



**Cosmetic
procedures:
ethical issues**

**NUFFIELD
COUNCIL ON
BIOETHICS**

Nuffield Council on Bioethics

David Archard (Chair from May 2017)

Jonathan Montgomery (Chair until March 2017)

Simon Caney

Tara Clancy

Jeanette Edwards*

Ann Gallagher

Andy Greenfield

Erica Haimes

Julian Hughes (Deputy Chair)

Roland Jackson

David Lawrence

Shaun Pattinson

Tom Shakespeare

Mona Siddiqui

Christine Watson

Robin Weiss

Heather Widdows

Adam Wishart

Karen Yeung**

Paquita de Zulueta

* co-opted member of the Council while chairing the Working Party on *Cosmetic procedures: ethical issues*

** co-opted member of the Council while chairing the Working Party on *Genome editing and human reproduction*

Secretariat

Hugh Whittall (Director)

Kate Harvey

Katharine Wright

Bettina Schmietow

Peter Mills

Anna Wilkinson

Catherine Joynson

Carol Perkins

Sarah Walker-Robson

Ranveig Svenning Berg

Shaun Griffin

Busayo Oladapo

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- To identify and define ethical questions raised by recent developments in biological and medical research that concern, or are likely to concern, the public interest;
- To make arrangements for the independent examination of such questions with appropriate involvement of relevant stakeholders;
- To inform and engage in policy and media debates about those ethical questions and provide informed comment on emerging issues related to or derived from NCOB's published or ongoing work; and
- To make policy recommendations to Government or other relevant bodies and to disseminate its work through published reports, briefings and other appropriate outputs.

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The Working Party also benefited considerably from the Nuffield Council's partnership in the AHRC-funded Beauty Demands Network, which ran from January 2015 to June 2016, bringing together academics, practitioners, and policy-makers to consider the changing requirements of beauty in a series of seminars that informed and stimulated the Working Party's discussions.

Foreword

The task that the Nuffield Council on Bioethics set itself – to investigate the use and provision of invasive, non-reconstructive cosmetic procedures – was both bold and timely. Bold insofar as it required consideration of the wider social, political and economic contexts in which cosmetic procedures are growing in popularity, and timely insofar as it was in step with, and in some ways ahead of, growing concerns, from many quarters, about the regulation, safety and consequences of some of these procedures. It has been a great honour and privilege to work with my fellow Working Party members and the Nuffield Council on this task.

I want to immediately and unequivocally extend a special thank you to Katharine Wright and Kate Harvey. The strengths the reader finds in this report are due to their skills, dedication and hard work. In addition, Kate's direct work with young people provided us with valuable new material and Katharine's facility for rendering multi-layered and multi-vocal meetings into coherent (and very helpful) minutes, and for asking just the right probing question at just the right time, was invaluable.

It is banal (and not very helpful) to say that the field of cosmetic procedures (from both user and provider perspectives) is complex. However, to ask ethical questions of it required us to scrutinise social, economic, psychological and cultural domains of social life that are not confined to cosmetic procedures. Amongst other things, we were compelled to think about the reach and limits of consumer culture, the medicalisation of the body and beauty, the ubiquity of social media, issues of mental health and body image – especially amongst young people, and the contours of discrimination and prejudice. Such scrutiny required and benefited from the kind of multidisciplinary working party, augmented by input from a wide range of 'stakeholder' perspectives, that has been a hallmark of the work of the Nuffield Council over the years. Clearly no one discipline or profession can adequately address the sprawling and diverse questions that arise in the current field of cosmetic procedures. And while the report has benefited from the wide range and substantial expertise and experience within the Working Party, it is greater than the sum of its parts.

As will be the case with readers, not all members of the Working Party necessarily agree with the emphasis at every point in the report. Indeed, we have not always agreed on how to treat the evidence available to us. However, we are agreed that evidence is sorely lacking and that, amongst other things, much better records need to be kept and made available. We are also in no doubt that this is an important, worthwhile and necessary report that begs attention - now.

We have made a number of strong recommendations geared towards specific actors and institutions on the understanding that some could be implemented immediately while others may take time. Here, I would like to thank members of the Working Party for their hard work and passion. And, on behalf of the Working Party, to thank the Council and the Council sub group for their constructive comments and criticisms throughout the process, and the external reviewers for their extremely helpful and considered feedback on an earlier draft.

I would like to extend a large and personal thank you to everybody who contributed to our survey and consultation exercises, attended our factfinding meetings, and agreed to be interviewed by members of the Working Party. I am both grateful and impressed by the efforts people put into our requests and of how generous they were with their time.

During our deliberations we heard from many thoughtful and thought-provoking people: workers, professionals, campaigners, regulators, researchers, administrators and managers

of health care, insurance and social media companies, journalists, clinicians, beauticians, and more – experts in their field. Many are performing sterling work, with integrity, and we heard of many examples of good and ethical practice. At the same time, many acknowledged or expressed concern about specific aspects of the promotion, provision and use of cosmetic procedures, or about the social milieu in which they are flourishing. We were often told, however, that the problem lay elsewhere: that it was beyond their control – out of their hands – things for ‘society itself’ to deal with. But of course society does not lie elsewhere – outside or beyond its members: its problems are our own. Shoulder shrugging and expecting change to come from somewhere else is not an adequate response to the issues we raise in this report. Our call is for those with a vested interest in cosmetic procedures *not* to be part of the problem.

We have focused primarily on policy and regulation in the UK. But people, materials and equipment readily travel across national borders and what happens in one jurisdiction clearly impacts on another. We have drawn on examples of alternative regulatory approaches, and learned from studies in other parts of the world. And we know that, in an interconnected world, the issues we have interrogated here also cross borders. It is our hope that this report will also be helpful to those asking similar questions outside the UK.

I hope that many readers from many different perspectives will find something of value in this report, and that it will provoke public debate and energise changes that are needed.

A handwritten signature in black ink, appearing to read 'Jeanette Edwards', written in a cursive style.

Jeanette Edwards, Chair of the Working Party

Members of the Working Party

Jeanette Edwards

Professor of Social Anthropology at the University of Manchester (Chair)

Sharron Brown

Clinical Nurse Specialist based at Chelsea and Westminster Hospital London HIV Facial Lipoatrophy Service, independent aesthetic nurse practitioner and British Association of Cosmetic Nurses board member

Clare Chambers

University Senior Lecturer, Faculty of Philosophy, University of Cambridge

Alex Clarke

Consultant Clinical Psychologist and Visiting Professor at the Centre for Appearance Research, University of the West of England

Mark Henley

Consultant Plastic, Reconstructive and Aesthetic Surgeon, Nottingham and Derby NHS Hospitals

Jane O'Brien

Independent consultant – medical regulation and ethics

James Partridge

Founder and Chief Executive of Changing Faces

Nichola Rumsey

Professor of Appearance Research at University of the West of England and Co-Director of the Centre for Appearance Research

Tom Shakespeare

Council member and Professor of Disability Research, Norwich Medical School

Shirley Tate

Professor of Race and Education, Leeds Beckett University

Michael Thomson

Professor of Health Law and Director of the Centre for Law & Social Justice, University of Leeds

Heather Widdows

Council member and John Ferguson Professor of Global Ethics, Department of Philosophy, University of Birmingham

Terms of reference

1. To consider, in the light of the many factors that may influence people's decisions to seek invasive non-reconstructive cosmetic procedures with the aim of enhancing or 'normalising' their appearance:
 - a The impact on wider society of the growing use of cosmetic procedures, and the socio-cultural contexts that play a role in stimulating demand for those procedures;
 - b Whether any particular responsibilities arise for those in the scientific and health sectors who develop, offer and promote cosmetic procedures?
 - c What, if any, are the ethical differences between cosmetic procedures and other ways of changing physical appearance, and the relevance of any such differences for professional responsibilities?
 - d Whether some procedures are ethically unacceptable, even if consented to?
 - e Whether there are certain people, or groups of people, to whom it would be unethical to offer cosmetic procedures, even if they consent to them?
 - f Whether further regulatory measures are needed?
2. To engage a wide range of people and organisations in the consideration of these questions.
3. To report and discuss findings and recommendations in appropriate ways to key decision-makers and other stakeholders.

Table of Contents

Nuffield Council on Bioethics	iii
Acknowledgments.....	vii
Foreword	ix
Members of the Working Party.....	xi
Terms of reference.....	xiii
Summary and conclusions	xvii
Introduction	1
Chapter 1 – The context: appearance and appearance ideals	6
Appearance ideals and cosmetic procedures: the social context.....	6
Anxiety about appearance: extent, impact and causes	8
Appearance and happiness	17
Definitional challenges: parameters of this report.....	18
Chapter 2 – Emerging ethical concerns.....	24
Introduction.....	24
Public health issues	27
Potential for discrimination	30
The context within which procedures are offered	31
Access to procedures by children and young people	32
Chapter 3 – The ‘business’ of cosmetic procedures	36
Introduction.....	37
The cosmetic procedures industry	37
Developmental drivers	43
Commercial competition between manufacturers.....	47
Other stakeholders.....	49
Chapter 4 – Current regulation of cosmetic procedures.....	54
Introduction.....	55
Who can provide cosmetic procedures?	55
Regulation of premises	66
Regulation of products and devices	69
Access to redress if things go wrong.....	72
Limitations on access to procedures	75
Regulation of images and advertising	77
Challenges of enforcement	84

Chapter 5 – Having a cosmetic procedure: influences and motivations	86
Introduction	86
Having a cosmetic procedure: what people aim to achieve	87
Having a cosmetic procedure: role models and influences	95
Reasons for the growing use of cosmetic procedures	105
Chapter 6 – Users’ satisfaction, outcomes, and risks	108
Introduction	108
Satisfaction with outcomes of cosmetic procedures	109
Evidence on risks of harm	112
Chapter 7 – Ethical analysis	124
Ethical distinctions and judgments	125
Challenging harmful or discriminatory ideals: responsibilities and power	130
Justifying supply-side regulation	134
Practitioner / user relationships	141
Chapter 8 – Policy implications and recommendations	146
Introduction	147
Demand-side approaches: tackling the wider social context	148
Supply-side approaches: regulating for safety and empowering users / patients	154
Access to procedures by children and young people	160
Practitioner / user relationships	161
Appendices	169
Appendix 1: Method of working	170
Appendix 2: Wider consultation for the report	177
List of abbreviations	182
Index	184

Summary and conclusions

Introduction

1. The growing use of invasive cosmetic procedures in the UK, and the absence of a coherent regulatory framework governing their use, received high levels of public attention in 2013 with the publication of the ‘Keogh report’. This report (itself the latest in a series of critical reviews of the cosmetic procedures industry over the previous decade) made wide-ranging recommendations to improve the safety of those using both surgical and non-surgical invasive cosmetic procedures. While some of these recommendations have been followed through, significant safety concerns remain. In particular:
 - Controls on the safety of some of the products used in procedures remain inadequate.
 - Requirements for practitioners to have particular qualifications and experience are only voluntary.
 - It is still too difficult for members of the public to identify appropriately qualified practitioners.
2. Moreover, the Keogh report explicitly chose “not [to make] judgements about whether the growth in cosmetic interventions is good or bad” but rather to focus on making what was already happening safer.
3. The Nuffield Council on Bioethics considers that the growing proliferation, promotion and use of cosmetic procedures deserves more detailed ethical consideration. In addition to the ongoing failure by successive governments to regulate to improve safety, none of the reviews undertaken to date has explored the potentially troubling factors that underlie this growth in interest in invasive procedures, undertaken for appearance-related reasons and provided in a highly commercial environment.
4. Ethical issues associated with the provision and uptake of cosmetic procedures potentially arise for a wide range of social actors, including: practitioners, providers, users, and potential users of these procedures; those responsible for manufacturing products and developing new procedures; those marketing, promoting and facilitating access to them; the media, both mainstream and social; and indeed society more broadly. They deserve proper scrutiny.
5. An important theme of this report is the difficulty in drawing sharp and consistent distinctions between therapeutic procedures, cosmetic procedures, and beauty practices. In some cases, the same procedure may be undertaken either for therapeutic or for appearance-related purposes, with distinctions therefore drawn in relation to motivation, rather than the nature of the procedure itself. Similarly, there are no clear dividing lines between some non-surgical cosmetic procedures and what is regarded as ‘routine’ beauty maintenance. For the purposes of this report the umbrella term ‘cosmetic procedures’ will be used for invasive, non-reconstructive procedures that share a number of common features:
 - Their purpose is to change a person’s appearance in accordance with perceptions of what is normal or desirable.
 - Their purpose is non-essential with respect to physical function.

