

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.

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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.

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

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'?

We suggest trying to distinguish between interventions aimed at restoration or amelioration, and those aimed at a purely cosmetic effect (e.g. primarily altering appearance rather than function). So breast reconstruction following mastectomy, or even breast reduction in cases where the size and weight of a woman's breasts are clearly detrimental to health, are therefore (arguably) not primarily cosmetic but 'restorative'. Of course, the treatment/ enhancement boundary can be fuzzy in some cases: an intervention can be medically motivated but with a result that is aesthetically pleasing to the patient and observer, and a change in appearance can have complex restorative effects, so that for example facial reconstruction or prosthetics can mean the difference between a cancer patient living as a recluse or as a functioning and social person. There is no doubt that our ideas of the beautiful are also tied up with ideas of the healthy, but we argue that seeing the result of surgery as *also* aesthetically pleasing is not the same as conducting surgery solely to achieve something aesthetically pleasing. (We'd like to note that this argument is likely to lead into some interesting epistemological/ontological debates, which we are not able to detail here, but also that in practice we can be more pragmatic, perhaps defining medical restoration as a response to pathological processes, trauma or iatrogenesis.)

Making the distinction as suggested may be helped in practice by developing different vocabulary. For example, distinguishing between 'therapeutic plastic surgery' (TPS) and 'cosmetic plastic surgery' (CPS).

It may be helpful also to distinguish according to the goal of a procedure's recipient, as well as by the procedure itself. We emphasise the goal, that is something to do with therapeutic intent (TI), rather than the motivation, to avoid the complexity of characterizing (in some comparable way) the motivations of individual recipients. If TI is not determined on an individual basis it can still be examined using an evidence base and professional guidelines (e.g Royal College Guidelines), in the same way that other medical interventions are judged. These characterizations and distinctions will necessarily be open to debate, like any other epistemological claim. There may be particularly complex discussions in certain areas, notably of body dysphoria/ dysmorphia, and any consensus is likely to be revised along with social and technical changes. But similar disputes and difficulties are faced in other areas of medicine; 'cosmetic interventions' are not unique here.

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?

The underlying aim of those seeking a procedure is likely to vary in detail, but fundamentally they will be seeking to improve the quality of their lives. Using the distinction drawn above, the procedure sought can be considered TPS in the presence of pathology, trauma, iatrogenesis, etc, even if the benefit is largely psychosocial, as in the example of facial reconstruction which is undertaken not in order to achieve a particular standard of beauty but to enable social integration and functioning. (We acknowledge the line between the two here is contestable.)

Current concerns about the goals of the providers focus largely on market-driven providers who may be unregulated, or even if regulated may arguably be providing something that many consider unnecessary or even harmful (to individual or society). Historically, many cosmetic procedures were developed in medical (and often military) setting with the aim of reconstructing catastrophic facial or other damage. In the context of CPS today the providers often act and behave like doctors even when (by our distinction) what they provide is not therapeutic. It is therefore worth considering the need for providers of CPS to have professional standards, like those of providers of TPS, to evaluate for example the validity of their 'patient's' request, capacity to give a valid informed consent, and so on. Artists such as Orlan are interesting cases here, and raise the question of whether we need a further category of artistic cosmetic surgery (ACS) or whether that should come under the heading of (non-therapeutic and voluntary) body modification.

We also think that the discussion here needs to go beyond whether or not someone can offer valid consent to CPS, and take seriously the broader, feminist-influenced argument that people (often but not only women) who pursue radical CPS are (unduly?) influenced by social pressures about appearance, especially gendered appearance, and by a regime of personal responsibility for *health* which includes having an appearance that is acceptable to the social group.

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?

There is a significant difference where surgical risks are involved. Two main issues arise here; one is of individual harms, and the resulting economic and other costs to the individual, as well as to the healthcare system in dealing with the consequences of surgical complications such as sepsis, haemorrhage and scarring. The second, broader problem is that the very real risks of surgery are increasingly downplayed in a context where surgical interventions become perceived as everyday or trivial.

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 have 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?

