intervention is important to identify. It may be therapeutic, restorative or enhancing. A therapy is a ‘treatment intended to relieve or heal a disorder’,³ for example the removal of a facial skin cancer. Restoration is about ‘returning something to its original condition’,⁴ for example using certain techniques to remove a cancer but retain appearance. Enhancement is about further improvement,⁵ becoming ‘better than well’. In cosmetic surgery, therapy and restoration effectively enable the patient to remain within or move toward the norm of the population of which they are a part. Restoration does not, therefore, include anti-ageing procedures, which are about moving towards the norm of a different – often younger – population, which can be seen as enhancement. Such anti-ageing procedures have no medical indication and

² Independent Healthcare Advisory Services. Good Medical Practice in Cosmetic Surgery / Procedures. May 2006

³ www.oxforddictionaries.com/definition/english/therapy

⁴ www.oxforddictionaries.com/definition/english/restoration

⁵ www.oxforddictionaries.com/definition/english/enhancement

may be 'trivial' procedures, such as dermal fillers, or anaesthetic-requiring procedures with significant associated risks, such as 'rejuvenating' genital surgery, e.g. labiaplasty, hymenoplasty and vaginal 'tightening' after childbirth.

b) From the perspective of the service provider

Cosmetic procedures may be viewed by providers as:

- 1) responding to the autonomous 'rights' of an individual
- 2) a profitable enterprise
- 3) a means of correcting natural appearances that distress the patient

We explore these in turn, then consider the duties of a doctor in cosmetic procedures, and finally suggest a 'guide to practice' framework that could help determine the ethical justifiability of a particular procedure.

1) Autonomy

Cosmetic procedures are frequently presented as enhancing women's autonomy, and a positive reflection of society's openness about body appearance and sexuality, assuming that the adult is competent and consent is fully informed. However these are not medically-indicated procedures, and when it carries a degree of risk it can be argued that such a procedure is not in the patient's best interests and is not a therapeutic option. Moreover what from one perspective can be seen as enhancing freedom of choice - to be able to alter one's body as one pleases - can, from another perspective, be seen as loading new pressure on women and girls to conform to increasingly stringent and abnormal expectations of what the female body should look like.

There are feminist arguments against cosmetic surgery. Quoting from an NSPCC qualitative study on sexting, Dickenson gives one girl's comment on the message sent by the prevalence of pornography: 'Your body should be like hers for him'.⁶ The ethical areas she then explores are consent, choice and patient autonomy, the duties of a doctor and the goal of medicine. She also quotes Urban Wiesing, crystallising the key question about cosmetic surgery from the doctor's perspective: 'It should not be asked whether a patient should have an aesthetic operation or not, but whether physicians should perform it.'⁷

Personal autonomy and choice has limits. A doctor not only has a responsibility to spell out the risks of a procedure but also a responsibility to refuse to carry out that procedure if, in his professional opinion, it would harm his patient. 'First do no harm' is a basic principle of ethical practice and should not be trumped by patient autonomy in the pursuit of enhanced appearances.

⁶ Ringrose J, Gill R, Livingstone S and Harvey L. A qualitative study of children, young people and 'sexting'. London: NSPCC, 2012:40

⁷ Wiesing U. Ethical aspects of aesthetic medicine. in Prendergast PM and Shiffman MA (eds.) Aesthetic Medicine. Berlin: Springer, 2011:7-11.

Bruce Keogh, in the foreword to the 2013 Department of Health review, urges 'The Government, regulators, provider organisations and professionals ... to make sure that individuals' health and safety is prioritised ahead of commercial interest'.⁸

The patient's consent should not be the only prerequisite. There are procedures that medical practitioners may not legally perform (eg euthanasia) even given the patient's consent. The function of consent in medical law is to protect the doctor from criminal charges; it should not be seen to carry the automatic 'right' to have the procedure consented to. There is no positive right to request a treatment which contravenes the clinical judgment of medical professionals.⁹

The UK Genital Mutilation Act 2003 regards the performance of genital surgery on any female as a criminal act unless it is necessary for her physical or mental health.¹⁰ (Labiaplasty for any reason is illegal under the Act, though no prosecutions have been brought.) Kelly and Foster draw attention to the risk 'that women who are already anxious or insecure about their genital appearance or sexual function may be further traumatised by undergoing what is an unproven surgical procedure.'¹¹

2) Profit

Profit-minded practitioners should not shelter behind patient autonomy in order to perform procedures that are not medically-indicated and that carry significant risk. Much cosmetic surgery is unregulated, financially motivated and preys on vulnerable people. Capitalising on vulnerable, appearance-conscious women with low levels of self esteem and confidence by promoting procedures for which no reliable evidence base exists, is exploitative and unethical. Moreover, in a resource-stretched NHS, there can be no place for such procedures.