- They are carried out by third parties in a clinical or quasi-clinical environment (while recognising that some of the ethical concerns raised may also arise in the context of procedures or products that people can use without third party involvement).
 - They are not ordinarily publicly funded through public health systems such as the UK NHS.
6. Such procedures include cosmetic surgery and dentistry, the use of botulinum toxins (botox) and dermal fillers, cosmetic skin peels, laser and intense pulsed light treatments, and invasive skin-lightening treatments.

Chapter 1 – The context: appearance and appearance ideals

7. Interest in bodily appearance is a universal social phenomenon and is not in itself a source of anxiety. However, concerns are growing about the degree of distress resulting from the perceived gap between personal appearance and prevailing and dominant appearance ideals; and about the potentially discriminatory nature of some of those ideals themselves.
8. Rising levels of ‘body dissatisfaction’ are associated with factors including:
- The huge growth in the use of social media
 - increased use of the rating of images of the self and the body, for example through social media ‘likes’, and through self-monitoring apps and games
 - the popularity of celebrity culture, ‘airbrushed’ images, and makeover shows
 - economic and social trends such as people retiring later, while having to compete in cultures that value youth and youthful appearance.
9. Advertising and marketing widely reinforce the belief that beauty is correlated with happiness and success. Women in particular are surrounded by the message that they have a duty to ‘make the best’ of themselves.
10. These developments arise in tandem with scientific advances that increasingly allow for parts of the body to be substituted and modified, and a dramatic growth in the commercially-driven cosmetic procedures industry.

Chapter 2 – Emerging ethical concerns

11. Having a cosmetic procedure, like other means of changing or managing appearance, can be experienced by individuals as positive and enabling. However their provision also has the potential for harm at societal level, which can operate alongside unproblematic personal use. A number of significant concerns about such ‘communal harms’ emerged early on in the project, and form the basis for our own ethical analysis in Chapter 7:
- The social and economic factors described in Chapter 1 may combine to exert pressure on people (especially, but not only, on girls and women) to conform to particular expectations with respect to appearance. These standards and ideals are socially, culturally and historically constructed, and socially enforced. Arguments based on ‘choice’ alone are therefore unlikely to be sufficient in enabling us to understand the ethical questions at stake.
 - The levels of anxiety arising in the context of pressures to conform to particular appearance ideals, and their impact on mental health, are a matter of public health concern. Moreover, the social expectations and ideals to which we are encouraged to

conform and aspire are not necessarily ethically neutral or value free. Many cosmetic interventions both reflect and promote gender, disability and racial norms, and hence may reinforce existing inequalities and discriminatory attitudes, despite countervailing changes in social attitudes towards diversity and inclusion.

- Adolescents may be particularly sensitive to pressures to conform to prevailing peer and social pressures, and are at a vulnerable stage of development with respect to their sense of their own identity. Their access to cosmetic procedures raises particular ethical concerns.
- The cosmetic procedures industry both exploits and generates these appearance insecurities by marketing invasive cosmetic procedures as medicalised 'solutions'. These are offered in environments that are, or feel, medical – and so which are associated with relationships of trust and concern for patient welfare. These associations raise further ethical concerns with respect to practitioners' responsibilities towards users / patients.

Chapter 3 – The 'business' of cosmetic procedures

12. Most cosmetic procedures are provided in the private sector, and the overlap between cosmetic procedures and the beauty industry makes this sector 'big business', driven by commercial interests and proactive marketing. The role of commerce is thus an important factor to take into account in exploring the ethical implications of the use of cosmetic procedures.
13. Accurate information about the size and value of the cosmetic procedures market is hard to find in the public domain, because of the fragmented nature of the market, limited reporting requirements, and commercial confidentiality. However, market intelligence assessments suggest sustained growth: one estimate of the UK cosmetic sector (surgical and non-surgical) was £3.6 billion in 2015, up from £720 million in 2005. In the US, the cosmetic surgery market alone was assessed in 2015 as \$20 billion.
14. Figures on the number of procedures undertaken are similarly elusive, but one 2009 UK estimate was of 1.2 million procedures a year (92% of which were non-surgical), with significant growth expected since. An association of NHS-qualified plastic surgeons working in the cosmetic sector reported a threefold increase in cosmetic surgeries between 2004 and 2015 undertaken by its members, followed by a 40% drop in 2016. In contrast the large commercial groups report ongoing growth in 2016. While procedures such as breast augmentations and reductions, liposuction, and surgery on the face retain popularity over time both in the UK and beyond, 'newer' procedures, such as buttock augmentations, penis enlargements, and female genital cosmetic surgery (FGCS) are also emerging as increasingly popular.
15. The development and marketing of new (or, in many cases 'repurposed') products and procedures are important drivers of the market, especially where they offer less invasive alternatives to surgery. Developments include:
 - the use of platelet-rich plasma in 'vampire' treatments;
 - 'fat freezing' as a non-surgical alternative to liposuction; and
 - the use of fillers and botox in new areas of the body, including ears, knees and feet.

16. Manufacturers of the products and equipment used in cosmetic procedures similarly compete for market share. In some cases, including in the production and sale of breast implants and dermal fillers, strong commercial competition has led to significant concerns about safety and quality.
17. The cosmetic procedures industry is made up of a complex network including: those who develop products, procedures and technologies; ‘provider’ companies and practitioners; financiers; agents; and advertisers. The business models through which cosmetic procedures are offered include:
 - self-employed health professionals;
 - private hospitals and clinics, who also provide mainstream medical care;
 - large commercial ‘group’ providers who specialise in cosmetic procedures; and
 - beauty salons, spas, gyms and other parts of the beauty and ‘wellness’ sector.

Chapter 4 – Current regulation of cosmetic procedures

18. The complex network of stakeholders engaged in the production, provision and marketing of cosmetic products and procedures is governed by a patchwork of regulatory measures, in which a series of reports in the last decade has identified significant gaps and flaws. Action in response to the 2013 Keogh report has remedied some, but not all, of these. There are ongoing challenges of enforcement, and limited means of redress for adverse outcomes, unless negligence can be demonstrated.
19. **Controls on practitioners:** There are few statutory limits on who may provide cosmetic procedures. In particular, there are no controls on who may provide non-surgical procedures, other than limitations on access to prescription medicines, and on procedures in the mouth. Professional regulation therefore plays an important role. Developments since the Keogh report include updated guidance for doctors by both the General Medical Council (GMC) and the Royal College of Surgeons (RCS); a voluntary certification scheme for surgeons working in the cosmetic sector; and progress in establishing a voluntary register of practitioners who meet required standards to perform non-surgical procedures.
20. **Controls over premises:** The Care Quality Commission (CQC) regulates private clinics and hospitals in England that provide cosmetic surgery, but not those that provide only non-surgical procedures. The CQC’s remit extends to how clinics are run (for example with respect to recruitment, record-keeping and equipment), but not to direct measures of the quality of care provided.
21. **Controls over products:** Devices and equipment marketed for non-medical purposes, such as many dermal fillers and implants, have historically been excluded from regulation within the EU but will be included from May 2020 under the Medical Devices Regulation 2017. How they will be regulated in the UK after Brexit, and what assessment criteria will be used in either the UK or EU member states, is unknown.
22. **Limits on access to procedures:** There are no statutory controls over access to cosmetic procedures by young people, although statutory minimum age-limits of 18 apply for other appearance-related procedures such as tattoos and sunbed use. There is legal uncertainty as to the extent to which some of the procedures marketed as FGCS may be prohibited by the Female Genital Mutilation Act 2003.
23. **Advertising and marketing** is subject to self-regulation by the Advertising Standards Authority (ASA) and the Committee of Advertising Practice (CAP) which require marketing

communications to be “legal, decent, honest and truthful”, and “prepared with a sense of responsibility to consumers and to society”. The ASA’s remit extends to commercial advertising online and in social media, but does not cover unsolicited endorsements in tweets or blogs or to images shared by social media users.

24. The **Equality Act 2010** prohibits discrimination on the grounds of “protected characteristics” such as age, gender and disability (including severe disfigurement). Appearance-related discrimination could fall under the Act if it were related to a protected characteristic.

Chapter 5 – Having a cosmetic procedure: influences and motivations

25. The research available at the moment exploring the motivations and influences that lead people to consider cosmetic procedures is disparate and variable in quality; and further, more robust, evidence is needed to provide a more thorough understanding of the field than is presently possible. This chapter draws on the published literature and the Working Party’s own evidence-gathering to summarise what is known about the motivations and influences that prompt people to consider using cosmetic procedures.
26. Different cohorts of prospective users of cosmetic procedures are attracted to particular procedures for different reasons, although very often linked through a common thread of wishing to ‘fit in’ with a particular peer group. Reasons cited in the published literature and in the Working Party’s own evidence gathering for having a cosmetic procedure include:
- wanting to look younger;
 - aiming to achieve ‘normality’, often defined with reference to peer group preferences regarding appearance, rather than in response to disfigurement;
 - hoping to improve self-esteem, or responding to body dissatisfaction;
 - hoping to achieve, or maintain, professional success; and
 - rejecting or conforming to social and cultural ideals.
27. However, only a minority of people who share one or more of these aims will decide to use cosmetic procedures in order to try to achieve them. A number of role models and influences have been identified as potentially significant in encouraging people to consider (or not to consider) cosmetic procedures. These include: the influence and attitudes of family, friends and peers; the influence of celebrity, media, social media, and pornography; concerns with respect to sex and relationships; experience of being bullied or teased; physical discomfort (as a contributory factor); changes in the body post-pregnancy; and affordability.
28. While these influences seem disparate, a common feature of some of them is that they make procedures seem more ‘available’ as they become more familiar, appropriate or affordable. Others arise out of particular events or personal histories.

Chapter 6 – Users’ satisfaction, outcomes, and risks

29. Most users of cosmetic procedures who are asked, report being satisfied with the initial outcomes of the procedures they have undertaken. Positive outcomes reported include improvements to self-esteem and well-being, feeling more attractive or less self-conscious, and receiving positive comments from others. It is not possible at present to

assess whether initial satisfaction is maintained over time, as there is a significant lack of data on long-term physical or psychological outcomes.

30. As in any other bodily intervention, cosmetic procedures entail a degree of physical risk. Physical harms may arise as a result of products used in the procedure, through poor practice, or from the inherent risks associated with the procedure, such as infection or (for surgical procedures) bleeding and adverse reactions to general anaesthesia. Some complications are minor and temporary while others are more substantial and longer-lasting.
31. Psychological complications, such as anxiety and depression following an operation, may be as common as physical complications after cosmetic surgery, though the research evidence is limited. Those with pre-existing mental disorders appear to be more likely to suffer negative psychosocial outcomes after procedures. This group includes not only those suffering from body dysmorphic disorder (BDD), but also people with high levels of stress, and people taking medication to aid sleep or for anxiety. There is also an association between use of breast implants and suicide: although the mechanics of this relationship are not clear, it is likely that the association reflects higher rates of pre-existing mental disorder.
32. The increasing availability of cosmetic procedures also potentially poses social and communal harms. These include:
 - encouraging a focus on appearance and adding to levels of appearance anxiety;
 - shifting perceptions of what is 'normal' and reinforcing discriminatory attitudes;
 - constructing ideals that can only be met through invasive means; and
 - adding to the pressures on those who might like to, but cannot, meet these ideals.

Chapter 7 – Ethical analysis

Ethical distinctions and judgments

33. Chapter 2 outlined the emerging ethical concerns associated with the growing use of cosmetic procedures in the UK and beyond, especially when considered in the context of increasing levels of appearance anxiety, cultivated and sustained by broader social, economic and technological factors. The empirical evidence explored in succeeding chapters provides significant support for the concerns raised: with respect to the potential harms to public health of adding to appearance anxieties; of contributing to discriminatory attitudes with respect to appearance; and with respect to the dangerous disjunction between assumptions of trust-based care centred around patient welfare, and the reality of an industry driven by commercial imperatives that packages and sells procedures as consumer goods. These concerns are particularly pressing when considering children's and young people's exposure to idealised body images and access to cosmetic procedures.
34. At the same time, while evidence about long-term outcomes is limited, we know that many people are satisfied at least initially with the outcome achieved by the procedure that they have had. Attention to one's own appearance, and the enjoyment that can be found in managing it, can contribute to the way in which individuals flourish, though the excess attention implicated in appearance anxiety and distress does not. Any action taken in response to the evidence of wider harms thus also needs to take into account the potential impact on individuals' preferences and choices.