There are a number of factors operating here, though it is hard to prioritise one or more over others. We note that the significance of factors will differ in different social or cultural groups, and also that we have found it hard to find rigorous examination of possible drivers in the literature, suggesting that this aspect of cosmetic procedures requires closer attention. The

Commented [JS1]: We would argue that separating out societal and intrapersonal factors in this way may be useful for analytic purposes but is highly artificial.

normalization of procedures is likely to be key. The real question, however, is why these procedures have become normalized in the first place. One factor is **increased availability** both financially, and also as the procedures are marketed as less invasive and serious than earlier generations of cosmetic procedures. A second is their promotion as an aspect of **normal self-care/wellbeing** (see advertising slogans such as “because you’re worth it” rather than “you’re really ugly as you are and need to change yourself”). This seems to be playing on the slippage between what is construed as medical/therapeutic to what is healthy/virtuous/life-style/desirable. It is interesting that dentistry (which has always been in the fuzzy zone between TPS and CPS) is becoming one of the main providers of ancillary ‘beauty treatments’ (fillers, Botox etc.). In this context it is worth looking at the style adopted by these providers: ‘beauticians’ have often dressed in uniforms that echo medical wear, enhancing the claim (which we would argue in the case of CPS is false) that something therapeutic or clinical is happening.

Less obviously, the demand for cosmetic procedures may also be driven by the way it provides a new, and apparently efficient and effective, way of satisfying the human propensity for self-creation and self-improvement. We wonder whether some traditional and perhaps more arduous routes to self-improvement are no longer attractive, or even unavailable?

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

Our answer to both of these questions is yes. The routinization raises issues that include the normalization of the procedures including surgery, as noted earlier. A particular concern is the trend towards procedures being taken up at lower ages (although generally still only permissible above the age of individual consent). It would be useful to gather reliable data on this trend, including young people’s motivations and especially the proportion of young people accessing CPS or other cosmetic procedures who regret their actions later in life.

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)?

We think that the increasing availability and use of cosmetic procedures inevitably has longterm influence on social norms concerning various kinds of bodily appearance and function. The knowledge that we already have about social norms of gendered embodiment and also those about ‘normal’/disabled bodies suggests that a likely outcome is a rise in negative attitudes towards bodies that fail to fit standard criteria of appearance and function and an increasing rigidity of those criteria. In principle, cosmetic techniques give the ability to transform bodies in all sorts of ways, including *away* from the standard, but are generally being used to bring the deviant body into conformity with the norm. (There are exceptions here, in which niche non-conventional groups use sometimes radical body decoration and modification to express individual beliefs, emotions and for cathartic purposes, but we do not discuss this further here.) There is an important question to be addressed about the extent to which the availability of cosmetic interventions blurs the line between the social *norm* and the *ideal* of appearance. The commercial manipulators of ‘style’ and ‘beauty’ employ highly efficacious manipulations to portray unrealistic standards of beauty and appearance, for example through

advertising that manipulates bodily and facial characteristics electronically, and presents them as the aspirational body-form.

We would not wish to suggest that bringing a body into conformity with a social norm is always wrong, but argue for a more critical appraisal of why a need is felt for certain kinds of correction and not others, and of the ethical issues associated with altering the individual to fit societal standards rather than the other way round. There are social costs that come with heightening the importance of particular kinds of appearance, having more rigid standards of acceptable appearance and functioning, for example by widening the societal gap between those with access to these procedures and those without. These questions have been discussed in the context of disability studies and, from a different perspective, in considering a neoliberal shift away from collective to individual responsibility for what might broadly be called human flourishing. Points like these seem highly relevant, but we have not yet seen extensive discussion in the context of cosmetic interventions.

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

In principle, we are in favour of proportionality arguments here: that more intrusive or risky interventions must be justified by greater severity of need. This approach could be taken towards 'purely' cosmetic interventions where the threshold of justification should be higher as the interventions become more drastic (fillers, botox; breast implants or genital modification for younger people might also trigger the 'higher threshold' reasoning). Cosmetic interventions that are intrusive or risky but that have clear goals of reducing pain and suffering, or minimising social and employment barriers, should face a lower threshold because of the severity of need.

Having said that, how this justificatory framework could be implemented and policed is another question. On the one hand the high paternalism of traditional medicine seems inappropriate (and unworkable), but on the other caving in to the laissez faire of commercial CPS/ cosmetic procedures is equally wrong. In a liberal society we generally accept the principle that people have freedom of action as long as they don't infringe negatively on others' liberty. In our discussions we have begun to highlight the need for 'wisdom' to navigate the myriad streams of what Bauman has called 'liquid modernity', a kind of wisdom that has to compete with the alternative logics of contemporary consumer society. There is currently a lack of serious discussion about individual and societal goods; individually and as a society we are reluctant to appear prescriptive, elitist or judgmental of others. We would like to suggest a role here for a form of 'critical public health' or an entirely new societal agency with the aim of provoking critical reflection and encouraging debate about the norms and drivers of body (and other) vogues.

