

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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Call for evidence: cosmetic procedures

Questions 1-3

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

This might at the outset best be left open as a catch-all for non-medical interventions intended to bring about enhancement of bodily appearance. The boundary between cosmetic procedure (implying intervention bordering on the medical) and other cosmetic modification is going to be a shifting one. How to think of / define cosmetic procedures may be the finishing point rather the starting point of the enquiry.

My response [last section below] focuses on one area where, however 'cosmetic', there are wide concerns, namely FGM and FGCS.

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 idea of cosmetics, putting on a face for the world, does not translate into all cultures nor across all types of bodily modification. In many populations in Britain and Europe [shorthand EI, European indigenous] it is on a continuum with fashion and self-conscious (formal or informal) presentation of the self through attention to appearance. Bodily ornamentation in other contexts may not be about the 'self' e.g. regal regalia, judge's wigs, uniforms of all kinds, while social groups may identify themselves by dress and decoration in a way that simultaneously presents self and group together. Some sex-change procedures may be sought under this latter rubric.

With reference to the same populations [EI] we also have to take into account ideas about the body, and the body as an icon of the self. (Quite apart from the legal protection accorded the body, such that intervention requires a person's consent.) People often use the vocabulary of possession: their body 'belongs' to them. The vocabulary for imagining the body as also belonging to their relatives, for example, is undeveloped. But the kinds of societal pressures mentioned in the next section are an analogue – people might feel their body in the sense of bodily appearance 'belongs' to others (and there are specialist circles of considerable influence here, eg the bodies of those who model fashions).

In any event, practices that alter bodily appearance are inevitably held to directly affect the 'self' and self-perception; in the case of cosmetic procedures there is a double self involved, in that the latter are usually regarded also as initiated by a person for that person's benefit, ie in self-interest. There is a further loop-back here, since the

self may also be regarded as suffering some kind of deficit in negative self-perception that body alteration can then alleviate. Seeking a sex-change procedure is often assumed to fall into this category (eg under the rubric of psychological well being).

There are other populations in Britain and Europe, and across the world, that would not see the connections here in quite this way.

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?*

See the response to no. 2, which has already drawn a comparison with clothes etc. So altering the appearance in other ways may help us *understand* some of the motivations behind cosmetic procedures. As also indicated, the unadorned (naked) body has a special place in certain cosmologies, such as that of EI, so that interference is regarded as affecting the self, and the person as an individual. (There is a political-legal dimension here, dating from *habeas corpus* and post-medieval secular 'respect' for the person through respect for the body; the religious body of medieval devotees did not belong to the person in the same way.)

Increasing demand for cosmetic procedures

Questions 4-8

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

Will depend on the demographics. Do we know about the profiles of age-related procedures? One factor among younger people is no doubt cultivation of peer pressure and friending (social media).

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

In general terms, increase ('normalization') is one way in which an ethical field changes, but in relation to specific categories, eg young girls, there may be problems with peer pressure etc.

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)?*

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

See below in relation to FGM.

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

The supply and regulation of cosmetic procedures

Questions 9-15

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

Interesting question! This will be a shifting boundary. Also heavily dependent on what population (what demographics) we are talking about. One might even approach the question the other way round, from the perspective of *well-being* rather than remedy as an aim of medical interventions, where one might want to stretch the concept of what is 'medical'. Would that stretch the concept of the patient too? (An analogue here with seeing medical services within a larger field of social services / public health.)

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

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.*

I think I might set the bar quite high, and in either case restrict procedures to those over 18 [or arguably 16]. The teenage years [in EI] are years of extremely fluid and uncertain self-definition, and I wouldn't argue that because people are already mature in many respects they are mature in all. I have no idea what the data from the fashion industry would tell us, but it would be interesting to know what kind of fashion-immunity people might come to acquire by the end of their teens.

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

The answer will vary according to the kind of authority structures that exist within families, and whether one wishes to support them or not (could go either way). In EI in the main I would suggest that current protocols of parental consent in many other spheres could well serve as models.

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

No – more urgent things to do. And one would quickly run into all kinds of grey areas. So my response is a pragmatic one.

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

For EI populations, whether the consumers/patients are over age or under age would make a difference. In the former case any responsibility for considering what a request might be 'about' (a displacement of other issues, say, or a protest against some norm) is much diminished by contrast with the latter. Up to a point people should be free to pursue what displacement fantasies they like. It is only worth mentioning because it would be hoped that, if there are issues elsewhere in people's lives in which public health / social services might have a concern, they should be known

about. (We need a linked up system!) But in the latter case the onus to explore 'hidden' issues is much greater.

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

Different parts of the body

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?*

I cannot give an explanation why I personally find FGM / FGCS hard to think about, or why I should regard the genitals as a special area of the body (by contrast with breasts, say). But it would have to do with the place of sex and the body in EI cosmology, and all the connotations of secrecy and privacy that arise, plus the gendering of personal identity (the attention paid to male / female gender that encourages counter-critiques eg from people considering themselves transgender). Social practices are likely to vary almost as much as individual proclivities (eg consider the Latin American acceptance in some circles that a woman prepares her pubic area through shaving etc. because it 'belongs' to her husband / partner – not to do so is 'dirty' and insulting to the partner).