35. In order to analyse what action might be taken, and by whom, in response to the harms we have identified, we have to consider if meaningful differences can be drawn between the procedures described as ‘cosmetic’; procedures considered therapeutic that nevertheless target appearance; and routine beauty procedures. However, it is simply not possible to draw a consistent and coherent distinction between what is cosmetic and what is therapeutic / reconstructive. Reconstructive procedures, just as much as cosmetic procedures, are influenced by cultural ideas about what is normal or desirable appearance. Nor can straightforward distinctions be made on the grounds of motivation. The common intuition that wanting to look ‘normal’ is a ‘better’ motivation than wanting to look ‘beautiful’ may be based on the belief that an unusual appearance may cause emotional distress that deserves to be alleviated in a way that a desire to enhance does not. However, this distinction is not borne out by the psychological evidence. There appears to be no correlation between severity of any disfigurement and degree of distress, and indeed people living with significant visual difference may be much happier with their appearance than others who might be regarded as beautiful.
36. **We therefore conclude that, instead of trying to ‘label’ particular procedures, or particular motivations, as ethically acceptable or non-acceptable, we need to consider the context in which those procedures are perceived and promoted as desirable – and then to explore the distinct ethical questions that arise within that context. These ethical questions can be broadly categorised as relating to:**
- responsibility for preventing or minimising various public health and discriminatory harms;
 - the preservation and maintenance of trust as part of the practitioner / user relationship in a clinical context; and
 - the extent to which particular responsibilities are owed to children.
37. **It is important to recognise that these ethical questions may also arise in connection with procedures that would generally be perceived as therapeutic interventions, or ‘simply’ as routine beauty treatments.**
38. **We suggest that an ethical framework for responding to these challenges needs to include two distinct elements, that can be broadly categorised as being concerned with the ‘demand’ and ‘supply’ aspects of the industry respectively:**
- On the ‘demand’ side, with reference to the social context in which appearance ideals are embedded, we explore the roles and responsibilities of those who potentially have the power to influence how these ideals emerge and are promulgated, and the extent to which they act to promote or to challenge harmful and discriminatory ideals.
 - On the ‘supply’ side, we consider the responsibilities of the cosmetic procedures industry and practitioners when they offer, or respond to requests for, procedures. [paragraphs 7.15–7.16]

Challenging harmful or discriminatory ideals: responsibilities and power

39. There are a number of key players who bear distinct responsibilities for the way in which appearance expectations and ideals are collectively promoted and reinforced and who also have the power to make things change. These include: the state; the beauty, fashion,

film and music industries; media and advertising; and the cosmetic procedures industry itself. Drawing on the notion of the ‘stewardship state’, elaborated in the Nuffield Council’s 2007 report *Public health: ethical issues*, we argue that the state has an ‘enabling’ role in public health, recognising that many aspects of contemporary life, ranging from the built environment and provision of public services to social pressures mediated through technological developments, have a major impact on people’s health, and yet lie outside the sphere of control of individuals. The further role of the stewardship state with respect to responding to inequalities provides clear justification for state action in combating discrimination and in actively promoting a fair society.

40. **We suggest that this understanding of the stewardship role of the state provides strong justification for action on the part of the state with respect to the ‘demand side’ factors that influence why people consider having a cosmetic procedure in the first place, and which can be associated with discriminatory practices and harm to public health. Such action needs to be proportionate, taking into account the need to justify potential intrusion into the rights and freedom of individuals. It also needs to be evidence-based, with respect to both the harms at stake, and the likelihood of the proposed policy interventions to succeed in mitigating them. [paragraph 7.21]**
41. The social responsibilities of the business sector are not necessarily limited to complying with regulatory requirements. The well-established concept of ‘corporate social responsibility’ (CSR) encompasses the obligation of businesses to act in ways that benefit both the interests of the organisation and those of society as a whole. Where business takes such social responsibilities seriously, then the need for state action may be diminished: a self-regulatory system that operates well, for example, may be as effective in protecting individuals from public health harms or discrimination as a statutory system.
42. **The cosmetic procedures industry is not solely responsible for creating the appearance ideals that have been critiqued in this report. However, it is complicit in encouraging them through the procedures it develops and promotes, and plays a further role in associating the potential for appearance change with the trust-based ‘brand’ of the health professional. [paragraph 7.26]**

Justifying supply-side regulation

43. The stewardship role of the state also clearly justifies action to ensure that individuals are not put at the risk of unnecessary and avoidable harm. It is thus relatively uncontroversial to argue for the setting and policing of standards across the sector that ensure that patients are treated in safe surroundings, with products or procedures that meet at least minimum safety requirements, and by practitioners who have the necessary skills and experience. The question is what those standards should be. In the regulation of therapeutic procedures, scope for benefit and the possibility of adverse outcome are weighed against each other, and risk is in some respects accepted in the context of potential health benefits. In the context of cosmetic procedures, we suggest that the appropriate level of physical risk to which patients / users should be exposed is considerably lower.
44. **We therefore suggest that, in the absence of physical health benefits, the regulation of invasive cosmetic procedures should start from the requirement proactively to demonstrate both user safety and effectiveness with respect to their claimed outcomes. That is to say, procedures and products should be demonstrated to be safe and effective *before* being allowed on to the market, rather than marketed until risks are discovered. [paragraph 7.31]**

Responsibilities with respect to children and young people

45. The responsibility of the state to take action to enable adults to live healthy lives, and to protect them where possible from avoidable harms, is even stronger with respect to the protection of children and young people. While there is an increasing focus on the importance of children and young people participating in healthcare decision-making, this is premised on the assumption that the proposed treatment is recommended by a health professional, and is in the child's best interests.
46. Similarly, parental discretion with respect to the decisions parents take on behalf of children is not boundless. The fact that a parent consents to a cosmetic procedure on behalf of their child, or even initiates consideration of that procedure, does not necessarily mean that it is ethically acceptable for a professional to provide it.
47. For pragmatic reasons, both law and policy frequently need to draw 'bright line' distinctions based on age, including determining the age at which in law, childhood and the associated parental responsibility comes to an end. We suggest that there are strong justifications for limiting access to cosmetic procedures to people over the age of 18, other than in exceptional cases.

Practitioner / user relationships

48. **Some of the ethical challenges that arise in connection with the provision and use of cosmetic procedures fall outside the sphere of influence of individual practitioners. They cannot be held primarily responsible for the many and various social factors that we have identified as contributing to growing anxiety about appearance, although their role in reinforcing these factors through the provision of cosmetic procedures should not be overlooked. Nor are they responsible for the inadequate and patchwork nature of regulation in this field or for the failures of some parts of the industry to demonstrate corporate social responsibility. However, they can, and must, hold themselves responsible for the ethical consequences of their own practice, ensuring that the way that they practise does not make them 'part of the problem'. [paragraph 7.44]**
49. An ethical approach would include:
 - Acting first and foremost in the best interests of their users / patients, and not taking on the role of a salesperson.
 - Using their influence to challenge inappropriate marketing or advertising on the part of employers or colleagues that risks undermining the consent process.
 - Recognising the limits of their own competence: not only with respect to their skills in providing particular procedures, but also with reference to understanding the needs, experiences and motivations that bring individuals to request those procedures. The fact that cosmetic procedures constitute a physical intervention whose hoped-for benefits are primarily psychological highlights the importance of practitioners, at the very least, having access to psychological expertise, through multidisciplinary working or other forms of professional and peer support.
 - Recognising the susceptibility of some of those seeking cosmetic procedures to the risks of sub-optimum outcomes. Practitioners should not hesitate to probe in some depth what users hope to achieve, and be frank about the evidence as to how likely these aims are to be realised.

- Ensuring potential users have access to the information and support they need to make a decision that is right for them. This includes discussing alternative interventions where the evidence suggests that these are more likely to be effective.
 - Being prepared to say 'no' to a request for a particular procedure, if, in their professional judgment, they are not confident that it is likely to achieve what the potential user hopes for.
 - Ensuring appropriate ongoing care where users suffer suboptimal outcomes from the procedure.
50. While ethical engagement between practitioner and user of cosmetic procedures cannot be reduced simply to the question of informed consent, nevertheless the approach taken to consent is a key element in that encounter. We suggest that in this context **shared decision making – where users or patients play an active role in decisions about their treatment or care – may prove a better model than the traditional consent process**, where patients are asked only to accept or refuse a treatment offered by their doctor. In genuinely shared decision-making, consultations should be partnerships between practitioner and user, in contrast both with the traditional understandings of the doctor / patient relationship and with models of consumer choice and high-pressure sales.

Chapter 8 – Conclusions and recommendations

51. Changes to promote more ethical practice are needed both on the 'demand' and on the 'supply' side, and two issues have emerged repeatedly throughout this inquiry that are significant in considering practical ways forward:
- **The absence of high quality data with respect to many of the issues touched upon by this report; and**
 - **The delays and failures of successive governments in responding to the series of major reports over the past decade that have laid bare the inadequate state of regulation of the cosmetic procedures industry. [paragraph 8.2]**
52. We therefore highlight where further work is urgently required to improve the information and research base. We also distinguish what, in our view, would be ideal and should be achieved in the long-term, and what may be more immediately achievable in the current regulatory environment.

Demand-side approaches: tackling the wider social context

53. The 'stewardship' role of the state includes positive public action to enable people to flourish with respect to both their physical and their mental health. Such public action is justified to counteract both the specific claims made about the positive effects of cosmetic procedures, and more generally to counter the effects of broader visual and media cultures in which choices about cosmetic procedures are embedded. It also justifies action in response to inequality and discrimination: the development and marketing of cosmetic procedures has the scope to contribute to discriminatory attitudes by endorsing particular appearance ideals and offering technical 'fixes' to achieve them.
54. Such responsibilities go wider than state actors, and we identify specific action that could be taken by industry both in the images and claims promulgated through advertising and in the wider role played by social and traditional media. We also look at the additional role that other organisations, including governmental bodies such as the Equality and Human Rights Commission (EHRC), could play.

Advertising

55. The Advertising Standards Authority (ASA) is currently looking at concerns about body image in advertising, as part of a broader investigation into gender stereotyping established in the light of the strong public response to the “Are you beach body ready?” advertisement. **We welcome this initiative, and highlight, in particular, the need for the ASA to find ways of taking into account the cumulative effect of multiple advertisements over time in which particular appearance ideals are promoted. [paragraph 8.10]**
56. In 2016, Transport for London (TfL) amended its advertising policy in order to refuse advertising that “could reasonably be seen as likely to cause pressure to conform to an unrealistic or unhealthy body shape, or as likely to create body confidence issues particularly among young people”. **We warmly support this initiative by TfL, and encourage the ASA and the Committee of Advertising Practice (CAP) to follow TfL’s approach in their own guidance to the industry. [paragraph 8.11]**

Recommendation 1: We recommend that the Advertising Standards Authority and the Committee of Advertising Practice follow the example of Transport for London in prohibiting advertising that is likely to create body confidence issues, or cause pressure to conform to an unrealistic or unhealthy body shape.

Recommendation 2: We recommend that the Advertising Standards Authority and the Committee of Advertising Practice revise their guidance to industry to make clear that the following practices are not acceptable in advertisements:

- **claiming, or strongly implying, that there is a likely link between cosmetic procedures and emotional benefit;**
- **using post-production techniques in circumstances where they can potentially contribute to discriminatory attitudes, unrealistic appearance ideals, or appearance-related anxiety.**

Recommendation 3: We further recommend that the Advertising Standards Authority works proactively to monitor compliance with such standards, in line with its recent commitments to devote more resources to proactive review of advertisements and its ongoing work on body image.

Social media and broadcast media

57. We welcome the fact that social media companies such as Facebook / Instagram are beginning to include concerns about body image in the campaigning and educational work they undertake among adolescents. However, much more needs to be done. **In the light of the increasing concerns emerging with respect to correlations between social media use and such body image issues, we suggest that collaborative work across the sector to tackle these issues falls squarely within the remit of their corporate social responsibilities. [paragraph 8.14]**
58. Similarly, we suggest that marketing apps designed for children as young as nine that encourage them to ‘play’ at having cosmetic surgery makeovers, is clearly inappropriate and irresponsible. **We endorse the campaign by Endangered Bodies which has established a petition to Apple, Google and Amazon requesting them to exclude**

from their app stores any cosmetic surgery games targeted at children. [paragraph 8.15]

59. Broadcast media have also played a part in influencing how cosmetic procedures are perceived, particularly through the growth and popularity of cosmetic surgery makeover shows. While there is considerable diversity within the genre with respect to attitudes to body image and appearance ideals, a common feature conveyed by many is the idea that surgical ‘fixes’ to problems are always available.

Recommendation 4: We recommend that the social media industry (including Facebook / Instagram, Snapchat, Twitter and YouTube) collaborate to establish and fund an independent programme of work, in order to understand better how social media contributes to appearance anxiety, and how this can be minimised; and to take action accordingly.

Recommendation 5: We recommend that Ofcom review the available evidence and consider whether specific guidance to accompany its Broadcasting Code is warranted with respect to the tacit messages about body image and appearance ideals that may be conveyed by makeover shows involving invasive cosmetic procedures.