3) Correcting natural appearance

Of course there will be situations where, for example, a child with 'bat ears' is so distressed by relentless teasing that she can no longer face the prospect of school attendance and surgical correction of the 'deformity' is considered appropriate.¹² Though not indicated on the grounds of physical health, mental health and social integration may be undermined to the point where intervention is considered necessary.

⁸ Department of Health. Review of the Regulation of Cosmetic Interventions: Final Report. April 2013:6

⁹ This principle has been upheld in a number of resource allocation cases (e.g. *R. v. Secretary of State for Social Services, ex parte Hincks* [1979] 123 Sol Jo 436). Outside the rationing context, in the case of *Pearce v United Bristol Healthcare Trust* (1999) 48 BMLR 118, a pregnant woman failed to persuade her obstetrician to carry out a Caesarean against his better clinical judgment, although the fetus was two weeks past dates and later died in utero. In *Re J (a minor)* [1991] 4 All ER 614, the court found that physicians were not obliged to resuscitate a severely brain-damaged child, contrary to his parents' request, "unless to do so seems appropriate to the doctors caring for him given the prevailing clinical situation".

¹⁰ <https://www.gov.uk/government/publications/the-female-genital-mutilation-act-2003>; Sections 1(2a), 1(3a) and 1(5).

¹¹ Kelly B, and Foster C. Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *International Journal of Obstetrics and Gynaecology*, 2012, 119(4): 390, citing Liao LM and Creighton SM. Requests for cosmetic genitoplasty: how should healthcare providers respond? *BMJ* 2007, 334(7603): 1090-2.

¹² www.patient.co.uk/doctor/Prominent-Ears.htm

The **duties of a doctor**, not simply the issues of choice and consent, should also be considered. Even if the right of a patient to a cosmetic procedure is granted, it does not imply a duty for the doctor to perform it. As stated above, his first duty is to 'do no harm', and in situations where there are no medical indications for a procedure but risks associated with anaesthesia, then the doctor's duty both to his patient and to his own conscience are questions with ethical significance. In our opinion, a doctor should never act against what he considers to be the best interests of his patient.

Trust by the patient in their doctor's motivation is central to the doctor/patient relationship. If there is an incentive, financial or otherwise, for a doctor to perform a particular procedure, that trust may be threatened.¹³

In our opinion, cosmetic surgery is not a consumer choice, to be regulated by consumer protection laws.¹⁴ Ethical guidelines should be determined not simply by an appeal to personal autonomy. The principles of non-maleficence ('do no harm'), beneficence ('patient's best interests) and justice (resource allocation) should carry greater weight.

A Guide to Practice

In seeking to decide whether a particular cosmetic procedure is an ethically justifiable one we suggest that weighing the three different parts in the following approach will help guide both patient and clinician:

Part 1: Where does the 'concern' lie on the normal distribution curve? Those with an appearance further from the norm would be deemed more suitable than those closer to the norm.

Part 2: What is the impact of the 'concern' on the health and wellbeing of the individual: physical, social, psychological and spiritual? Those more severely affected, following detailed assessment of the impact and failure to adequately improve wellbeing using other methods, for example psychological interventions, would be deemed more in need of a surgical intervention than those with minimal impact on wellbeing.

Part 3: How safe and effective is the procedure? The safer and more effective a procedure, the more likely it is to be ethically justified.

Using this approach, ethical justification for a therapeutic or restorative surgical intervention for people at the extremes of the height distribution curve is less likely due to the risks and poor effectiveness of surgery. Ethical justification for surgical intervention would be more likely for someone with a 40HH breast size, who is experiencing unresolvable social, psychological and physical pain. Ethical justification is less likely for offering rejuvenating or genital surgery for someone near the norm for their age group.

This framework will aid clinical decision-making and inform patient expectation.

¹³ Hinsch K. Bad doc, greedy doc? Is it ethical for physicians to add cosmetic procedures to their core practice? *Women's Bioethics Project*, 2009, available at:

http://www.womensbioethics.org/index.php?p=Bad_Doc,_Greedy_Doc&s=335.

