

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.

Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester

NUFFIELD COUNCIL ^{ON} BIOETHICS

**Cosmetic procedures:
ethical issues**

Call for evidence

11 January 2016

(Closing date: 18 March 2016)

Introduction

The availability and use of invasive cosmetic procedures, both surgical and non-surgical, to enhance or 'normalise' appearance has grown significantly in recent decades: both in terms of the number of procedures on offer and the numbers of people who choose to undergo them. The Nuffield Council on Bioethics has established a working party to explore the ethical issues that arise in connection with this increasing access to cosmetic procedures.

The working party would like to hear from as many people and organisations as possible who have an interest in cosmetic procedures, and this call for evidence is open to anyone who wishes to respond. In addition to the call for evidence, we will be using a variety of consultative methods to ensure that we hear from a diverse range of people with personal or professional experience of cosmetic procedures, or opinions about the impact of the growing availability of such procedures on social attitudes to appearance. Please [contact us](#) if you would like to be kept up-to-date with opportunities to contribute, or to alert us to other people or organisations who would be interested in knowing about this project.

When responding to this call for evidence, feel free to answer as many, or as few, questions as you wish, and please use the 'any other comments' section to contribute any opinions or evidence that do not fit elsewhere. Where possible, please explain the reasons behind your responses, and the evidence or experience on which you are basing them, as this is more useful to the working party than simple yes/no answers.

Definitions and aims	Increasing demand for cosmetic procedures
The supply and regulation of cosmetic procedures	Different parts of the body
Any other comments?	
How to submit your response	

Definitions and aims

There are no clearly agreed definitions as to what constitutes a cosmetic procedure. Even in surgical procedures, it is not always straightforward to draw clear dividing lines between reconstructive or therapeutic procedures and those undertaken for cosmetic purposes: breast reconstructions after mastectomy, for example, are essentially undertaken for aesthetic reasons, rather than because they are medically necessary; and procedures regarded as 'cosmetic' may also be necessary after bariatric surgery.

People seeking cosmetic procedures may do so in order to enhance their appearance in accordance with prevailing beauty norms (for example in seeking breast augmentation, facelifts, and liposuction, or in the routine use of dental braces for children), or alternatively in order to 'normalise' their appearance (for example when seeking surgery for prominent ears). Less routine examples of procedures offered include: limb-lengthening surgery, the removal of additional fingers or toes, and gender reassignment procedures. The desire to be 'more beautiful' or look 'more normal' may also be underpinned by the hope that changes in appearance will lead to greater happiness, or greater success.

For non-surgical procedures, it is difficult to draw clear dividing lines between everyday beauty routines and procedures that span the beauty/clinical divide, such as chemical peels, laser treatments, skin-whitening treatments, dermal fillers and botulinum toxin ('Botox'). Further distinctions arise between these procedures and other methods used to change appearance, such as tanning, piercing and tattooing, which are not ordinarily described as cosmetic procedures.

Questions 1-3

1. What, in your view, counts as a 'cosmetic procedure'?

A cosmetic procedure is any procedure that involves invasive surgery or injectables to enhance or change a person's appearance. A procedure that cannot be reversed without leaving markers of the procedures behind. Procedures that are rooted in socially constructed ideas about what counts as either attractive in a normative way or desirable for an individual.

2. What do you see as the underlying aim of cosmetic procedures (a) from the perspective of those seeking a procedure and (b) from the perspective of those providing procedures? How does this differ for different social groups?

- a) I can only answer these question in relation to my research over the last 8 years on breast augmentations with 30 British women, my work on the breast registry and data from a project on cosmetic surgery tourism funded by the ESRC that interviewed women and men who travelled for a range of procedures and agents who provided

facilitated these procedures. My answers to these questions will be based on this data and will focus predominately on the data from women who have had breast augmentations, the largest sector of the cosmetic surgery market.

Research that I have undertaken with people who have had cosmetic surgery suggests that consumers of cosmetic procedures have many different explanations and desires for turning to the market to change their appearance. I have interviewed many women who have had breast augmentations and their rationale includes:

- to *repair* damage done after child birth- to get their pre-pregnancy body back,
- to *correct* breasts that have been labeled as 'abnormal' i.e. asymmetrical or to increase the size of small breasts,
- to *enhance* existing breasts to meet social norms that are desirable and attain a specific status within a peer group (even if their breasts are not particularly small or problematic).
- Other groups of consumers who have had other procedures such as tummy tucks or weight loss surgery- desire normality and to obtain a '*normal*' body.
- Interviews with men who have had hair transplants or eyelid surgery suggest that men engage with cosmetic surgery to appear younger, attractive and dynamic. The market for hair transplants is also one of the largest markets for cosmetic procedures.
- The market for cosmetic procedures are also becoming more normalized and available on the high street. This is trivializing medical aspects of invasive procedures and marketing non-invasive procedures as beauty treatments.

Those seeking cosmetic procedures engage with the social world they live in and mediate their desire for cosmetic surgery within very defined parameters of what is acceptable and what is not for their social context. These narratives about good or bad breasts or bodies for examples are developed through a range of different contexts that include peer groups and family, the social contexts and how cosmetic surgery is used as a status symbol, the media and gendered, aged, classed and racialised norms and aspirations.

While many have gendered procedures to enhance their gendered identity, gender may only be part of the reason. Many procedures are used to establish status or can improve a person's ability to engage with a labour market. For example, having a face lift may allow a person to prolong a working life in professions where looking good and younger is important. In China many young women have eyelid surgery to stand out from others in the labour market and present as modern and socially mobile. Skin lightening treatments are also used to increase employability in societies where racism hinders access to some professions.