Other action to challenge discriminatory ideals

60. Contemporary concerns about exclusion and discrimination in connection with appearance exist alongside significant momentum towards more inclusive attitudes towards diversity. The Face Equality Campaign, the BeReal campaign, and Models of Diversity, for example, all aim to promote acceptance of greater diversity of appearance in various sectors, including in business and employment. **We commend the work of these and similar campaigns, while recognising the need for companies to go beyond the ‘letter’ of signing up to such a pledge and ensure that their actions and wider commercial strategy are in tune with its spirit. [paragraph 8.18]**
61. Discrimination on the grounds of appearance often coincides with, or contributes to, discrimination on other grounds, such as age, race and disability, that are already prohibited under the Equality Act 2010. Full use of existing powers, not only of enforcement, but also through advice and guidance, should be made to challenge discrimination based on appearance.

Recommendation 6: We recommend that the Equality and Human Rights Commission:

- **develop and publish specific guidance on disfigurement and appearance-related discrimination, founded on the requirements of existing equality legislation; and**
- **take discrimination related to appearance into account when monitoring discrimination relating to areas such as age, race, gender and disability.**

Responsibilities of the state towards children and young people

62. The stewardship role of the state is particularly strong in relation to its responsibilities to protect the welfare, including the mental health and well-being, of children. Given the way that many of the appearance-related pressures described in this report are embedded in

technologies that are an increasingly important part of people's lives, it is crucial to help children and young people to deal with them robustly from an early age, alongside action to challenge at source those pressures that are potentially discriminatory or harmful. **We endorse the work of the Be Real campaign in developing and promoting evidence-based teaching resources on body image, and emphasise the importance of all children having access to such resources. [paragraph 8.21]**

Recommendation 7: We recommend that the Department for Education act to ensure that all children and young people have access to evidence-based resources on body image, whether through PSHE (personal, social, health and economic education) lessons or through other (compulsory) elements of the curriculum.

Supply-side approaches: regulating for safety and empowering users / patients

63. **We endorse all Keogh's recommendations, and believe that they should be implemented in full.** Our recommendations seek wherever possible to make use of existing regulatory mechanisms, while also highlighting where we believe legislative change to be essential. **We also urge the Royal College of Surgeons to consider how best to continue taking a leadership role with respect to promoting and supporting high standards in cosmetic surgery. In order to maintain impetus with respect to high standards in this commercialised area of surgery, a dedicated and permanent resource within the Royal College will be required. [paragraph 8.24]**

Making products and procedures safer

64. The regulation of invasive cosmetic products and procedures should start from the requirement proactively to demonstrate both safety and effectiveness with respect to their claimed outcomes. In this respect, EU and UK regulation has historically been far too lax (see paragraph 21). While, from May 2020, devices such as dermal fillers, cosmetic implants and liposuction equipment will be regulated in EU member states on the same basis as medical devices (we refer to these below as 'cosmetic devices'), it is currently unclear how clinical assessment of the risks and benefits of these cosmetic devices will be carried out. Much will depend on the content of the 'common specifications' to be developed for use by those making these assessments; and on how consistently these specifications will then be applied.
65. While the inclusion of cosmetic devices within the Medical Devices Regulation is welcome, it will still be a further three years before the new requirements will be applied within EU member states. It is also unclear at this stage whether the UK will aim to harmonise its regulatory requirements with those of the EU, or whether it will take the opportunity to adopt a different approach.

Recommendation 8: We recommend to the European Commission that the 'common specifications' for the clinical assessment of cosmetic devices, to be developed under the Medical Devices Regulation 2017, should be based on the need proactively to demonstrate both safety and effectiveness with respect to their claimed benefits through clinical trial data and robust outcome measures.

CE marking should also be dependent on commitments to collect and publish long-term outcome data.

Recommendation 9: We recommend that the Department of Health and the Medicines and Healthcare products Regulatory Agency, in the lead up to Brexit, develop a UK approach to the regulation of cosmetic devices based on the need proactively to demonstrate both safety and effectiveness with respect to their claimed benefits through clinical trial data and robust outcome measures. Marketing authorisation should be dependent on commitments to collect and publish long-term outcome data.

Recommendation 10: We recommend that the Department of Health bring forward stand-alone legislation to make all dermal fillers prescription-only.

Recommendation 11: We recommend that, until new standards relating to safety and effectiveness of cosmetic devices are in place, insurers of cosmetic practitioners (including the medical and dental defence organisations who provide indemnity cover as a benefit of membership) should, as a matter of good practice, restrict indemnity to procedures using dermal fillers approved under the US regulatory system by the FDA.

66. On the specific question of FGCS, we note how the specialist medical colleges in the US and in Australia / New Zealand have cautioned their members against offering procedures that lack current peer-reviewed scientific evidence, other than in the context of an appropriately constructed clinical trial. In contrast, in the UK the Royal College of Obstetricians and Gynaecologists takes a permissive approach to FGCS on the basis that there is an absence of evidence as to harm. There is also a concerning lack of clarity as to whether procedures offered as FGCS fall within the ambit of the Female Genital Mutilation Act 2003.

Recommendation 12: We recommend that the Royal College of Obstetricians and Gynaecologists should review its guidance to its members on female genital cosmetic surgery and emphasise the need for evidence, demonstrating safety and effectiveness with respect to claimed outcomes, *before* procedures are offered outside a research setting.

Recommendation 13: We recommend that the Home Office should clarify the circumstances in which procedures offered as ‘FGCS’ do, or do not, fall within the ambit of the FGM Act, in the light of ongoing concerns as to their legality.

Regulating practitioners

67. We recognise and endorse the progress that has been made with respect to the regulation of practitioners since the publication of the Keogh report. Nevertheless, we remain concerned about both the speed of progress, and the significant gaps in protection that remain: in particular, the regrettable absence of statutory controls over the standards and qualifications required for cosmetic practitioners. It remains the case that a practitioner with inadequate, or no, qualifications, is legally permitted to offer invasive non-surgical cosmetic procedures.
68. **We welcome the work by the Royal College of Surgeons in developing a certification scheme, under which surgeons working in a variety of surgical specialties can demonstrate their competence in performing particular cosmetic**

procedures or groups of procedures. [paragraph 8.32] However, we are concerned that this scheme, like so many other good practice initiatives, is voluntary, and that access to appropriate training for those wishing to specialise in cosmetic, rather than reconstructive, surgery, can be difficult.

Recommendation 14: We recommend that the Royal College of Surgeons require, and enable, all members of the College who practise cosmetic surgery to participate in its certification scheme.

Recommendation 15: We recommend that the Royal College of Surgeons work with the other surgical Royal Colleges, the major private providers of cosmetic surgery, and professional bodies representing surgeons working in the cosmetic sector, to ensure that those wishing to specialise in cosmetic surgery are able to access the training that they need to achieve the necessary standards.

Recommendation 16: We recommend that the General Medical Council and the medical defence associations work together to ensure that surgeons who are performing cosmetic surgery must meet these requirements in order to be indemnified when performing such surgery. One possible approach would be through the proposed ‘credentialing’ scheme currently being developed by the General Medical Council.

69. We welcome the publication by both the GMC and the RCS of detailed guidance to doctors with respect to the high ethical standards expected of those working in the cosmetic sector. We further welcome the work undertaken by the newly established Joint Council for Cosmetic Practitioners (JCCP) to develop a similar code of practice.

Recommendation 17: We recommend that other regulatory bodies whose registrants provide cosmetic procedures, in particular the General Dental Council and the Nursing and Midwifery Council, develop specific guidance on cosmetic practice for their own registrants, to complement the guidance issued by the General Medical Council and the Royal College of Surgeons.

70. We recognise that there are limitations on the scope for professional regulatory bodies proactively to ‘police’ their guidance. Nevertheless, it is clear from ongoing concerns about inappropriate access to prescription-only medicines such as botox that the current entirely reactive approach is inadequate to protect users. **We welcome the GMC’s commitment to monitoring the implementation of its latest guidance on cosmetic practice, and suggest that this offers an opportunity to explore ways in which regulators could work with other organisations, for example Trading Standards, Citizens Advice, and the Care Quality Commission, to alert them to examples of malpractice that might otherwise not reach them in the form of a complaint. [paragraph 8.34]**
71. **We endorse the work carried out by Health Education England (HEE) setting required standards for training and practice (regardless of professional background of the practitioner) across a range of non-surgical procedures. We also welcome the establishment of the new Joint Council for Cosmetic Practitioners (JCCP), and its commitment to seek registration with the Professional Standards Authority. [paragraph 8.35]** In the absence of any statutory requirements for practitioners to be registered with the JCCP, the effectiveness of its work is likely to be highly dependent on levels of public awareness of its existence and its role. It is therefore

particularly important that those registered with the JCCP are able to demonstrate that they are accredited practitioners, for example through the use of the Professional Standards Authority’s ‘accredited registers quality mark’.

Recommendation 18: We recommend that, once the Joint Council for Cosmetic Practitioners has achieved accreditation with the Professional Standards Authority, Public Health England and its counterparts in the other countries of the UK should initiate a public awareness campaign to publicise the existence of the quality mark, alongside other sources of user advice, once available. Such a campaign should also draw attention to the lack of regulatory controls on practitioners not covered by the quality mark.

Regulation of premises and of provider organisations

72. The regulation of the premises from which cosmetic procedures are offered is a significant cause for concern, leaving users of non-surgical treatments, in particular, with unacceptably low levels of protection. **We conclude that the role of the Care Quality Commission (CQC) should be extended in a proportionate manner to all premises where invasive non-surgical procedures, covered by the accreditation system to be developed by the Joint Council on Cosmetic Practitioners, are provided. [paragraph 8.37]** Local authorities already have the discretion to license premises providing cosmetic procedures involving intense pulsed light and lasers: pending legislative change, and as a minimum, local authorities should be encouraged to follow the example of the London boroughs and others, and make use of this discretionary power to protect their residents. The cost of such registration and inspection should be borne by the private sector providers.
73. **The CQC role for both surgical and non-surgical procedures should further be extended to ensure that ‘providers’ – the individuals, partnerships or organisations responsible for running hospitals or clinics – share responsibility for the quality of care provided with the doctors with whom they contract to provide the direct medical care. [paragraph 8.38]**

Recommendation 19: We recommend that the Department of Health act to extend the role of the Care Quality Commission (CQC) to all premises where invasive non-surgical procedures are provided.

Recommendation 20: We recommend that the CQC review its registration and inspection criteria for providers of cosmetic procedures so that, as a minimum providers are held responsible for:

- ensuring that surgeons providing services under contract to them are certified under the Royal College of Surgeons’ scheme, once fully in force;
- ensuring that any practitioners providing non-surgical procedures under their name are registered with a body accredited by the Professional Standards Authority (when non-surgical procedures are brought within the CQC’s remit); and
- taking the lead in responding to any complaints and litigation in connection with care provided under their name, regardless of the employment status of the practitioner concerned.

74. A common thread of concern that has run through this report relates to the lack of even basic data with respect to cosmetic practice, and the difficulties this creates in supporting evidence-based practice. While we welcome the creation of the Private Healthcare Information Network (PHIN) to which private hospitals are now required to submit data, we note the absence of any equivalent requirements with respect to the collection of data on non-surgical procedures. **We conclude that as an absolute minimum, information should be collected and made publicly available with respect to the number and type of cosmetic procedures (surgical and non-surgical) carried out, alongside basic demographic data regarding those seeking procedures. Anonymised pre-treatment and post-treatment outcome data (both short-term and long-term) are also crucial in order to improve the current poor evidence base with respect to the outcomes of procedures. [paragraph 8.40]**

Recommendation 21: We recommend that the UK departments of health should work with the Royal College of Surgeons, the Joint Council for Cosmetic Practitioners, the Private Healthcare Information Network, and the Care Quality Commission to find ways to close the significant gaps in data collection that currently remain.

Recommendation 22: We further recommend that the clinical codes used by the NHS to record and classify patient information should be adjusted to enable the NHS to record accurate information about any complications of cosmetic practice that require follow-up treatment in the NHS.

Access to procedures by children and young people

75. **We conclude that there should be a strong presumption against access to cosmetic procedures by children and young people under the age of 18. [paragraph 8.42]**
76. **Drawing on best practice for reconstructive surgery within the NHS, we conclude that invasive non-reconstructive cosmetic procedures should only ever be offered to a child in the context of care by a multidisciplinary team. [paragraph 8.45]** This should be in an environment away from commercial pressures, where everyone's input (in particular that of the child) can be heard, and with a clear focus on the welfare of the child. In particular, careful consideration should be given to the question of whether there are good reasons why the procedure could not be delayed until adulthood. It should therefore be impossible for someone under 18 to access cosmetic surgery with the involvement of only a single practitioner, or to walk in off the street and have access to an invasive non-surgical procedure in a clinic or salon.