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

We have no specific personal experience except that one of us was ethics advisor for the Centrefold project, a Wellcome Trust-funded short animated film on labiaplasty [<http://nrl.northumbria.ac.uk/9588/>]. This film raised several concerns about the marketing of cosmetic procedures to younger (and more vulnerable) people, especially women. (The concerns raised by genital cosmetic procedures specifically are discussed later.) Similar

concerns apply in dental advertising, which appears as much concerned with their cosmetic appearance as with maintaining functional teeth and oral hygiene. These are obvious sources of income generation in an area of medicine that has become increasingly commercialized in the UK.

Concern about the commercialization of healthcare is not new, and much of the existing discussion would apply to the advertising, marketing and promotion of cosmetic interventions. One aspect we would like to flag up, that seems more distinctive of cosmetic procedures, is a currently popular double-bind message in cosmetic advertising exemplified by “because you’re worth it”: that it is important to have self-respect, to love yourself and your body, and yet paradoxically the way to demonstrate this care for your body is to alter it to satisfy an external norm.

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?

“It depends” is the obvious answer – on the type of procedure, the therapeutic need, and the individual goal. It has been argued that a patient stands in a very different position of responsibility and dependence to the provider than does a consumer; and so people who elect for a non-necessary intervention might be considered primarily consumers, with the different relationship that entails. Nevertheless, when undergoing an invasive surgical procedure, even if by choice rather than need, it’s a patient who is on the operating table and in the recovery room, irrespective of why they are there, or indeed who is paying for it.

If we follow the distinction drawn earlier between TPS and CPS, then in TPS there is no doubt the recipient is a patient. With CPS perhaps there is a need to distinguish between CPS (ie surgery) and other cosmetic procedures. For CPS there ought to be a professional standard but one in which the relationship is neither that of doctor/patient nor that of customer/ service provider – e.g. there might need to be a different, distinctive model for counseling and informed consent. There may be more flexibility for (nonsurgical) cosmetic procedures but there is still a need to ensure that practitioners are registered, competent, open to scrutiny by a professional body etc.

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

Probably information that is closer to the medical/informed consent model or the commercial/consumer model according to the type of procedure and provider, as we’ve sketched out above. In any case, the difference between these two types of information provision is less distinct than it was, as more data on success rates for non-cosmetic procedures by different clinics is increasingly available to and used by patients.

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?

a) It might be preferable to say 'should not normally have access'. This could include minors or those with compromised capacity, where in some cases access may be being sought by parents rather than the 'patient'. The TCS/ CPS distinction helps here; we would argue for a distinct but equally rigorous form of counselling and consent, proportionate to the nature of the procedure.

b) Examples of such circumstance would be when it is clearly not in the best interests of the *patient* (the question then arises of who decides this). However, we suggest that there needs to be a discussion of when access to cosmetic procedure is not in the interests of *society more broadly*: see our notion of a 'critical public health' agency, above. Much of this discussion reflects the tension between the compassionate desire to change people who are suffering because of hostile social attitudes, and the possibly more laudable long term goal of changing discriminatory social attitudes (which might demand the continued suffering of individuals in the short term). For example, people with the classic features of Down syndrome have been given facial cosmetic surgery to make these features less noticeable. It has been argued that however beneficial to the individual person, it is ultimately not in best interests of society or of Down syndrome people themselves to collude with rather than challenge discriminatory social responses.

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

Parents are already able to make decisions about other kinds of procedures for their children, as long as the welfare of the child paramount. So the short answer is that while parents should be allowed to make these decisions about cosmetic procedures, they should be subject to the same limitations and criteria we have for controlling parental decisions in many other areas of life.

It has often been argued that all parental interventions done with the good of the child in mind are equivalent, e.g. that genetic intervention (should it become possible) raises no more/different ethical issues than postnatal educational interventions. Parallels might be drawn for cosmetic interventions. There are some hard questions to be explored about the parental motivation for initiating or agreeing to CPS or other cosmetic interventions. Some earlier empirical research by one of us (JLS) highlighted the strong cultural intuition in the UK that a child is in some sense a gift, or in Feinberg's phrase has a right to an open future. This would conflict with any attempt to 'improve' a child's appearance for purely or predominantly cosmetic reasons

An area of growing importance here is the approach to transgender minors, an area in transition that is moving towards adoption as a recognized medical specialism. There are debates about whether these interventions are or should be positioned as medical, cosmetic, or a bit of both; whether there should be a lower age limit; and what rights and responsibilities parents have. This is too large an area for full discussion here, but in our opinion may be suitable for a future treatment by the Nuffield Council on Bioethics.