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?*

The implications are highly significant. Up to now I have been talking about EI populations, but within the UK and Europe are populations who keep alive their distinctiveness from EI (that is, they are seen by themselves and others as having origins 'elsewhere'). They may not share EI views of the body, self-ownership, and so forth. There are numerous issues here, raising ethical problems similar to those raised by all debates as to the degree of 'assimilation' or 'autonomy' to be accorded such populations. I point to one aspect of current debate as it concerns FGM.

This is the way in which a contrast is made in the terms themselves between procedures interpreted as 'cosmetic' and enhancing (FGCS) and those interpreted as 'abusive' or mutilative (FGM). A comparison is useful – each helps us understand the other. Thus whatever one thinks about them, the aesthetic motives of those seeking FGCS helps EI people to understand the aesthetic motives of FGM, while the fact that FGM is often carried out under coercive conditions help us to think about the societal coercion behind FGCS. In my opinion, they should be treated alike.

Consider inconsistencies in present attitudes. (1) In EI ['population A'], a FGCS procedure on someone under 18 is at present treated as inadmissible because it is 'without consent'; over 18 it is a matter of choice, and abuse doesn't come into the picture. When FGM ['population B'] is at issue, the procedure *itself* is regarded as abusive, and age of consent is not the crucial issue.

(2) In pop. A the person succumbs to the dictates of society through peer pressure, fashion etc.; in pop B it may be the dictates of society through close kin. This apparently is the huge cultural difference that makes EI people separate the two practices and separate the two populations. (It obscures the fact that there *is* a difference in that for pop. A the practice is not widespread and thus appears elective, while in pop. B it may be expected of everyone.)

(3) In pop A the cosmetic / aesthetic effects fall into a regime of body enhancement and body alteration so it is generally o.k. In pop B cosmetic / aesthetic effects are disregarded or taken to be grotesque (though members of pop B themselves might say that the aesthetics is to do with more than self-beautifying – it is also making the body appropriately reproductive).

The difference is whose viewpoint: the views noted here are those of [EI] pop. A in relation to **part of itself** and in relation to [minority] pop B **as other from** itself. This is how discrimination works.

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?*

(a) Much will turn on further classifications, that is whether either FGCS or FGM are regarded as violent and / or [in the case of under-age girls] a form of a child-abuse. But in what way is violence or abuse mitigated when the practice is re-classified from FGM to 'cosmetic surgery'?

(b) Much will also turn on the nature of parent-child relations, and how one deals with the parent's duty to enhance the situation of the child. (I am thinking of the frequent observation that FGM is invariably intended to be very opposite of harmful in the eyes of those who conduct the procedure; indeed, in their own lights, they may be acting 'with the best interests of the child' in mind.

(c) What value is to be placed on the reasons for enhancement of appearance? One difference between FGM and FGCS is the apparent willingness of the person as an individual. Perhaps we need to be wary of arguments that pitch 'individual satisfactions' against 'traditional norms'. When aesthetic reasons are recognised for the practice of FGM, it is likely to be in the context of appeal to 'tradition' or 'social norms' [bad], by contrast with FGCS, which is patently to do with personal (individual) enhancement / therapy [good]. Yet we also know that in the former case, individuals may wish to align themselves with social norms, while in the latter an emphasis on the individual is a social norm itself.

(d) Finally, by not treating these practices together, we fail to seize the opportunity of understanding just what may lie behind FGM. That is, perhaps those who seek the same

mutilation for cosmetic reasons (FGCS) *might give us some insight* into the appeal and value of FGM cutting. Indeed one might regard some of the reasons given for the latter as ethically more acceptable in local terms, as when it is justified in terms of increasing fertility or making a woman marriageable.

My personal opinion is that in the UK under-age people should be protected from both FGM and FGCS as forms of harm (whoever inflicts it).^{*} The violence with which it is done is a separate issue, but the violence does not make the act of cutting itself 'abusive'. What is problematic is that to call one but not the other abusive -- or cosmetic -- divides consumers / patients into different kinds of populations; it would be more ethically sensitive to see that each practice contains elements of *both* mutilation / abuse *and* bodily enhancement / therapy.

*A high age barrier (18) would of course effectively prevent FGM from being an index of marriageability.

Any other comments?

Up to date information on FGM in the UK seems sparse, but perhaps you have found otherwise! Negative consequences of FGM are reported, but not positive ones. There have been some illuminating studies of FGM in Somalia and the Sudan, including reports of people giving up the practice, which would provide useful comparisons. In this connection the anthropologist who has written with most knowledge *and sense* about FGM in that part of the world (and more generally) is Prof Janice Boddy (Toronto). I would put great weight on her opinion.

Africa Today published a series of illuminating articles on the topic in summer 2007. Issues concerning human rights there (eg Boddy, *Canadian Journal African Studies* 2007) are **not** 'just about' Africa: the arguments wheeled forward are very relevant to mainstream / minority debates in the UK.

How to submit your response

Please email your response to Kate Harvey (kharvey@nuffieldbioethics.org), with 'Cosmetic procedures' in the subject line. If possible, responses should be in the form of a single Word document, with question numbers clearly indicated.

References