Recommendation 23: We recommend that the UK departments of health work with the relevant health regulators, Royal Colleges, professional associations, and major provider organisations to ensure that children and young people under the age of 18 are not able to access cosmetic procedures, other than in the context of multidisciplinary healthcare.

Practitioner / user relationships

77. An essential element in empowering users to make choices that are right for them is access to high quality information. The active marketing of invasive cosmetic procedures by the commercial sector can lead to procedures being seen as trivial, or potential risks downplayed. The information that prospective users obtain *before* they first have a consultation with a practitioner is highly influential in determining attitudes to procedures, and we welcome initiatives by the RCS, the British Association of Aesthetic Plastic Surgeons (BAAPS), and the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) to improve the information available in the public domain for prospective patients / users. However, we suggest that more needs to be done.
78. Given the commercial nature of much of the cosmetic procedures market, we suggest that as part of their corporate social responsibilities, commercial providers should take a lead in providing the funding for an independent programme of work to develop and maintain a hub of information to be made available free to users or prospective users of cosmetic procedures. Building on the existing information available through various sources, such a programme should be taken forward in collaboration with users themselves, alongside those with relevant professional expertise, such as the RCS, the JCCP, BAAPS, and BAPRAS. It should also include consideration of the most effective means of presenting and disseminating information, including through social media.

Recommendation 24: We recommend that the major providers of cosmetic procedures collaborate with both the relevant professional bodies, and users of cosmetic procedures, to fund the independent development, regular updating, and wide dissemination of detailed information for users about both surgical and non-surgical procedures.

79. Such an initiative should also include prompts for the kinds of questions prospective users should feel able to ask provider companies and practitioners. In the box below, we suggest some of the most important questions that users should feel able to ask.

Prompts for questions to ask providers / practitioners

- What qualifications does the practitioner have to perform the procedure?
- What will the procedure involve?
- What pain or discomfort am I likely to feel during or after the procedure? How long is any pain or discomfort likely to last?
- How long will the effects of the procedure last? Will it need to be repeated?
- What are the consequences of the procedure? (for example, will there be any scars or lack of sensation? What is the impact of breast implants on breastfeeding?)
- What is the range of possible aesthetic outcomes from this procedure, assuming it goes well? What is a realistic expectation?
- What are the worst- and best-case scenarios?
- What risks are associated with the treatment? How serious are they, and how often do they arise?
- How good is the evidence that this practice is a) safe; b) effective in achieving the desired appearance; c) effective in achieving any other desired aims such as providing psychological or social benefits?
- What will it all cost? Will there be repeated costs? (is this a procedure I need to have every few months?)
- At what point can I change my mind, without having to pay anyway?
- How will you manage any complications? Who will pay?
- What will happen if I don't like the outcome?
- What records will you keep? Will I get a copy?
- If there's a problem, how will you deal with a complaint? Will the company handle it, or will you pass it on to the doctor / practitioner to deal with?

80. Provider organisations also have further responsibilities including the way that they communicate with potential users at the initial point of contact; their consent policies, and how these intersect with binding financial commitments; and commitments to multidisciplinary working.

Recommendation 25: We recommend that the major providers of cosmetic procedures jointly develop a code of best practice to which they, and all practitioners working in their name, should adhere. Such a code should include:

- **Recognition of the importance of clear distinctions between sales staff and practitioners, with 'consultations' and 'advice' only offered by appropriately qualified staff.**
- **Commitment to shared decision-making and a two-part consent process, with no financial commitments asked of users before the end of this process.**
- **Recognition of the limits of one's experience as a practitioner, and commitment to multidisciplinary practice.**
- **Commitment to obtaining information where necessary from the user's GP, as a default position.**

81. Difficult situations arise for practitioners when they are doubtful about the likelihood of the procedure achieving the benefits for which the user hopes. This is a particular challenge for practitioners working within commercial and competitive healthcare settings. More research is needed to enable practitioners to have access to better evidence on the factors

underpinning both positive and negative outcomes of cosmetic procedures, and effective tools to help them identify and support prospective users at risk of poor outcomes. Access to training is also essential.

Recommendation 26: We recommend that the UK Research Councils and other major research funders should actively encourage high quality interdisciplinary research proposals that aim to fill the significant gaps in the evidence base identified in this report with respect to the provision and use of cosmetic procedures. Such research is essential in order to promote more ethical practice in the sector. In addition to the recommendations already made with respect to much improved data collection, we highlight the need for research:

- to improve understanding of the factors associated with poor outcomes after cosmetic procedures, and the development of practical tools to help practitioners identify and support prospective users who are more likely to have such outcomes; and
- to improve the evidence base with respect to the long-term physical and psychological outcomes, both positive and negative, of different cosmetic procedures.

Redress

82. When things go wrong from the point of view of the patient / user, it is clearly important that providers have systems in place to respond appropriately, whether the complaint arises as a result of poor practice, of adverse consequences unconnected with poor practice, or because the outcome did not meet expectations. **We agree with the Keogh report that patients / users of cosmetic procedures would best be protected by extending the role of the Parliamentary and Health Service Ombudsman. [paragraph 8.57]** In the absence of such legislative action, we believe that as a minimum all providers of cosmetic procedures should be required to sign up to an independent arbitration service.

Recommendation 27: We recommend that the Care Quality Commission should require all providers within its remit to guarantee access to an independent arbitration service, in cases where complaints cannot be resolved to patients' / users' satisfaction at provider level.

Introduction

The growing use of invasive cosmetic procedures in the UK, and the absence of a coherent regulatory framework governing their use, received high levels of public attention in 2013 with the publication of the ‘Keogh report’, itself the latest in a series of critical reviews of the cosmetic procedures industry over the previous decade.¹ The 2013 report, commissioned by the English Department of Health from its Medical Director, Sir Bruce Keogh, described aspects of the cosmetic procedures industry as “a crisis waiting to happen”,² and made wide-ranging recommendations to improve the safety of those using both surgical and non-surgical invasive cosmetic procedures.

While some of these recommendations have been followed through, a number of the most significant have not, and many of the safety concerns identified by the Keogh report remain as acute as ever. In particular, controls on the safety of some of the products used in procedures remain completely inadequate, requirements for practitioners to have the qualifications and experience needed for safe practice remain voluntary, and it is still too difficult for members of the public to identify appropriately qualified practitioners.

Moreover, the Keogh report explicitly chose “not [to make] judgements about whether the growth in cosmetic interventions is good or bad” but rather to focus on making what was already happening safer.³ This approach contrasted with that taken in Scotland where, in a review of the implications for Scotland of the Keogh report, the Scottish Cosmetic Interventions Expert Group (SCIEG) included recommendations to support positive body image in the light of concerns that “a false image of what is normal, age appropriate or can be altered permanently” might be growing.⁴

The Nuffield Council on Bioethics considers that the increasing use of cosmetic procedures deserves more detailed ethical consideration, both in the light of ongoing failure by successive governments to regulate to improve safety, and because none of these reviews has explored the potentially troubling factors that underlie this growth in interest in invasive procedures, undertaken for appearance-related reasons and provided in a highly commercial environment. Ethical issues associated with the provision and uptake of cosmetic procedures potentially arise for a wide range of social actors: for practitioners, users, and potential users of these procedures; for those responsible for manufacturing products and developing new procedures; for those marketing, promoting and facilitating access to them; for the media, both mainstream and social; and indeed for society more broadly. They deserve proper scrutiny.

The Council therefore established an expert Working Party in 2015 to explore these issues. The main focus of concern for the Working Party, in accordance with the Council’s own Terms of Reference, has been on the ethical implications of scientific and biomedical advances in this field, and on procedures provided in a clinical environment or in one (‘quasi-clinical’) where the high standards, professionalism, and trust-based relationships associated with clinical care are implied or assumed. However, these procedures do not exist in a vacuum, and it is essential

¹ The ‘Keogh report’ was commissioned by the Department of Health to review the regulation of cosmetic procedures (both surgical and non-surgical) in the light of multiple concerns about the cosmetic sector exposed as a result of the PIP implant scandal: 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>. Sir Bruce Keogh is also the author of earlier reports, notably with respect to the medical implications of PIP implants.

² *ibid.*, at paragraph 1.16.

³ *ibid.*, at paragraph 1.19.

⁴ Scottish Cosmetic Interventions Expert Group (2015) *Scottish Cosmetic Interventions Expert Group: report*, available at: <http://www.gov.scot/Resource/0048/00481503.pdf>, at page 39.

for their provision to be seen in a broader social and cultural context, such as the scope for industry-led pressures on targeted groups to conform and aspire to particular beauty ideals. The provision of cosmetic procedures straddles a number of different domains: for example of medicine / clinical care (associated with regulated environments and trust-based relationships between professionals and patients), of business and consumerism, and of visual culture and social media. In order to explore the ethical significance of the growing use of such procedures, it was critical for the Working Party to be alert to each of these domains, and to the complex ways in which they interact. Further, in considering the specific issues raised by cosmetic procedures, the Working Party felt it important to consider the extent to which these procedures lie within a continuum of the many other ways in which people manage and change the appearance they present to others, whether through clothes, make-up, or more permanent means of changing the body. While some of the ethical concerns identified are specific to invasive procedures provided in a clinical environment, others may be more broadly applicable.

In what follows, we explore and develop these issues, drawing on the empirical evidence available to us to inform our ethical analysis, in order to make practical policy recommendations that we believe will foster more ethical practice in the domain of cosmetic procedures:

- **Chapter 1** presents the context in which the demand for invasive cosmetic procedures is situated: the universal nature of interest in bodily appearance and in the presentation of the physical body; sociocultural expectations about appearance, and the potential for these to become pressures to achieve appearance ideals; the rising concerns about anxiety provoked by an increasing preoccupation with bodily appearance ('appearance anxiety'); and widely promoted beliefs correlating beauty with happiness and success.
- **Chapter 2** identifies the broad ethical concerns that underpinned the Council's decision to establish this project, and that were reinforced from early on in our investigations. These include the potential for significant harm to public health caused by social pressures to conform to unattainable, and sometimes discriminatory, appearance ideals; the particular susceptibility of children and young people to such pressures; and the role of the cosmetic procedures industry in both exploiting and generating appearance insecurities in order to offer medicalised 'solutions'. We felt it important to set out these concerns at the outset, while returning later in the report (see Chapter 7 below) to offer our own ethical analysis, based on the empirical evidence obtained throughout our inquiry.
- **Chapter 3** outlines the business and commercial elements of the cosmetic procedures industry including: an overview of the growth in procedures and the market value of the industry; industry drivers, including both innovation and development, and the marketing of repurposed products and procedures; the diverse business models, from individual self-employed practitioners to very large companies; and the complex network of stakeholders involved, including financiers, insurers, advertisers, and agents.
- **Chapter 4** summarises the way in which cosmetic procedures, practitioners, and products are currently regulated and licensed within the UK and the changes that have taken place as a result of the 2013 Keogh report. The chapter highlights where regulatory concerns still remain; and provides a brief overview of the controls on how these procedures are advertised and promoted.
- **Chapter 5** brings together the available empirical evidence on what influences the decision to have a cosmetic procedure, including what people hope to achieve when they have a cosmetic procedure; and what influences and role models encourage them to use cosmetic procedures rather than other means to achieve these ends.

- **Chapter 6** looks at what is known with respect to the outcomes of cosmetic procedures, highlighting the significant limitations of the evidence available. It provides an overview of the empirical evidence on people's satisfaction after they have had a cosmetic procedure, and a summary of the evidence with respect to harms that may ensue as a result of invasive cosmetic procedures.
- **Chapter 7** then sets out the Working Party's own ethical stance, rooting our analysis in the empirical evidence at our disposal. It challenges the discriminatory nature of the assumptions and ideals that appear to lie behind growing pressures to consider undergoing invasive procedures to change the body and demonstrates the need for responsive action at both state and industry-level. It then considers what is required, in the light of social pressures that limit rather than extend choice, to promote a more ethical basis for the encounter between practitioner / provider, and user.
- **Chapter 8** turns these ethical considerations into practical policy recommendations.

Finally, a note on **terminology**. We use the term 'practitioner' to refer to the individuals directly providing cosmetic procedures (whether they are a health professional or other practitioner, such as beauty therapist); and the term 'provider' to refer to the companies (commercial or not-for-profit) who are responsible for the clinics or hospitals where these services are offered. We have used the term 'user' to refer to those undertaking cosmetic procedures, unless explicitly referring to surgery, where 'patient' seems more appropriate. The dilemma about which terms to use (including patient, client, consumer, user, or customer) itself shows the complexity of this field which embraces both surgical and non-surgical procedures, all of which are elective, and which are delivered primarily by the commercial sector, in clinical or quasi-clinical settings. We discuss the challenges arising out of these blurred boundaries further in Chapters 1 and 7 (see paragraphs 1.20–1.23, and 7.2–7.9).