- b) Again there are many practitioners who provide cosmetic services and they are not a homogenous group with the same aims or working in the same type of organization or sector of the industry. Many plastic surgeons that belong to the main UK professional organization are concerned about the demand for cosmetic surgery and how to develop best practice in relation to patients who see themselves first and foremost as clients and consumers rather than patients. However, this is also a global industry and consumer and surgeons are mobile and international. Surgeons are also under pressure to pay back educational fees and this could be having an impact on the ethical working practices in a profitable market.

Regardless of which sector of the industry surgeons are in, my research suggests that most surgeons and practitioners believe in particular essentialist gender norms that shape their idea of what constitutes perceptions of ideal female or male body. Surgeons, are also embedded in a society that draw on normative understandings about what counts as beautiful or attractive from cultural and social positioning. Gendered, classed, aged and racialised norms intersect to shape and decide who 'needs' cosmetic procedures and who does not. If a woman presents and says that she does not feel like a real woman because she has small breasts or as one surgeon put it 'fried eggs' - she does not conform to a social ideal of womanhood. Many surgeons would understand this person's desire for surgery to argue that surgery is 'needed'. Increasingly this is being normalized and linked psychological issues and the pain of not feeling like a 'real woman'. When in fact the desire is linked to social pressures to conform.

The fact that most women who have breast cancer are offered reconstructive surgery as part of the treatment also indicates that ideas about femininity, concepts of 'real' womanhood have become tied up with particular ideas about 'breasts' and what they are for. The social context that cosmetic surgery procedures such as breast augmentations take place within are therefore very important for both the consumer and the practitioner.

- 3. Most people use their clothes, hairstyle, and make up to beautify themselves. Does it make a difference when appearance is altered through biomedical or surgical procedures?**

Clothes, make up and hairstyles can be taken on and off or changed without any permanent impact on the physical body or long-term risks to how the body functions. There are also a wide range of styles and ways that people can wear their hair or clothes.

However, surgery and other cosmetic procedures often involve life long risk and a commitment to other procedures. It also usually involves a very narrow range of what is acceptable viewed as attractive. Hence similar styles of noses, chins, eye-lids or breast size being reproduced on different people because the shape is fashionable rather than fitting the face.

Increasing demand for cosmetic procedures

While there are no authoritative figures on the number of surgical or non-surgical procedures carried out in the UK or elsewhere, it is clear from the limited statistics available that the number of cosmetic procedures carried out has grown considerably in recent decades.¹ Although it remains the case that the majority of people undergoing procedures are women, the ratio of men to women having procedures has remained constant as the numbers choosing procedures has grown (men continuing to make up around a tenth of all those undertaking procedures).² Research exploring the factors that motivate people to undertake cosmetic procedures has highlighted both societal factors (such as the pressure to look young, media and celebrity influence, and seeking to conform to cultural or social ideals),³ and intrapersonal factors (such as body dissatisfaction and impact on self-esteem, teasing, and experience of family and friends).⁴

There is less research evidence exploring the reasons underpinning the radical *growth* in use of cosmetic procedures. Suggested explanations include increasing affordability; technological change making more procedures available; the pervasiveness of celebrity culture; the development of digitally manipulated photographs (leading to ever-more unrealistic representations of beauty); the rise in the use of social media (including the trend of postings 'selfies' online) and self-monitoring apps; and easier access to pornography depicting unrealistic images of what is normal or desirable.⁵ In the context of the UK, these proposed explanations are also embedded in a society where body image is poor compared with other countries.⁶

The substantial increase in the number of cosmetic procedures performed has led to some commentators to argue that these procedures are becoming 'normalised': that is, that both cosmetic surgery, and invasive non-surgical procedures such as the use of injectable fillers and Botox, are increasingly perceived as routine, rather than exceptional, ways of changing one's appearance.⁷ This perception has, in turn, led to concerns that what is regarded as a desirable, or even acceptable, appearance may become increasingly narrow, increasing pressure on those whose appearance does not conform to these norms, and reinforcing stereotypes with respect to factors such as age, gender, sexuality, race, ethnicity, class, disability, and disfigurement.⁸ It is also argued that the risks involved are increasingly likely to

be overlooked or downplayed, if having a procedure is seen as something 'normal' or 'routine'.⁹ In contrast, others take the view that the increasing use of cosmetic procedures should be seen as positive and empowering: enabling people to access procedures to change aspects of their appearance that they do not like, or that cause them distress.¹⁰

Questions 4-8

4. What do you think are the main drivers generating the increasing demand for cosmetic procedures, both surgical and non-surgical?

It is difficult to say which came first the procedure or the demand. Cosmetic procedures are nothing new however, the market has expanded because they have: a) become cheaper making it accessible to people who were previously economically excluded; b) new technologies have made such procedures safer and easier to change aspects of a person's body they may be unhappy with for what ever reason; c) cosmetic surgery is now a profitable niche market of a globalized private medical industry; d) procedures are increasing used as markers of status and becoming normalized among some communities.

The neoliberal shift towards privatization and de-regulation in health has resulted in markets for cosmetic surgery being almost entirely separated from medical concerns and restraints and as this market has expanded, individuals are encouraged to engage with various types of body work, including gyms, hairdressing, clothing, dental care etc as well as cosmetic work to ensure their own value. Some argue that this is linked to the neoliberal agenda where the body becomes a project. Others extend this argument to argue that body image is increasingly important to many aspects of the social world and is used to mediate processes of inclusion or exclusion in societies. Sometimes this can have an impact on key areas such as how people are integrated into the work place or opportunities for social contact and success.