We referred earlier to the ethical questions raised by the normalization of disability (appearance or function). Depending on the intervention, this may be primarily cosmetic, and frequently involves a decision by parents on behalf of a disabled child. There are some interesting parallels with the parental role in cosmetic intervention for gender transitions in minors.

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

Non-surgical cosmetic procedures require practitioners to have training and certification, a register, and requirement for ongoing professional accreditation.

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

Provision of appropriate, transparent information, as with medical procedures or devices; accreditation of some kind, discussed above; the equivalent of post-marketing surveillance.

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

We feel that current regulatory measures are too lax but are moving towards something more appropriate with moves towards accreditation. Our main concern however is less with regulatory measures than with public acceptance of and attitudes towards cosmetic procedures.

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?**

It is clear that male and female genitals are culturally sensitive in a way that other areas of the body are not (at least not in western cultures). Given that this is an area of the body that is virtually never on public display, there are stronger reasons to question the rationale/motivation for these interventions than there would be for (say) liposuction or rhinoplasty. As discussed further below, this creates or exacerbates some associated ethical challenges.

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?**

In principle, this says that many existing practices of labiaplasty are illegal unless persuasively argued for on grounds of mental health necessity. There are a couple of problems with this. One is that ‘mental harm’ can be liberally interpreted if not rigorously defined and monitored. There is a suspicion that many women presenting for labiaplasty are experiencing a wish rather than great mental anguish, and as a result both provider and client are colluding in a fiction in order to stay within the law. Second, successful arguments (ie leading to surgery) along these lines reinforces the belief that these *are* areas of the body which, although not on public display, need to conform to criteria of appearance if the person is not going to suffer mental harm, with potential impact on societal norms in the way we have already discussed.

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?**

We have already mentioned the most obvious one, that these are culturally sensitive and (in complex ways) morally loaded areas of the body. They are usually also invisible areas, ie unlike the face, limbs and so on, in everyday life they are normally not on public view except in very specific circumstances (pornography, art, medical contexts). As a result, accurate

information about what is normal/abnormal for genitalia (and hence when intervention might be considered) is less prevalent and harder to disseminate by public health efforts, especially among some cultural groups. The lack of knowledge means that people's ideas about genital normality/abnormality are strongly influenced by media imagery and pornography, and there is some evidence that this influence is widening with the spread of the internet, particularly among adolescents. Their physical and emotional immaturity may mean that some young people are also particularly vulnerable to misinformation about genital appearance and the need (or lack of it) for cosmetic intervention.

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.

We are keeping the following comments short; they are about areas that are technically and socially complex, and would in our opinion need thoughtful public and professional dialogue with a range of stakeholders.

(1) We noted that there is no mention in this document of the specific cases of gender modification (ie for transgender individuals), the normalisation of appearance or function for people with disabilities, and the rare but intriguing phenomenon of people wanting interventions that are actively disabling, and which would be judged as not just medically unnecessary, but in breach of the physician's obligation to 'do no harm'. While we appreciate that the focus of this call for evidence has been on the more familiar forms of common cosmetic procedures, it would be a mistake if only these were to shape the parameters of our thinking about cosmetic interventions. In different ways, each of these more unusual cases represent extreme, ambiguous or contextually conditional versions of the ethical dilemmas that 'ordinary' cosmetic procedures present. They also demonstrate how our evaluation of their permissibility varies not only according to individual opinion, but also in line with cultural beliefs (that are likely to change over time); in these particular cases they include beliefs about such things as personal autonomy, the existence of gender dysphoria as a medical condition, or whether disability is an individual pathology or a social response to anomalous bodies.

(2) We suggest a need for further exploration of healthcare professionals' responses to the growing use of cosmetic procedures, in a wider sense than simply looking at the responsibilities of cosmetic practitioners themselves. For example, does a growing acceptance of CPS procedures soften the professional obligation not to perform potentially harmful interventions unless absolutely necessary, and if so does this have broader implications for the ethos of twenty-first century medicine and medical training; if there is increasing pressure for healthcare services to offer cosmetic procedures, what are the economic consequences, and does it come into conflict with healthcare professionals' beliefs about their responsibilities to their patients and to society?

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*

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aesthetic / cosmetic procedures performed in 2010, available at:
<http://www.isaps.org/Media/Default/global-statistics/ISAPS-Results-Procedures-2010.pdf>.
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.