Chapter 1

The context: appearance
and appearance ideals

Chapter 1 – The context: appearance and appearance ideals

Chapter 1: overview

Interest in bodily appearance is a universal social phenomenon and is not in itself a source of anxiety. However, concerns are growing about the degree of distress resulting from the perceived gap between personal appearance and prevailing and dominant appearance ideals; and about the potentially discriminatory nature of some of those ideals themselves.

Rising levels of ‘body dissatisfaction’ are associated with factors including:

- the huge growth in the use of social media
- increased use of the rating of images of the self and the body, for example through social media ‘likes’, and through self-monitoring apps and games
- the popularity of celebrity culture, ‘airbrushed’ images, and makeover shows
- economic and social trends such as people retiring later, while having to compete in cultures that value youth and youthful appearance.

Advertising and marketing widely reinforce the belief that beauty is correlated with happiness and success. Women in particular are surrounded by the message that they have a duty to ‘make the best’ of themselves.

These developments arise in tandem with scientific advances that increasingly allow for parts of the body to be substituted and modified, and a dramatic growth in the commercially-driven cosmetic procedures industry.

Appearance ideals and cosmetic procedures: the social context

- 1.1 Cosmetic procedures, in the form of both cosmetic surgery and invasive non-surgical procedures such as the use of injectable products or lasers to change the appearance of the skin, constitute one of the many ways in which people can change and manage the appearance they present to others.
- 1.2 While widespread access to cosmetic procedures is a relatively modern phenomenon,⁵ a degree of interest in bodily appearance itself is universal. Throughout the ages and across the world, people have modified their bodies and shaped the image they present to others through their clothing, make-up, and hairstyles, as well as through more permanent techniques such as tattoos, piercings, and surgery. This modification of the body and presentation of the physical self is an intrinsic element of life as a social being: it makes identities visible, marks boundaries between different groups and classes of people, and expresses personal senses of dignity and pride.⁶
- 1.3 What is regarded as ‘ideal’ appearance is socially and historically shaped, and hence dynamic and evolving; moreover, contemporaneous ideals can be multiple and

⁵ For a detailed history of cosmetic surgery and its “startling growth” since the 1980s, see: Gilman S (2000) *Making the body beautiful: a cultural history of aesthetic surgery* (Princeton and Oxford: Princeton University Press), at page 3.

⁶ See, for example, the discussion of dignity and self-image in the context of care for older people. See particularly: Öhlander M (2009) Dignity and dementia: an analysis of dignity of identity and dignity work in a small residential home, in *Dignity in care for older people*, Nordenfelt L (Editor) (Chichester: Wiley-Blackwell), at chapter 4.

competing (see Box 1.1). Such ideals influence both what is regarded as ‘beautiful’ (what is admirable or exquisite), and also what is perceived as ‘normal’ (being able to ‘pass’ without comment⁷). Thus the appearance ideals that are dominant in a particular culture or subculture, at a particular time, exert influence not only on those who wish to stand out and be admired for their appearance, but also on those who wish simply to fit in.

Box 1.1: Examples of appearance ideals and their social context

Changing fashions in female body shape

Over the past century, the desirable female shape in the west has included both the androgynous flapper fashions of the 1920s and the 1950s Marilyn Monroe ‘sweater girl’.⁸ There are now contrasting and competing ideals between those of the fashion world (thin and angular with very small breasts), and the world of celebrity (an accentuated thin waist with large breasts, and also a large bottom).⁹ The increasing value placed on larger bottoms and also larger lips in this one contemporary ideal also illustrates how features that at one time were denigrated as belonging to the black body have become desirable, with white women having buttock augmentations and lip fillers to achieve the desired look.¹⁰

Youthful appearance and the media

A focus on youthful appearance dominates magazine publications:¹¹ looking old can be the subject of “society’s revulsion”,¹² or simply render older adults less visible.¹³ Ageing female celebrities are vilified in some media quarters,¹⁴ and both male and female actors over the age of 60 are underrepresented in parts of the Hollywood film industry.¹⁵

Desirable bodies in the male gay community

A number of contrasting appearance ideals are present in the male gay community: for example, one ideal is the ‘bear’ – a gay man who is typically large and hirsute;¹⁶ while

⁷ As Gilman illustrates, the social importance of being able to ‘pass’ was an important influence in the development of procedures to mitigate the effects of disfigurement: Gilman S (2000) *Making the body beautiful: a cultural history of aesthetic surgery* (Princeton and Oxford: Princeton University Press), pp21-6.

⁸ See, for example, Grogan S (2017) *Body image: understanding body dissatisfaction in men, women and children*, Third Edition (Abingdon: Routledge), pp18-23.

⁹ See, for example, Ahern AL, Bennett KM, Kelly M, and Hetherington MM (2010) A qualitative exploration of young women’s attitudes towards the thin ideal *Journal of Health Psychology* **16**(1): 70-9, at page 73, where one participant observes: “I think Jennifer Lopez and Beyoncé [Knowles] have developed a craze for curves... I wouldn’t say these supermodels [gestures to images of Kate Moss and Jodie Kidd] are the ideal image”. See also: McDonald M (1995) *Representing women: myths of femininity in the popular media* (London; New York: E. Arnold).

¹⁰ See, for example, The Guardian (23 September 2014) *Why does a black butt only look good in white skin?*, available at: <https://www.theguardian.com/commentisfree/2014/sep/23/why-black-bum-only-good-white-skin-cultural-appropriation>.

¹¹ See, for example, Hurd Clarke L, Bennett EV, and Liu C (2014) Aging and masculinity: portrayals in men’s magazines *Journal of Aging Studies* **31**: 26-33. See also: Brooks A (2017) *The ways women age: using and refusing cosmetic intervention* (New York: New York University Press), at page 130, which notes “relentless youthful images in the media”, including in magazines and on television.

¹² The Old Women’s Project (2006) “*We need a theoretical base*”: *Cynthia Rich, women’s studies, and ageism*, available at: http://www.oldwomensproject.org/nwsa_journal.htm, cited in Brooks A (2017) *The ways women age: using and refusing cosmetic intervention* (New York: New York University Press), at page 94.

¹³ See, for example, Brooks A (2017) *The ways women age: using and refusing cosmetic intervention* (New York: New York University Press), at page 215, which notes the observation of actor Diane Keaton that “As you get older, you’re looked at less.”

¹⁴ See, for example, Fairclough K (2012) Nothing less than perfect: female celebrity, ageing and hyper-scrutiny in the gossip industry *Celebrity Studies* **3**(1): 90-103.

¹⁵ Lauzen MM, and Dozier DM (2005) Maintaining the double standard: portrayals of age and gender in popular films *Sex Roles* **52**(7): 437-46.

¹⁶ See, for example, Hennen P (2005) Bear bodies, bear masculinity *Gender & Society* **19**(1): 25-43; and Moskowitz DA, Turrubiates J, Lozano H, and Hajek C (2013) Physical, behavioral, and psychological traits of gay men identifying as bears *Archives of Sexual Behavior* **42**(5): 775-84.

another, in contrast, is the ‘twink’ – a gay man who is typically young, thin, and hairless.¹⁷

- 1.4 This report focuses primarily on the UK, but it is important to recognise that cosmetic procedures and appearance ideals are global phenomena, and there is a significant interchange of ideas, practices, and ideals within and between countries that influences fashion trends internationally.¹⁸
- 1.5 Similarly, ideals and attitudes to the use of cosmetic procedures to achieve a desired look (for example the preference for achieving visible as opposed to discreet ‘natural’ bodily change) differ across and within countries, and are shaped by social structures including those of gender, class, sexuality, and status.¹⁹ The role played by politics and economics in influencing what people do with their bodies, and how appearance ideals emerge and evolve, should not be overlooked (see paragraph 1.12).

Anxiety about appearance: extent, impact and causes

- 1.6 While interest in physical appearance is a universal phenomenon with a very long history, there are increasing concerns in the early twenty-first century with respect to the degree of preoccupation and distress experienced as a result of the perceived gap between personal appearance and prevailing appearance ideals (described variously as ‘body image dissatisfaction’, ‘body image anxiety’, ‘appearance dissatisfaction’ or ‘appearance anxiety’: see Box 1.2 below). There is a growing body of research evidence on current levels of body image anxiety, how such anxiety manifests in people’s behaviour, and how this may change as a person ages.
- 1.7 It has been reported that a significant minority of the general UK population is dissatisfied with their appearance.²⁰ Adolescence has been highlighted especially as a point at which levels of positive body image may decline rapidly.²¹ Unhappiness or dissatisfaction with appearance are more likely to be identified in girls than boys, although the evidence is complex and changing.²² One longitudinal study, for example, found that body

¹⁷ Cash TF, and Smolak L (Editors) (2011) *Body image: a handbook of science, practice, and prevention*, Second Edition (New York: The Guilford Press), at page 216.

¹⁸ While the US, for example, is recognised as a global reference point for celebrity, fashion and beauty ideals through its film and media exports, other countries are regionally influential: for example, South Korea (in East and South East Asia), Brazil (in Latin America) and Lebanon (in the Middle East). Bollywood is as influential as Hollywood in many parts of the world, while ‘Persian beauty’ ideals are aspirational for many young British Asian women.

¹⁹ See, for example, Holliday R, Bell D, Jones M, Probyn E, and Sanchez Taylor, J (2014) *Sun, sea, sand and silicone: mapping cosmetic surgery tourism - final report*, available at: <http://1n1xkd2j1u702vcxsr1pe3h6.wpengine.netdna-cdn.com/files/2012/11/Sun-Sea-Final-Report.pdf>.

²⁰ Government Equalities Office (2014) *Body confidence: findings from the British social attitudes survey*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363188/Body_Confidence_Findings_October_2014.docx, at page 4.

²¹ Department of Children and Youth Affairs (2012) *How we see it: report of a survey on young people’s body image*, available at: <http://www.dcy.gov.ie/documents/chilyouthparticipation/BodyImage/DCYABodyImageReport.pdf>, at page 33. An upward linear increase in body dissatisfaction among a cohort of young people (both male and female) assessed at middle school, high school, and young adulthood has also been observed in a US context: Bucchianeri MM, Arikian AJ, Hannan PJ, Eisenberg ME, and Neumark-Sztainer D (2013) Body dissatisfaction from adolescence to young adulthood: findings from a 10-year longitudinal study *Body Image* **10(1)**: 1-7. McDool E, Powell P, Roberts J, and Taylor K (2016) Social media use and children’s wellbeing *IZA Institute of Labor Economics* **1041**, at page 13, found that less than 20% of survey respondents aged between ten and 15 stated that they were “completely happy” with their appearance. Survey responses were drawn from the UK Household Longitudinal Study and its youth self-completion questionnaire.

²² See, for example, The Children’s Society (2016) *The good childhood report*, available at: http://www.childrensociety.org.uk/sites/default/files/pcr090_mainreport_web.pdf, at page 15; and Children’s Worlds (2016) *Children’s views on their lives and well-being in 17 countries: key messages from each country*, available at: http://www.isciweb.org/_Uploads/dbsAttachedFiles/KeyMessagesfromeachcountry_final.pdf, at page 17. See also: Internet Matters (2017) *1 in 5 parents admit their child has received cruel comments online*, available at: <https://www.internetmatters.org/hub/guidance/1-in-5-parents-admit-their-child-has-received-cruel-comments-online/>, as

dissatisfaction increased for adolescent (13-16 year old) girls over a two-year period, while that of their male counterparts decreased,²³ although another found increasing dissatisfaction also among young men.²⁴ While many of the reported surveys focus on adolescents, research with very young children has illustrated how concerns about physical appearance are found in children as young as five.²⁵

- 1.8 As girls move through adolescence into adulthood, body satisfaction may improve slightly,²⁶ and then stabilise;²⁷ one UK-based study, for example, found that women aged between 16 and 63 had broadly similar concerns about their bodies, primarily related to questions of weight (concerns about stomach, hips, and thighs).²⁸ At particular time-points, concerns may increase: the post-natal period, for example, has been identified as a particular source of anxiety for women, with many feeling under pressure to regain their pre-pregnancy body as soon as possible after the birth of their child.²⁹

Box 1.2: Body image terminology³⁰

A straightforward and widely used definition of body image is “a person’s perceptions, thoughts, and feelings about his or her body.”³¹

Body image is influenced by sociocultural and individual psychological factors, and is widely acknowledged to be multidimensional. As a result, there are many different definitions and ways of measuring or assessing it. However, there is broad agreement that the construct involves perceptions of the self (the ‘inside view’), alongside one or more of the following components:

- affective: the feelings and emotions associated with self-perceptions of appearance;

reported exclusively by Mirror (20 May 2017) *One gender is more likely to be taunted and bullied on social media than the other*, available at: <http://www.mirror.co.uk/tech/one-gender-more-likely-taunted-10461938>. This survey of 2,000 parents found that 17.4% reported that their sons had been bullied online over body image, compared with 15.7% who said their daughters had been similarly bullied.