In the UK, body image has been shaped by long-term historical processes. On the one hand these histories relate to the social construction of gender, but they are also greatly influenced by government policies that have shaped poverty levels, health and well being, food cultures, transport, access to sport and mobility, as well as gendered and racialised cultures. Political and economic agendas therefore create the forms that bodies take. Marketing some procedures as aids to self-confidence suggests that they are solutions to poor body image, but the root causes of 'poor' bodies or body image is ultimately a political, economic and social issue.

I feel that children should be taught about body image issues at school and encouraged to engage with their bodies in different ways through sport, dance etc. Young girls especially are very susceptible to body image issues perhaps because they they are less likely to be encouraged into sport. Many schools cannot offer regular sporting activities and may have poor facilities. It is often left to the parent to provide for expensive sporting activity for their children and teenagers. Social class and culture therefore impacts on how young bodies develop and are maintained and ultimately how young people mature and cultivate a relationship with their bodies.

In my research, I have interviewed working class parents who bought breast augmentations for their daughters and believed that this would give their daughters the confidence to be attractive and socially mobile. However, I have also interviewed middle class parents who would never dream of giving their daughters the gift of larger breasts, but did pay for regular swimming, climbing, gymnastic or other sporting lessons and their daughters had no wish for cosmetic surgery. Over the years, the cost of lessons added up to much more than the cost of breast augmentations. This highlights how class and economic status shapes who enters the market for cosmetic procedures as consumers.

5. Do you think it is becoming more routine to undertake cosmetic procedures? If so, in your view, does this raise any ethical issues?

Yes- these procedures are becoming normalized for some, but not all. The messages in the UK are very classed and racialised and it is mostly the white working, aspirant classes and newly affluent who are turning to cosmetic procedures. There is little evidence that the established middle classes or Black British or Asian communities are turning to the cosmetic market in large numbers as cultural value is obtained through other means and privilege is marked in other ways.

It raises a number of ethical issues. Medicine is no longer about healing or mending bodies but about changing and modifying them so that they fit in or are normalized, but there has been little discussion about how these norms are justified and what is shaping them. We should also be concerned that this market is not exploiting those who are vulnerable and ill informed. We should be discussing whether there is a need to protect young people who are insecure about how they look and thinking about how to counter the narrow messages about appearance in schools and socially through they media. There is also very little to challenge this market and how it is developing and there is a need to develop alternative narratives about bodies that are positive.

6. **How (if at all) does the increasing availability and use of cosmetic procedures affect social norms generally: for example with respect to assumptions about age, gender, race, disability etc (see above)?**

There has been a narrowing of what is acceptable or considered beautiful. Femininity demands a range of adjustments to hair, body and skin. It is not just breast augmentations that are linked to femininity. Gender also cuts across racialised ideas about womanhood so that cosmetic surgery procedures are racialised as well as gendered.

Racialised procedures are linked to the desire to be socially mobile as well as performances of gender. For example, women in China have eye-lid or chin shaving surgery to improve their chances of employment, while butt implants for black women to reinforce desirability. Skin lightening creams and procedures across the world, are also popular. Many of these are illegal and can be dangerous yet they are marketed and used because racial capital is sort to improve employment opportunities or status and beauty is often linked to lighter skin tones. Long straight hair is also driving a market in real hair from Latin America, China and India that is then sold across Africa, the EU and America. 'Aging well' is a marker of wealth as well as health. There will be more pressure on the older to engage in the cosmetic market not just to look acceptable but also to prolong a working lives and erase signs of ageing. The normalization of cosmetic procedures also has implications for those who are disability or disfigured because of birth or illness such as cancer.

Social norms are shifting the way people engage with their bodies to perform different identities and will impact on processes of exclusion and inclusion and it is argued reinforces inequalities linked to race, gender, age and disability by promoting an ideal that is often Eurocentric, young and able bodied.

7. **Are some motivations for having a cosmetic procedure 'better' than others? If so, what are they, and who should judge?**

Any motivation for cosmetic surgery has to be placed within a social context and social contexts can change. We remove warts and other minor skin problems without thinking of these procedures as cosmetic. At the moment we do justify helping to change of the appearance of some people who are disfigured, disabled and regarded as deformed. This type of surgery is viewed a having a value and a good because it improves the social life of the individual. However there are many ethical questions about taking this approach and it is increasingly contested that this is best for the patient and society. What counts a deformity also depends on normative visual conventions that are being questioned. The moral debates about what the surgeon's

responsibility is in regards to patients who feel shamed or embarrassed, humiliated or excluded for not being 'normal' have to engage with wider societal debates. There is an idea that surgery can fix any problem that the patient perceives rather than provided help for patients to realize the many different options there are for how people can live their lives. There is a need to open up a discussion about some of these debates.

8. Do you have any thoughts about, or experience of, the ways in which cosmetic procedures are advertised, marketed or promoted in the UK?

In Germany cosmetic surgery is not advertised on billboards so that people and especially young people, are not subject to this type of marketing. Of course it does not mean that people do not have cosmetic procedures, but it does mean that they have to be much more committed to the idea in order to seek out clinics. Although there has been a stop to marketing techniques such as two for one breast augmentation on Groupon, prices for cosmetic procedures are generally getting lower as the market is competitive. Greater regulation can help, but there is still no regulation of agents or clinics who provide cosmetic surgery abroad and as this is a global market more needs to be done to develop global agreements and accreditations for consumers. The market for injectables is also becoming more normalized as this is not regarded as invasive. I welcome the increased regulation of this market so that they have to be performed in accredited establishment.