¹⁴ See, for example, Department of Health (2012) Minutes: review of the regulation of cosmetic interventions December 2012 meeting, available at: <http://transparency.dh.gov.uk/2013/01/15/rcci-21dec2012/>, item 7. Here the committee appears to accept the consumer model of 'buyer beware'.

Q.3 Does it make a difference when appearance is altered through biomedical or surgical procedures?

Clothes, hairstyling and make-up have long been used by people to beautify themselves – to ‘make the most’ of the features they have. Seeking to change those given features through biomedical or surgical means, in an attempt to become more attractive, is of a different order. Where the intention is to correct disfigurement arising from injury or illness, intervention is appropriate, but not otherwise.

Q.4-8 Increasing demand for cosmetic procedures

There is enormous pressure to appear not so much ‘normal’ as ‘ideal’. As recognised in Nuffield’s background paper to this consultation, the ‘celebrity culture’, the widespread use of ‘airbrushing’ in magazines and body-perfect models in advertising, regular stories in the press about famous people’s operations, the popularity of TV ‘makeover programmes’ and the ‘mainstreaming’ of pornography all contribute to a growing pressure on women and girls to conform to increasingly demanding, unrealistic and abnormal expectations of what the female body should look like.¹⁵

Young women and girls are particularly vulnerable to peer- pressure and self-doubt about body image. NSPCC reports have highlighted the increasing use of pornography and ‘sexting’ among teenagers, with photos and YouTube videos of their girlfriends being used as a form of ‘currency’ among young men.¹⁶

The quest for a ‘perfect body’ may, in reality, be the quest for self-esteem, value and acceptance. Such basic human needs are better and more naturally provided through loving and affirming relationships, among family and friends, and/or, if necessary, psychological interventions.

There has been rapid growth in the number of requests among some ethnic minority groups for cosmetic surgery.¹⁷ Discriminatory stereotyping can limit opportunities for some ethnic minorities and requests for such procedures as eyelid surgery to create a more ‘Caucasian’ eye among East Asians may reflect this. On the other hand, a US study suggests that minority ethnic cosmetic surgery patients do not necessarily want to look more ‘white’, but, if anything, more like the ‘ideal’ for their own ethnic group.¹⁸

Social stigma may also be the reason behind requests for facial cosmetic surgery for people with Down Syndrome.¹⁹ Society needs to recognise that ‘different’ is not ‘abnormal’, and that personal identity and social acceptance must not depend on individual conformity to some idealised norm when it comes to appearance.

¹⁵ http://nuffieldbioethics.org/wp-content/uploads/Forward_look_Background_paper_on-_aesthetic__cosmetic_procedures.pdf

¹⁶ Ringrosse J et al. 2012:8

¹⁷ Wimalawansa S et al. Socioeconomic trends of ethnic cosmetic surgery: trends and potential impact the African American, Asian American, Latin American, and Middle Eastern communities have on cosmetic surgery *Seminars in Plastic Surgery* 23(3); 2009:159-62

¹⁸ Ibid.

¹⁹ Katz S, and Kravetz S. Facial plastic surgery for people with Down syndrome: research findings and their professional and social implications, *American Journal of Mental Retardation* 94(2); 1989:101-10; Frank AW. Emily’s scars: surgical shapings, *Hastings Center Report* 34(2); 2004:18-29.

Q. 9-15 The supply and regulation of cosmetic procedures

The majority of cosmetic procedures in UK are performed outside the National Health Service and beyond the remit of the professions. It is therefore a largely unregulated business where profit is clearly the incentive. The 2010 Mintel Report (Cosmetic Surgery, Market Intelligence) estimated that by 2015 the UK cosmetic surgery market would be worth £3.6 billion.²⁰

The regulation and safety of cosmetic surgery appears to be a big concern. *On the face of it*, a report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), highlighted several patient safety concerns.²¹ They also noted that while a number of patients were likely to have unrealistic expectations of cosmetic surgery and deep-seated problems, in only 4% of sites was it normal practice for a patient to see a Clinical Psychologist.²²

The Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer, noting unacceptable methods of advertising, made 20 recommendations and concluded that, “Although there is no one authoritative source of evidence to show that significant harm is caused to patients by cosmetic surgery, evidence from numerous bodies, as related in this report, suggests that there are grounds for concern.”²³