- ²³ Bearman SK, Presnell K, Martinez E, and Stice E (2006) The skinny on body dissatisfaction: a longitudinal study of adolescent girls and boys *Journal of Youth and Adolescence* **35**(2): 217-29.
- ²⁴ Eisenberg ME, Neumark-Sztainer D, and Paxton SJ (2006) Five-year change in body satisfaction among adolescents *Journal of Psychosomatic Research* **61**(4): 521-7. This large scale US study (1,130 adolescent males, 1,386 adolescent females) notes, at page 525, that “on average, body satisfaction decreases as youths move through two phases of adolescence, with the notable exception of older females, whose body satisfaction improved slightly. In general, larger decreases in satisfaction were seen in younger adolescents, certain racial / ethnic groups of males, and among those whose BMI increased over the 5-year period.”
- ²⁵ PACEY (2016) *Body confidence*, available at: <https://www.pacey.org.uk/bodyconfidence/>. See also: Lowes J, and Tiggemann M (2003) Body dissatisfaction, dieting awareness and the impact of parental influence in young children *British Journal of Health Psychology* **8**(2): 135-47; Dohnt HK, and Tiggemann M (2005) Peer influences on body dissatisfaction and dieting awareness in young girls *British Journal of Developmental Psychology* **23**(1): 103-16; Dohnt H, and Tiggemann M (2006) The contribution of peer and media influences to the development of body satisfaction and self-esteem in young girls: a prospective study *Developmental Psychology* **42**(5): 929-36; and Spiel EC, Paxton SJ, and Yager Z (2012) Weight attitudes in 3- to 5-year-old children: age differences and cross-sectional predictors *Body Image* **9**(4): 524-7.
- ²⁶ Eisenberg ME, Neumark-Sztainer D, and Paxton SJ (2006) Five-year change in body satisfaction among adolescents *Journal of Psychosomatic Research* **61**(4): 521-7.
- ²⁷ Öberg P, and Tornstam L (1999) Body images among men and women of different ages *Ageing and Society* **19**(5): 629-44; and Holsen I, Jones DC, and Birkeland MS (2012) Body image satisfaction among Norwegian adolescents and young adults: a longitudinal study of the influence of interpersonal relationships and BMI *Body Image* **9**(2): 201-8.
- ²⁸ Grogan S (2017) *Body image: understanding body dissatisfaction in men, women and children*, Third Edition (Abingdon: Routledge), at page 147.
- ²⁹ *ibid.*, at page 147; and Hodgkinson EL, Smith DM, and Wittkowski A (2014) Women’s experiences of their pregnancy and postpartum body image: a systematic review and meta-synthesis *BMC Pregnancy and Childbirth* **14**(1): 330.
- ³⁰ Krawczyk R, Menzel J, and Thompson JK (2012) Methodological issues in the study of body image and appearance, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 43.
- ³¹ Grogan S (2017) *Body image: understanding body dissatisfaction in men, women and children*, Third Edition (Abingdon: Routledge), at page 4.

- cognitive: thoughts and beliefs associated with self-perceptions of appearance – for example conclusions made on the basis of self-evaluations of attractiveness, and beliefs resulting from cultural messages of beauty; and
- behaviours: the outward signs of the way a person feels and thinks about their physical appearance.

Body image can refer to a judgment of overall appearance, or it can be site-specific: for example a person may like their eyes, but not their legs. It relates predominantly to appearance but may also include elements of function.

Appearance (dis)satisfaction or **body (dis)satisfaction** exists on a continuum: the extent to which a person likes or dislikes their looks. This involves thoughts and may also be associated with feelings or emotions. Appearance (dis)satisfaction may also influence behaviours.

Appearance-related worry and anxiety refer to a combination of emotions and thoughts. These can also be influenced by, and influence, behaviours. For example:

- Dissatisfaction may result in, or be associated with, behaviours such as clothing choices, dieting, and seeking cosmetic procedures.
- Anxiety may result in, or be associated with, behaviours such as avoidance of mirrors (or mirror checking), and avoidance of social situations.

Until recently, the majority of research focused on (dis)satisfaction with weight and shape, and the term ‘body image’ became heavily associated with this. In the last decade, research on other aspects of appearance and also on visible difference (disfigurement) has increased. Researchers in these fields are using ‘appearance’ (dis)satisfaction, worry, and anxiety to denote a broader interest.

- 1.9 The impact of appearance dissatisfaction on young people’s behaviour has been a particular focus of concern. Among girls, the latest in a series of surveys undertaken by the Girlguiding organisation indicates that a growing lack of confidence with respect to their appearance is holding them back from doing many things that they enjoy, such as wearing the clothes they like, having their photograph taken, participating in sport or exercise, speaking up in class, using social media, socialising, or generally having fun with their friends.³² For young women in particular,³³ body image may be among their most pressing concerns,³⁴ and a significant number of young people in their late teens

³² Girlguiding (2016) *Girls’ attitudes survey*, available at: <https://www.girlguiding.org.uk/globalassets/docs-and-resources/research-and-campaigns/girls-attitudes-survey-2016.pdf>. At page 7, this survey notes, for example, that 53% of 11-21-year-old participants agreed with the statement that “people make girls think that how they look is the most important thing about them”.

³³ See, for example, NSPCC (13 July 2016) *Modern pressures leaving girls with crippling fears about how they look*, available at: <https://www.nspcc.org.uk/what-we-do/news-opinion/girls-body-image-concerns/>, which notes that girls are eight-times more likely to contact ChildLine with body image worries than boys. In 2015-6, ChildLine received 1,596 contacts from girls worried about body image, marking a 17% increase on the previous year. See also: Mission Australia (2016) *Youth survey report 2016*, available at: <https://www.missionaustralia.com.au/documents/research/young-people-research/677-mission-australia-youth-survey-report-2016/file>, pp20-1, where, although body image was one of the ‘top three’ personal concerns for young people, extreme concern was significantly higher for adolescent females than males (18% and 6%, respectively).

³⁴ See, for example, Mission Australia (2016) *Youth survey report 2016*, available at: <https://www.missionaustralia.com.au/documents/research/young-people-research/677-mission-australia-youth-survey-report-2016/file>, where body image, coping with stress, and school or study problems were nominated by both male and female survey participants as their ‘top three’ issues of personal concern. See also: Central YMCA (2016) *The challenge of being young in modern Britain*, available at: <http://www.ymca.co.uk/content/pdf/World-of-Good-report-Central-YMCA.pdf>, which concludes that “issues of body image” was one of the five challenges which had most impact on young people at the time at which they survey was carried out; and Children’s Worlds (2016) *Children’s views on their lives and well-being in 17 countries: key messages from each country*, available at: http://www.isciweb.org/_Uploads/dbsAttachedFiles/KeyMessagesfromeachcountry_final.pdf, at page 16 where particularly low rates of satisfaction are observed with bodies and appearance among children in England. See also: BBC News (20 December 2016) *Growing up young*, available at: <http://www.bbc.co.uk/news/resources/1dt-710ceafb-a26b-4a6c-9698->

report that they care more about their appearance than their physical health.³⁵ The public policy response has included a number of high profile 'body image summits' initiated by UK health ministers;³⁶ the establishment of an All Party Parliamentary Group (APPG) on Body Image,³⁷ leading to the Campaign for Body Confidence;³⁸ and, most recently, work to develop evidence-based materials to support young people in dealing with these pressures (see Box 1.3).

Box 1.3: Work on body image in schools

- The Be Real Campaign (which evolved from the All Party Parliamentary Group on Body Image and the Campaign for Body Confidence) launched a national toolkit for schools in January 2017.³⁹ This toolkit provides a range of resources for schools to implement, such as templates for student campaigns and assemblies, and checklists for embedding positive attitudes to body image throughout school policies. It also provides links to evidence-based resources for workshops aimed at both teenagers and young adults, focusing on issues such as unrealistic appearance ideals, the impact of social media and celebrity culture, ways of reducing appearance-focused comparisons, and how to achieve positive behaviour change.
- The Be Real Campaign is campaigning for evidence-based body image intervention materials to be included in the personal, social, health, and economic (PSHE) curriculum, as recommended by the APPG.⁴⁰ The recommendation that PSHE should be compulsory, and should include consideration of body image as one of the issues that young people are concerned about online, was reiterated in March 2017 by the House of Lords Communications Committee.⁴¹

1.10 Differences in appearance satisfaction between men and women also continue into adulthood, with dissatisfaction rates among women in western countries reported to be significantly higher than among men.⁴² Within adult populations, a significant minority of

94800bb739f9 where young women highlight pressures they face to "meet that standard" when 'good' bodies are posted to social media accounts.

³⁵ National Citizen Service (26 April 2017) *Body image - the facts*, available at: <http://www.ncsyes.co.uk/themix/body-image-facts>. The National Citizen Service asked 1,002 16-17-year-olds in England a range of questions relating to body image. One of its findings indicated that 27% of this group cared more about their appearance than their physical health.

³⁶ See, for example, BBC News (10 April 2000) *Government 'summit' over thin models*, available at: http://news.bbc.co.uk/1/hi/uk_politics/708186.stm; and Home Office (24 February 2012) *UN summit to discuss body image in media*, available at: <https://www.gov.uk/government/news/un-summit-to-discuss-body-image-in-media>.

³⁷ Parliament.UK (2015) *Register of all-party groups: body image*, available at: <https://www.publications.parliament.uk/pa/cm/cmllparty/register/body-image.htm>.

³⁸ Campaign for Body Confidence (2013) *About the Campaign for Body Confidence*, available at: <https://campaignforbodyconfidence.wordpress.com/about/>.

³⁹ Be Real (17 January 2017) *Be Real launches body confidence research and schools' toolkit*, available at: <http://www.berealcampaign.co.uk/news-and-events/2017/01/17/be-real-launches-body-confidence-research-and-schools-toolkit/>. See also: PSHE Association (2017) *Key standards in teaching about body image*, available at: <https://www.pshe-association.org.uk/curriculum-and-resources/resources/key-standards-teaching-about-body-image>.

⁴⁰ See: All Party Parliamentary Group on Body Image (2012) *Reflections on body image*, available at: https://issuu.com/bodyimage/docs/reflections_on_body_image?printButtonEnabled=false&backgroundColor=%23222222, at 1.12; and Be Real (2017) *Homepage*, available at: <http://www.berealcampaign.co.uk/>.

⁴¹ House of Lords Select Committee on Communications (2017) *Growing up with the internet*, available at: <https://www.publications.parliament.uk/pa/ld201617/ldselect/ldcomuni/130/130.pdf>, at paragraph 318.

⁴² Government Equalities Office (2014) *Body confidence: findings from the British social attitudes survey*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363188/Body_Confidence_Findings_October_2014.docx. See also: Furnham A, and Greaves N (1994) Gender and locus of control correlates of body image dissatisfaction *European Journal of Personality* 8: 183-200; Feingold A, and Mazzella R (1998) Gender differences in body image are increasing *Psychological Science* 9(3): 190-5; and Stronge S, Greaves LM, Milojev P *et al.* (2015) Facebook is linked to body dissatisfaction: comparing users and non-users *Sex Roles* 73(5): 200-13.

women may worry about their appearance,⁴³ and this has been linked with poor self-esteem and a wider impact on well-being.⁴⁴ However, increases in body satisfaction, and a greater focus on health rather than appearance, have been found in women over 60;⁴⁵ and by the age of 80, women may be more content with their own appearance than men.⁴⁶

1.11 While much of the research in this area provides contemporaneous ‘snapshots’ of appearance concerns at specific time points, several sources suggest that appearance anxiety is growing in the UK and in other countries in the western world, especially among young people. The surveys carried out by the Girlguiding organisation, for example (see paragraph 1.9), have identified a significant decline in how happy girls in the UK feel about the way they look.⁴⁷ A trend from 2002 onwards for girls’ unhappiness with their appearance has been noted by the Children’s Society,⁴⁸ and the NSPCC has highlighted the increasing number of counselling sessions with young people in which issues of body image are raised.⁴⁹ Studies which focus specifically on adults have also suggested that levels of appearance dissatisfaction may be increasing.⁵⁰ This is particularly the case for women,⁵¹ as indicated by one of the few longitudinal studies on body image dissatisfaction rates.⁵²

1.12 Research exploring the causes of these rising levels of anxiety about appearance is still at a relatively early stage. However, links are being made with a number of features of contemporary life, associated for example with technological advances, patterns of work and retirement, and broader social and economic shifts in how the self and responsibility are understood. These features affect diverse parts of the population in different ways (see, for example, Box 1.4 below for an account of young people’s experiences), and include:

- **An exponential growth in the use of social media,**⁵³ which has been associated with greater unhappiness about appearance, particularly among children and young

⁴³ See, for example, a UK survey undertaken with 1,831 women by YouGov (2012) *Women on body image (Sun)*, available at: https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/okvwoomyhk/YG-Archives-Life-Sun-BodyImage-050712.pdf. This survey found that 33% of participants feel negative about their appearance.