The supply and regulation of cosmetic procedures

A number of features of cosmetic procedures raise particular challenges for regulation, when compared with 'therapeutic' interventions:

- Cosmetic treatments will usually be initiated by the patient/consumer, rather than proposed by a health professional after a diagnosis. This may affect the nature of the consent process. It also raises questions as to the professional's responsibilities if they believe the procedure is not in the patient's best interests, or if there are other less invasive ways that patients/consumers might be able to achieve their goals.
- Most cosmetic procedures are provided by the private sector, rather than the NHS. Information accessed by patients/consumers will often be in the form of marketing material, rather than 'patient information', and people may feel a degree of pressure to go ahead with treatment.

- Outcomes may be more subjective: a professional may regard a treatment as ‘successful’, while the patient may feel disappointed that their expectations have not been met.

Over the past decade, there have been a number of expert inquiries in the UK looking into the way cosmetic procedures, in particular surgical procedures, are regulated,¹¹ culminating in the 2013 *Review of the regulation of cosmetic interventions* (the Keogh report) commissioned by the English Department of Health.¹² Repeated concerns raised include issues of patient safety (particularly with reference to the quality of implants and injectable fillers); the training and qualifications of those providing procedures; and the quality of information available to potential patients, both with respect to the risks and likely outcomes of procedures, and with respect to choice of practitioner.

The Keogh report highlighted the absence of any standards of accredited training for those providing non-surgical procedures, whether health professionals, such as doctors, nurses, or dentists; or others, such as beauty therapists. The report recommended the development of such standards, accompanied by compulsory registration of all practitioners providing cosmetic procedures, with the aim of ensuring that only practitioners who had acquired the necessary qualifications to achieve registration should be allowed to practise. The Department of Health’s response did not accept the need for such a registration system, but promised to explore other legislative options, including a possible role for health professionals taking a supervisory role with respect to some cosmetic procedures carried out by non-health professionals.¹³

In the light of other recommendations made in the Keogh review, there has been considerable activity by regulatory and educational bodies in the past two years, with a particular focus on defining standards for those providing cosmetic procedures (whether clinically qualified or not), and making it easier for patients to identify appropriately qualified practitioners and to make informed choices:

- Health Education England has been commissioned by the Department of Health to develop accredited qualifications for providers of non-surgical procedures, and its final report, including implementation proposals, was published in January 2016.¹⁴
- The General Medical Council (GMC) is developing a system of ‘credentialing’ so that doctors with a credential in a particular field of practice, such as cosmetic practice, can have this recorded in their entry on the medical register.¹⁵ The GMC has also issued draft ethical guidance for all doctors who offer cosmetic procedures.¹⁶
- The Royal College of Surgeons has established a Cosmetic Surgery Interspecialty Committee (CSIC) with a remit to develop standards for training and certification across the range of specialties offering cosmetic surgery; develop high quality patient information; and develop clinical outcome measures.¹⁷

Particular regulatory issues may arise with respect to access to cosmetic procedures by children and young people, or by others regarded as vulnerable in some way, such as people with body dysmorphic disorder (BDD). With respect to children, while parents are legally entitled to provide consent for their children's medical treatment, their authority to provide consent for invasive procedures undertaken for cosmetic purposes is more uncertain. Comparisons may be drawn with other areas of regulation, such as the *Tattooing of Minors Act 1969* which specifically prohibits practitioners from tattooing persons under the age of 18.¹⁸ Similar regulations apply to the use of sunbeds by children and young people under the age of 18, other than when under medical supervision.¹⁹

Questions 9-15

9. **Do you think that people seeking cosmetic procedures are 'patients' or 'consumers', neither, or both?**

I have talked to surgeons who use the words 'patient' and 'clients' interchangeably. As 'consumers' people who have procedures are viewed under a corporate agenda as empowered and as 'clients' or 'patients' they are seen as vulnerable. But it is clear that the boundaries between professional medicine and the neo-liberal market has become more blurry and this has also resulted in blurry boundaries around who is a client and who is a patient.

From my research, I have found that during the consultation, people seeking cosmetic procedures such as breast augmentations are consumers first and foremost. They are paying for a procedure they 'desire' rather than need because of a medical necessity. The consultation mirrors a sales encounter in some aspects as the consumer is concerned about 'looks' and advice on type of implant is given as well as price and implications of surgery. Because the individual is a consumer they can make demands of the surgeon and overrule their recommendations. For example, a woman with capsular construction may wish for the implant to be replaced rather than removed to allow for the breast to recover. Doctors may therefore perform procedures they may be uncomfortable with doing, but as the client is paying they may feel that if they do not do it someone else less skilled might end up doing it. So they do what the patient wishes even if they do not wholly recommend it. Consumers of cosmetic procedures become patients only when the surgery is being performed and during the aftercare.

If those who chose to have elective cosmetic procedures were regarded as patients first and foremost, they would received the same advice across a number of different clinics and from different surgeons. They would not be empowered as consumers are to demand procedures that surgeons do not recommend.

I have also found in my research that many women feel as if they are treated as consumers first and foremost. One woman for example argued that she should never have had breast surgery first place as she didn't need them pointed out that on reflection, her experience of buying breast augmentations was 'driven by profit'.

Umm.... I had an up lift as well as implants which was a mistake. I should never done that. And the doctor said that I should never have had that done. I didn't tell him that he was one of the three doctors that had said that I should do it. Which again makes me think that it is a money-making thing.

The financial aspect of the sales encounter was highlighted and problematised by a number of women who felt that money motivated the clinics to build rapport with them in order to encourage them to have the surgery.

Julie: A lot of it is done with the women that work with them and um I find them quiet unpleasant. They treat you like cattle.

Researchers: Are they nurses? Doctors

Julie: No they are like PAs. They are on the phone to you and then when you get there they're very smiley and over pleasant and you pay your deposit. It's a business, a money making business and over time I've come to realise just how much it is just about making money.