The 2013 Department of Health review suggested that 'a person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen or a toothbrush'.²⁴ We have already quoted Sir Bruce Keogh's foreword to that review, urging “the Government, regulators, provider organisations and professionals ... to make sure that individuals' health and safety is prioritised ahead of commercial interest”.²⁵

In general there is little regulation of cosmetic procedures from the Care Quality Commission and no system in place (outside the civil courts) to compensate patients who may be harmed. Neither is there any national evidence base tracking implants or procedures. When things do go wrong it is often the NHS that has to deal with adverse outcomes and pick up the costs.²⁶

9. Those seeking cosmetic procedures should be treated as patients, not consumers

10. As patients, they should be given all the information necessary to enable them to give informed consent

11. Some people seek cosmetic procedures as the 'solution' to needs that cannot be successfully addressed by such procedures. Those most vulnerable to exploitation by profit-motivated providers are the very ones least likely to be helped by the 'product'. Deep-seated feelings of insecurity, lack

²⁰ Department of Health (2012) Minutes: review of the regulation of cosmetic interventions, available at: <http://transparency.dh.gov.uk/2012/09/07/rcci-3august2012/>

²¹ NCEPOD. *On the face of it*. A review of the organisational structures surrounding the practice of cosmetic surgery. September 2010:4

²² Ibid:7

²³ *Expert Group on the Regulation of Cosmetic Surgery*. Report to the Chief Medical Officer. Department of Health, January 2005:20

²⁴ >Department of Health. April 2013:5

²⁵ Ibid:6

²⁶ NHS. PIP breast implants - latest from the NHS. 18 June 2012

of self-esteem, rejection and isolation are not likely to be solved by a cosmetic approach. A holistic therapeutic approach to mental, psychological and spiritual health is needed.

12. Parents should always be involved in decisions about the care and welfare of their children. However, parents should not be able to 'force' a purely cosmetic procedure upon their child. Neither should they dismiss the concerns of a child who complains of relentless teasing or bullying on account of his or her appearance. Family liaison, support and counsel should be provided when common sense fails or there is a breakdown of communication between the generations.

13. A system of appraisal and regulation should extend to cover those who perform all cosmetic procedures. Clear policies for health and safety, complaints procedures and compensation are required.

14. Responsibilities should be the same as for those developing, marketing and supplying products for use in therapeutic plastic surgery procedures, and should include the tracking of outcomes and maintaining databases that could be used for research purposes.

15. We consider current regulatory measures for cosmetic procedures are too lax.

Q. 16-18 Different parts of the body

16. The parts of the body which are more 'problematic' than others are those where intervention carries the greatest risks of collateral damage or poor outcomes, particularly if the procedures are being carried out by those without the necessary training and skills. Procedures involving eyelids, nasal and facial reconstruction, and genital surgery are of particular concern. The eyes and face are the most 'visible' and expressive parts of the body – poor outcomes here are especially distressing. Genital procedures involve the most 'intimate' areas of the body and poor outcomes undermine confidence at a fundamental level.

17. The implications of the Female Genital Mutilation Act mean that procedures beyond its provisions are illegal. As a result, those seeking genital 'rejuvenation' procedures may be 'forced' into the hands of private practitioners, more skilled in self-promotion than in surgical technique. The answer is not to soften the terms of the Act, but to tighten the regulation of such private practitioners.

18. Gender reassignment surgery should not be seen as a cosmetic procedure.

Christians are not opposed to all cosmetic surgery. Indeed, as in the ethical framework described earlier, the Christian seeking to promote healing, health and wellbeing would support most therapeutic and restorative interventions. They may find themselves advocating for those denied much-needed cosmetic surgery. They may also work to encourage the development of national and international standards in this whole area, looking also to see how similar approaches can be applied to other interventions, for example orthodontics.

Cosmetic procedures may be therapeutic, restorative or enhancing in aim. Discernment of motivation, both by those seeking the procedures and those offering to perform them, is important. Tighter regulation of the sector is needed in order to avoid exploitation of vulnerable people.

Patients' health and safety must take priority over commercial interests. Education, affirmation and accessible advice are needed for impressionable young people who, lacking a sense of self-worth, may otherwise see cosmetic procedures as a means to improve their feelings of attractiveness.

Public Policy Department

Christian Medical Fellowship

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