While another interviewee noted how her experience of having breast augmentation was very financially driven:

Alison: It was a very financially driven experience.

Researcher: In what way?

Alison: Yes, I wanted them, but there wasn't a lot of discussion over advantages or disadvantages or any life duration or any alternatives or thinking period, nor discussion about what lead me to have this discussion and why you wanted them. I had the money and as long as I had the cash, I could have the operation and that is basically how it went. As simply as that.

The experience of some women who have brought breast augmentation highlight how the consultation process is failing them in a number of ways because they are treated as consumers who have choices, yet are not always fully engaged or informed about the medical process. Suggesting that patients can interpret their procedure as not a serious medical intervention because they are reading this from their sales experience with the clinic or surgeon.

10. What information should be made available to those considering a procedure?

Depends on the procedure- but for breast augmentations, many of my interviewees were unaware that they would need surgery again at some point and had been told that their breast implant was for life. They should be sure that they have enough saving to remove/remove and replace their breast implants if they need to at any time after having surgery.

Detailed and vivid information should be provided on the risks- for example capsular contraction- many of my interviewees did not know what this was and what it would entail if they developed this problem. A conversation or handout on the topic is not taken in by many patient consumers who have just decided to have the procedure as fast as possible. Many of my interviewees had their first consultation a week before surgery and their research was based on price and speed their surgery could be fit in. For example one woman told me 'they did discuss the risks, but you almost don't hear them'. She was more concerned with just getting her procedure done before her holiday.

Another woman gave this advice:

I think that if I was to have conversed with somebody who was about to have it I wouldn't say don't have it, but I would say, go at the consultation and do some research. Take some questions back to the consultant and ask him to have a real understanding of what she wants and how you want to look at the end of it. I had breasts that were very saggy and I haven't considered anything other than how to not being saggy. I hadn't considered shape, I hadn't considered size and hadn't considered my body ageing and my boobs not aging. I think, I'm not regretting it, I would rather have them than not have them, but if I was going to again, I would've had smaller implants and possibly teardrop shape. I think my breasts look too artificial when they're outside of the bra. And that's not what I was trying to achieve.

Information on breast size and what would happen if they wanted their breast implants removed at any time. Some women I interviewed also regretted the type and size of implant they were given and felt that they would make different choices now.

Alison: I would like to not have the visual of type of implant that I have had. He asked me to go to Asda to buy some barley wheat and to buy a sports bra and to put the wheat into the sports bra, which I did, empty the packages out until the size and look that I wanted and that's what I did. I got these two bras of barley wheat and put them in the bra and emptied them out until I got the weight that I wanted. Then he weighed the wheat and showed me the implants that corresponded with that and thought no that's too big, then we went down a size

and I thought, yeah that's about right, and that's the size I got. And that's what I got.

This account was not very different from others about how their size was chosen. Some women went into a changing room and tried on a tight white T-Shirt over a bra of various sizes to decide which 'look' they liked the best. There was no detailed information about how change in size would impact on posture, feeling and touch and loss of sensation.

Other information:

- Information on pretests and types of implants.
- Breast implant registry information
- The fact that not everyone is the same and can have the same procedure.
- Amount of time off from work
- Implications for the future and how patients think that they will deal with them. Everything from change in posture to, exercise, impact on breast cancer screening and breasts feeding, future surgery and problems with old implants and the aging process.
- The need to start saving for the next breast implant and that breast implants do not last a life-time.
- A cooling off period of at least six months and counseling should be available before hand.

11. Are there (a) any people or groups of people who should not have access to cosmetic procedures or (b) any circumstances in which procedures should not be offered?

Breast augmentations should not be offered to anyone under 25 or anyone who has had a major life event within the last two or three years. For example:

- Anyone who has had a child within the last 2-3 years – women need time to adjust to their new post-partum body and the focus on the body at this time can often be related to a lack of control more generally after having a child. In interviews with women, many regretted having surgery soon after childbirth. One woman who had surgery at 30 after having two children talked about the regret she had after having surgery. She described it as a 'crazy thing' and placed in in the context of not being able to manage her new life.

I was horrified and I thought what on earth have I done, I was in such pain and mine had come out of the muscle. I felt like I had been hit by a bus. It was just a

moment of madness. And I had a one and half year old and a six month old. Obviously it was a bit of crazy thinking.

She, like two other interviewed, talked about the shock of having children and how this knocked her self-esteem and confidence and destroyed her body, but if she had waited, she would have been 'too busy to think about her boobs' and her partner really did not want her to do it. Another woman stated that her body was not that bad, only that she felt it had changed and with time she would have got used to it.

Another woman noted how even though she was pleased with her surgery and that they look better than they were before, she has now realised that she will have to have surgery again to maintain them and is dreading this. Her advice to others was:

I would want to say to people who are thinking of having it done, DO NOT HAVE IT DONE, unless you absolutely hate your body. Not just for big boobs, or I want DD, it's just not worth the worry. There will always be something that worries you if you're that way inclined'

- Any one recently separated, divorced or bereaved.

I have interviewed three women who had surgery after divorces or separation in middle age. One woman who had a breast augmentation and a tummy tuck at 46 after the breakup of a 30 year relationship was shocked by the extent the surgery had impacted on her emotionally as well as physically. When I first interviewed her five years ago just after the surgery she said that she was happy. But now she now feels that her decision was also shaped by coming out of a long relationship and this was a major factor in her decision to have surgery.

- I do not think that cosmetic surgery should be offered as a solution to a mental health issue as there is little evidence that this works as a form of treatment.
- Breast augmentations should not be offered to children. However, there needs to be a wider discussion about how cosmetic procedures is beneficial or not to those who are disfigured. I have not done research in this area and do not know enough about the impact on such procedures to provide a fuller answer.

I have interviewed women who admitted they lied about their personal situation to doctors, so I feel that some form of counselling should be required.

12. **To what extent should parents be allowed to make decisions about cosmetic procedures for their children?**

Parents generally want to do the best for their child and there are many procedures where parents might feel that their child would suffer less social exclusion if they had

cosmetic procedures. However, the value of such procedures are socially constructed and I would be concerned that parents are engaging with the long term impact of any procedure for the child rather than trying to expand the narratives about self worth to include people who do not present as 'normal'.

Parents, family members, partners should not be involved in the decision making procedure or allowed to pay for breast augmentations. Breast augmentations are highly valued in some communities as status symbols, often given as gifts by parents, boyfriends and husbands, and they are perceived to reflect the status of the family or individual, representing success and providing honour to the women. Two of my interviews had their breast augmentations paid for by their parents who felt that it would give their children confidence and was as one father put it 'a gift for life'.

One women, who described her background as coming from a working class northern city, had implants as soon as she had the money because it was the expected thing to do in her community. Since having the surgery in her 20s she had become socially mobile and was considering reducing or removing her implants because they were not valued in the same way in middle class communities she now moved in. She had fake breasts that had looked like fake breasts and this was a now a problem. She wanted to distance her herself from her 'shameless' class identity and second time round she decided to reduced the size of her implants and described her mum's reaction to this decision:

The first time round I just wanted massive boobs. Like my mum said this time I can't understand why on earth you'd go smaller? I said to her because it's not all about having big knockers, there is more to it. It's about fitting into bras, being about to wear a dress that is the right size all of or just fitting into clothes and closing buttons. I just don't want to be all boob. And she's like, I can't understand why you'd spend 2 grand and not go bigger. She couldn't grasp it.

What her mother couldn't grasp is how big showy (fake) breasts position women low in the social hierarchy as middle class breasts are hidden and made inconspicuous. The social value of these objects go beyond the physical benefits to the individual and medical assessments should also take this into account and discuss the ethics of providing breast surgery to young women under 25.

13. Should there be any guidelines or regulation on who can provide non-surgical cosmetic procedures?

Yes- training and licenses should be issued to all individuals and premises providing non-surgical cosmetic procedures and all procedures should be undertaken on a licensed

premises to avoid trivializing procedures. All procedure should involve some form of pre testing to ensure that allergic reactions are taken into account.

What are the responsibilities of those who develop, market, or supply cosmetic procedures?

Cosmetic procedures are medical procedures first and foremost and this should be at the forefront of how the market is developed. If the market is expanding by encouraging procedures that reinforce particular narrow ideals about gender, race and sexuality then there needs to have an open and ethical and moral debate about this as this market does not operate in a social vacuum and can reinforce social inequalities.

14. Do you believe that current regulatory measures for cosmetic procedures are appropriate, too lax, or too restrictive?

Too Lax- market driven so profit driven. Not about medical concerns and medicine alone can not cure social problems.

Different parts of the body

The latest statistics from the British Association of Aesthetic Plastic Surgeons (BAAPS) highlight how fashions in cosmetic procedures may change, with people choosing treatment in 2014 showing more interest in “subtle understated” procedures such as eyelid surgery, facelifts and fat transfers, accompanied by a significant drop in the number of breast augmentations.²⁰ A further area of change relates to the extension of cosmetic procedures to more body parts, such as the growing interest in female genital cosmetic surgery,²¹ buttock augmentation,²² and penis enlargements.²³ While such procedures are becoming increasingly popular, they sometimes elicit different responses from those generated by longer-established procedures, such as those undertaken on the face, abdomen or breasts.²⁴

Questions 16-18

16. Thinking of cosmetic procedures, are there some parts of the body that are more problematic than others? If so, can you explain why?

In western societies it has become normalised to believe that having protruding ears pinned back is a good thing to do and that improving facial features for those who are disfigured also provides greater social acceptance for individuals who can be socially excluded because of how they look. However the market for cosmetic procedures is gradually developing norms about different aspects of the body that had once been invisible and private. ‘Bat wings’, small or wonky breasts, tummies and bottoms, neat small labias, large penises, more hair, smooth face etc. In New York there are podiatrists who operate on the foot of women so that they can fit into particular shoes i.e. shortening the toes and narrowing the foot. There is a demand for what is called ‘technoluxe’ procedures that follow on from another markets that demand a particular type of body i.e. good breasts to make a dress hang nicely without a bra.

Some of these procedures are being used by the individuals to reshape themselves into a project of their own making. To be more of an individual or because they have the money and want to purchase products that enhance their status and this status is often linked to a gendered or sexualised identity.

There is a concern about whether procedures impact on function of the body part and whether there are risks in the future to how the body part might function. But there are also other questions we should ask that link into more moral debates such as should we allow the market for this to develop even if there is demand? These question ultimately

link into the types of society and cultures we develop ideas about our bodies and their value.

We should also be aware that consumer/social tastes can change and what might be fashionable and hip now might not be in twenty or fifty years times. For example, smoking was once regarded as cool and is now regarded as a social health issue. People also once had their teeth pulled out and replaced with dentures to present as modern and this would not have the same meaning today. I believe that many of the procedures on offer in 2016 will be regarded as the same as having teeth pulled out in the 1930s.

17. **The *Female Genital Mutilation Act 2003* prohibits the excision or mutilation of “any part of a girl’s [or woman’s] labia majora, labia minora or clitoris”, unless this is held to be necessary for her physical or mental health. What are the implications of the Act for female genital cosmetic surgery?**

If this is the definition of female genital mutilation then the Act prohibits genital cosmetic surgery unless there is a mental or physical issue. The increasing trend for genital procedures is interesting as the market for this procedure began by trying to normalise the demand and consumption for vaginal surgery as a ‘choice’ consumers were making for enhancing their vaginas to make it easier to wear tight jeans. More recent trends indicate that the professional plastic and cosmetic associations in the US are using narratives around mental health and well being to shift this type of gendering procedures onto safer grounds after critiques from feminists that link these types of procedures into debates about legalising female genital mutilation and reinforcing oppressive gendered ideals. Radical feminists such as Sheila Jefferies also point out that the increasing sexualisation of the media and easy access of porn have shaped aesthetic ideals for vaginas. Again the social and gendered context that these procedures are taking place in cannot be ignored.

We should be careful about how cosmetic markets create a ‘need’ for procedures when there has otherwise been none. As the Act stands there is a way of legitimising vaginal procedures as long as they are linked to issues around well-being and mental health. All a woman has to do to have vaginal surgery is to express the ‘pain’ of not feeling ‘normal’. Again there is little to challenge what this normal should be and research in the Netherlands also shows that women are fully aware of how to use narratives around mental health to obtain cosmetic surgery (Davis, 1995).

So again there is a moral and ethical debate to be had about how far cosmetic surgery should go in shaping gendered ideals and whether not fitting into a gender ideal is enough of a mental health issue to merit surgery. Perhaps we should instead challenge gender inequality and the culture that makes particular performances of gender so

important. If young women had true equality and did not have to perform their sexuality as part of their femininity, perhaps there would be less demand for these procedures.

There is also an issue about how this impacts on procedures such as penis enlargement and modification. This is also a growing market and linked to gendered status and value. Perhaps the Act should be extended to also cover penis enlargements as both procedures are gendering and reinforce essentialist gendered identities that are normalised.

18. Thinking of genital procedures more broadly, are there any distinctive ethical issues, including gender issues, that do not apply to other parts of the body?

See answer 16.

There are many procedures that are linked into gendered performances. Breasts are regarded as the visual symbol for womanhood and represents femininity and a woman's sexuality. Although they are not objects, feminists have argued that they are objectified and increasing the market for breast implants have made some women think of their breasts as objects that can be exchanged and replaced and modified at will. One only has to think of the wide range of names we use to call breasts to realise that they are culturally important and have social value.

Boobs, hooters, jugs, fried eggs, melons, knockers, fun bags etc. tell us breasts are very social part of the body. The size and shape of breasts, how a woman displays her breasts or does not display them, whether they are propped up or worn without a bra all tell us something about that woman's gendered, classed, aged, sexual, racialised and ethnic identity.

Vaginas, penises and the genitals are less visible but equally linked to constructions of womanhood and manhood and how we feel about these parts of the body should not be left to the market alone to decide. There is therefore an ethical debate to be had about the direction we allow this market to take and how we engage with the demand for such procedures and how it will shape our ideas about gender in the future.

Any other comments?

Please highlight any relevant areas you think we have omitted, or any other views you would like to express about the ethical issues arising in connection with cosmetic procedures.

References

- 1 See, for example, the 2010 Mintel market intelligence report on cosmetic surgery, which highlighted that the value of the cosmetic sector in the UK had risen from £720 million in 2005 to £2.3 billion in 2010, and was estimated to grow to a value of £3.6 billion by 2015 (cited in: Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>). The British Association of Aesthetic Plastic Surgeons (BAAPS) collects its own figures on the number of procedures carried out by surgeons who are members of the Association, with figures rising from 16,367 procedures in 2004 (see: The British Association of Aesthetic and Plastic Surgeons (24 January 2005) *British Association of Aesthetic Plastic Surgeons announce annual audit results*, available at: <http://baaps.org.uk/about-us/audit/779-british-association-of-aesthetic-plastic-surgeons-announce-annual-audit-results>) to 45,506 in 2014 (see: The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>). The 2014 figures in fact showed the first annual *decrease* (down 9% from 2013) after a decade of increases, a change ascribed to a 'post-austerity' boom in 2013 leading to double-digit rises, now "returning to a more rational level."
- 2 91% of procedures carried out by members of the British Association of Aesthetic Plastic Surgeons in 2014 were on women, and this ratio between men and women seeking procedures has remained constant over a number of years. See: The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>.
- 3 See, for example, Hurd Clarke L, and Griffin M (2007) The body natural and the body unnatural: beauty work and aging *Journal of Aging Studies* **21(3)**: 187-201; Swami V (2009) Body appreciation, media influence, and weight status predict consideration of cosmetic surgery among female undergraduates *Body Image* **6(4)**: 315-7; Menzel J, Sperry S, Small B *et al.* (2011) Internalization of appearance ideals and cosmetic surgery attitudes: a test of the tripartite influence model of body image *Sex Roles* **65(7-8)**: 469-77; and Nabi RL, and Keblusek L (2014) Inspired by hope, motivated by envy: comparing the effects of discrete emotions in the process of social comparison to media figures *Media Psychology* **17(2)**: 208-34.
- 4 See, for example, Markey CN, and Markey PM (2009) Correlates of young women's interest in obtaining cosmetic surgery *Sex Roles* **61(3-4)**: 158-66; Goodman MP, Placik OJ, Benson III RH *et al.* (2010) A large multicenter outcome study of female genital plastic surgery *The Journal of Sexual Medicine* **7(4)**: 1565-77; Eriksen S, and Goering S (2011) A test of the agency hypothesis in women's cosmetic surgery usage *Sex Roles* **64(11-12)**: 888-901; and Tranter B, and Hanson D (2015) The social bases of cosmetic surgery in Australia *Journal of Sociology* **51(2)**: 189-206.
- 5 Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>, paragraphs 1.5-1.6, citing research commissioned from Creative Research Ltd. with the general public, GPs, and teenagers.
- 6 See: YouGov (21 July 2015) *Over a third of Brits are unhappy with their bodies*, available at: <https://yougov.co.uk/news/2015/07/21/over-third-brits-unhappy-their-bodies-celebrity-cu/>. This survey indicates that 37% of British people were not very happy or not happy at all with their body image and weight. The highest rate of positive body image was found in Indonesia, where 78% claim to be happy with their body weight and shape.
- 7 Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>, at paragraph 1.4; Creative Research (2013) *Regulation of cosmetic interventions: research among the general public and practitioners*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192029/Regulation_of_Cosmetic_Interventions_Research_Report.pdf, at paragraph 1.2.1.
- 8 See, for example, Hurd Clarke L, and Griffin M (2008) Visible and invisible ageing: beauty work as a response to ageism *Ageing & Society* **28(5)**: 653-74; Sanchez Taylor J (2012) Fake breasts and power: gender, class and cosmetic surgery *Women's Studies International Forum* **35(6)**: 458-66; Gulbas LE (2013) Embodying racism: race, rhinoplasty, and self-esteem in Venezuela *Qualitative Health Research* **23(3)**: 326-35.
- 9 Creative Research (2013) *Regulation of cosmetic interventions: research among the general public and practitioners*, available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192029/Regulation_of_Cosmetic_Interventions_Research_Report.pdf, pp29-30.

10 See, for example, the discussion in Gagne P, and McGaughey D (2002) Designing women: cultural hegemony and the exercise of power among women who have undergone elective mammoplasty *Gender and Society* **16(6)**: 814-38.

11 Including: Department of Health (2005) *Expert Group on the Regulation of Cosmetic Surgery: report to the Chief Medical Officer*, available at: http://webarchive.nationalarchives.gov.uk/20081105143757/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4102046 (the Cayton report); NCEPOD (2010) *On the face of it: a review of the organisational structures surrounding the practice of cosmetic surgery*, available at: <http://www.ncepod.org.uk/2010cs.htm>; and Department of Health (2012) *Poly Implant Prosthèse (PIP) breast implants: final report of the Expert Group*, available at: <https://www.gov.uk/government/publications/poly-implant-prothese-pip-breast-implants-final-report-of-the-expert-group>.

12 Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>.

13 Department of Health (2014) *Government response to the review of the regulation of cosmetic interventions*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf.

14 Health Education England (8 January 2016) *New qualifications unveiled to improve the safety of non-surgical cosmetic procedures*, available at: <https://hee.nhs.uk/news-events/news/new-qualifications-unveiled-improve-safety-non-surgical-cosmetic-procedures>.

15 General Medical Council (2015) *Credentialing*, available at: http://www.gmc-uk.org/education/continuing_professional_development/27258.asp.

16 General Medical Council (2015) *Guidance for all doctors who offer cosmetic interventions: a public consultation on our draft guidance*, available at: http://www.gmc-uk.org/Guidance_for_all_doctors_who_offer_cosmetic_interventions_consultation_english__2__distributed.pdf_61281552.pdf.

17 Royal College of Surgeons (2015) *Cosmetic surgery: certification updates*, available at: <https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/certification-updates>.

18 *Tattooing of Minors Act 1969*, available at: <http://www.legislation.gov.uk/ukpga/1969/24/introduction,section.1>.

19 *Sunbeds (Regulation) Act 2010*, available at: <http://www.legislation.gov.uk/ukpga/2010/20/contents,sections.2.and.3>.

20 The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>.

21 One UK provider of cosmetic procedures observed a 45 per cent increase in enquiries for female genital cosmetic procedures between 2010 and 2013. The provider also found that recipients of this range of procedures were getting younger: the average age of patients in 2010 was 35; in 2013, this had fallen to 28. See: Transform (30 August 2013) *Transform reports surge in enquiries for vaginoplasty procedures*, available at: <https://www.transforminglives.co.uk/news-blog/news/2013/08/transform-reports-surge-in-enquiries-for-vaginoplasty-procedures/>.

22 International Society of Aesthetic Plastic Surgeons' (ISAPS) data show a near 400% increase between 2010 and 2014. See: International Society of Aesthetic Plastic Surgery (2014) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2014*, available at: <http://www.isaps.org/Media/Default/global-statistics/2015%20ISAPS%20Results.pdf>; International Society of Aesthetic Plastic Surgery (2013) *ISAPS' international survey on aesthetic / cosmetic procedures performed in 2010*, available at: <http://www.isaps.org/Media/Default/global-statistics/ISAPS-Results-Procedures-2010.pdf>.

23 ISAPS annual statistics include the figure of 10,053 penis enlargement operations in 2014, but do not list this procedure in 2010. See: International Society of Aesthetic Plastic Surgery (2014) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2014*, available at: <http://www.isaps.org/Media/Default/global-statistics/2015%20ISAPS%20Results.pdf>; International Society of Aesthetic Plastic Surgery (2013) *ISAPS' international survey on aesthetic / cosmetic procedures performed in 2010*, available at: <http://www.isaps.org/Media/Default/global-statistics/ISAPS-Results-Procedures-2010.pdf>.

²⁴ See, for example, the concerns expressed about motivations for female cosmetic genital surgery, as in Royal College of Obstetricians and Gynaecologists (2013) *Ethical opinion paper: ethical considerations in relation to female genital cosmetic surgery (FGCS)*, available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf>: it is difficult to imagine concerns being expressed in the same way about cosmetic procedures undertaken on the face or breasts.