⁴⁴ See, for example, Furnham A, and Greaves N (1994) Gender and locus of control correlates of body image dissatisfaction *European Journal of Personality* **8**: 183-200; and Webster J, and Tiggemann M (2003) The relationship between women’s body satisfaction and self-image across the life span: the role of cognitive control *The Journal of Genetic Psychology* **164**(2): 241-52.

⁴⁵ Tiggemann M (2004) Body image across the adult life span: stability and change *Body Image* **1**(1): 29-41.

⁴⁶ Baker L, and Gringart E (2009) Body image and self-esteem in older adulthood *Ageing and Society* **29**(6): 977-95.

⁴⁷ See: Girlguiding (2016) *Girls’ attitudes survey*, available at: <https://www.girlguiding.org.uk/globalassets/docs-and-resources/research-and-campaigns/girls-attitudes-survey-2016.pdf>, at page 5. This survey notes a significant decline in how happy girls aged between seven and 21 feel about their appearance over the past five years: in 2011, 73% of survey respondents were happy with how they looked, which fell to 61% in 2016.

⁴⁸ The Children’s Society (2016) *The good childhood report*, available at: http://www.childrenssociety.org.uk/sites/default/files/pcr090_mainreport_web.pdf, at page 15.

⁴⁹ NSPCC (2015) *Under pressure: ChildLine review - what’s affected children in April 2013 - March 2014*, available at: <https://www.nspcc.org.uk/globalassets/documents/annual-reports/childline-review-under-pressure.pdf>, at page 12.

⁵⁰ For example, the 2016 Dove survey asked participants to indicate whether they “feel worse about themselves when they look at beautiful women in magazines”. In 2004, 19% of UK women answered ‘yes’; this percentage rose to 42% in 2016. See: Edelman Intelligence (2016) *The Dove global beauty and confidence report* (London: Edelman Intelligence), at page 19.

⁵¹ *ibid.* See also: Cash TF, and Henry PE (1995) Women’s body images: the results of a national survey in the USA *Sex Roles* **33**(1): 19-28; See further: discussion pieces in the popular press: The Guardian (14 October 2014) *Why is women’s body image anxiety at such devastating levels?*, available at: <https://www.theguardian.com/lifeandstyle/2014/oct/14/women-body-image-anxiety-improve-body-confidence>.

⁵² Cash TF, Morrow JA, Hrabosky JI, and Perry AA (2004) How has body image changed? A cross-sectional investigation of college women and men from 1983 to 2001 *Journal of Consulting and Clinical Psychology* **72**(6): 1081-9.

⁵³ Slater A, Tiggemann M, and Jarman H (2017) Social media use and body image concerns in young adults (*in preparation*) found that young women aged 18-19 in the UK spend almost three hours a day on social media, while young men spend just over two hours. A recent survey of 1,400 people aged 18-25 across seven countries found that 100% of participants use Facebook, with 80%-90% of women also using Instagram: Slater A, Lunde C, De Vries D *et al.* (2017) Appearance matters online: a cross-cultural study of young men’s and young women’s social networking use, cyberbullying and appearance

people.⁵⁴ The precise nature of that correlation is not yet well understood, but likely causes include the interactive nature of social media use, with the active posting and sharing of photographs, and the corresponding growth in emotive and quantifiable judgments ('likes'⁵⁵) and the rating of appearance by 'friends'.⁵⁶ These judgments contribute to a sense of a competitive environment, based on the evaluation of one's appearance by others; and because they are communicated through mobile phones, they are ever-present, encouraging constant self-checking.⁵⁷ Moreover, the scope for digitally altering and enhancing photographs exacerbates the perceived need always to 'look one's best' and makes it harder to accept realistic images: nearly three-quarters of young people report that they use filters to enhance their photographs, while nearly ten per cent state that they alter their image to look thinner.⁵⁸ At the same time, social media also provides a vehicle for emerging counter-narratives, challenging the dominance of particular appearance ideals, through the use of tweets and images with hashtags such as #effyourbeautystandards, #celebratemysize, and #bodypositive.⁵⁹

- **The growth in 'self-monitoring' apps and games** that similarly encourage the constant measuring and judgment of one's face and body.⁶⁰ The use of apps that monitor how far people walk, how many calories they consume, or how well they sleep has been an everyday feature of life for many people for some time; increasingly, however, apps are being marketed that encourage users to explore how their bodies could be changed and 'improved', in some cases with the additional feature of linking

concerns (*in preparation*). Further, McDool E, Powell P, Roberts J, and Taylor K (2016) Social media use and children's wellbeing *IZA Institute of Labor Economics* **1041** drew on questionnaires submitted by young people between the ages of ten and 15 to the UK Household Longitudinal Study, and notes, at page 9, that 77% of respondents belonged to social networking sites such as Bebo, Facebook, or Myspace.

- ⁵⁴ See, for example, Tiggemann M, and Slater A (2013) NetGirls: the internet, Facebook, and body image concern in adolescent girls *International Journal of Eating Disorders* **46(6)**: 630-3; Tiggemann M, and Slater A (2014) NetTweens: the internet and body image concerns in preteenage girls *The Journal of Early Adolescence* **34(5)**: 606-20; Holland G, and Tiggemann M (2016) A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes *Body Image* **17**: 100-10; and cDool E, Powell P, Roberts J, and Taylor K (2016) Social media use and children's wellbeing *IZA Institute of Labor Economics* **1041**. See also: Department for Education (2016) *Longitudinal study of young people in England cohort 2: health and wellbeing at wave 2 - research report*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/599871/LSYPE2_w2-research_report.pdf, at page 19, which highlights research that suggests negative associations between the use of screen-based media (including smartphones) and happiness.
- ⁵⁵ See, for example, BBC Radio 4 (6 March 2015) *Women of the World and Annie Lennox*, available at: <http://www.bbc.co.uk/programmes/b0543k08>, where young female contributors note that "It's all become a competition for 'likes'"; and "When someone is getting all of these 'likes' on their selfies, and then you post photos and there's nothing there, it makes you feel that other people are doing better than you." See also: Ofcom (2016) *Children's media lives - year 3 findings*, available at: www.ofcom.org.uk/_data/assets/pdf_file/0015/94002/Childrens-Media-Lives-Year-3-report.pdf, at page 42, where one participant notes that "a lot of her friends went 'off-private' in order to get more 'likes' for the posts on Instagram, as this would make them seem more popular."
- ⁵⁶ Holland G, and Tiggemann M (2016) A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes *Body Image* **17**: 100-10, at page 102.
- ⁵⁷ Factfinding meeting on visual culture and cosmetic procedures, 22 June 2016. See also: The Guardian (9 December 2016) *Selfies, Snapchat and sassy ladies: a teen's guide to social media*, available at: <https://www.theguardian.com/lifeandstyle/2016/dec/09/teen-guide-social-media-selfies-snapchat>.
- ⁵⁸ Slater A, Tiggemann M, and Jarman H (2017) Social media use and body image concerns in young adults (*in preparation*). See also: McLean SA, Paxton SJ, Wertheim EH, and Masters J (2015) Photoshopping the selfie: self photo editing and photo investment are associated with body dissatisfaction in adolescent girls *International Journal of Eating Disorders* **48(8)**: 1132-40.
- ⁵⁹ See also: The Washington Post (27 February 2017) *No more diets or self hate: how a nude Facebook photo showed women how to love their bodies*, available at: <https://www.washingtonpost.com/news/inspired-life/wp/2017/02/27/no-more-diets-or-self-hate-how-a-nude-facebook-photo-showed-women-how-to-love-their-bodies/>. For a critique of social media approaches to body positive messages, and some of their limitations, see: Lawrence E (11 March 2016) *(De)constructing body positivity on Twitter: Beauty Demands blogpost*, available at: <http://beautydemands.blogspot.co.uk/2016/03/deconstructing-body-positivity-on.html>.
- ⁶⁰ It has been suggested that self-tracking practices and devices promote "self-knowledge through numbers". See: Lupton D (2016) *The quantified self* (Malden, Massachusetts: Polity Press).

directly to a cosmetic surgeon for a ‘real life consultation’. Some of these apps are presented as games, marketed both to adults and to children as young as nine.⁶¹

- **A growing ‘visual diet’** of celebrity images, makeover shows and airbrushed advertising, resulting in exposure to an ever-increasing quantity of appearance-related messages on television, the internet, and social media. While these images will not necessarily be accepted uncritically, their ubiquity encourages constant comparison not simply with celebrities and supermodels (rather than with friends, colleagues, and classmates, as in the past), but also with manipulated and enhanced images of those celebrities.⁶² The presentation of such images is also often linked with the celebrity lifestyle, fuelling the ‘beauty myth’ that conflates success and happiness with the achievement of a particular look.⁶³
- **Trends in the political economy:** while the age of retirement in the UK is repeatedly being pushed back, the increasing expectation that people will work until their late 60s or beyond coexists with a rhetoric in many contexts that values youth. The common conflation between youthful appearance and being healthy and fit for work (see also paragraph 1.13) creates scope for considerable pressure on people as they age, with respect to many aspects of their appearance. These trends come on top of existing challenges and inequalities within the labour market where facets of appearance related to age, body shape, skin colour, teeth, and hair are already influential.⁶⁴
- **Cultural shifts in how the body is perceived:** there have been striking changes in the ways in which the body and its integrity are understood. Scientific and medical advances, for example, allow for various body parts – organs, tissues, substances – to be substituted,⁶⁵ and the body itself is perceived as more malleable: something that can be modified, enhanced, worked-upon, and improved.⁶⁶
- **Neoliberal notions of the self:** amidst the broader social, political and economic changes that have been identified variously as late-capitalism or neo-liberalism, there have been striking changes in the way in which the individual and individual responsibilities are understood. These have included a growing sense of a moral imperative for individuals to work upon themselves, including upon their physical body

⁶¹ Nuffield Council on Bioethics (26 October 2015) *Blog: smaller nose? Bigger boobs? Flatter stomach? There’s an app for that.*, available at: <http://nuffieldbioethics.org/blog/2015/smaller-nose-bigger-boobs-flatter-stomach-app/>.

⁶² Maltby J, Giles DC, Barber L, and McCutcheon LE (2005) Intense-personal celebrity worship and body image: evidence of a link among female adolescents *British Journal of Health Psychology* **10(1)**: 17-32. See also: Fardouly J, and Vartanian LR (2015) Negative comparisons about one’s appearance mediate the relationship between Facebook usage and body image concerns *Body Image* **12**: 82-8; and Brown Z, and Tiggemann M (2016) Attractive celebrity and peer images on Instagram: effect on women’s mood and body image *Body Image* **19**: 37-43.

⁶³ For a useful overview of the research in this field, see: The Independent (9 June 2015) *Does being beautiful get you further in life?*, available at: <http://www.independent.co.uk/life-style/health-and-families/features/does-being-beautiful-get-you-further-in-life-10305543.html>. See also: Lee S-Y (2009) The power of beauty in reality plastic surgery shows: romance, career, and happiness *Communication, Culture & Critique* **2(4)**: 503-19. See further: Partridge J (2012) Persuading the public: new face values for the 21st century, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at page 474, who argues that “the simplistic link between good looks and happiness needs regular debunking.”

⁶⁴ See, for example, Cavico FJ, Muffler SC, and Mujtaba BG (2012) Appearance discrimination in employment: legal and ethical implications of “lookism” and “lookphobia” *Equality, Diversity and Inclusion: An International Journal* **32(1)**: 83-119; New Republic (31 August 2014) *Hooters hires based on looks. So do many companies. And there’s no law against it.*, available at: <https://newrepublic.com/article/118683/why-we-need-law-protect-against-appearance-discrimination>; and Sierminska E (2015) Does it pay to be beautiful? *IZA World of Labor* **161**.

⁶⁵ See, for example, Dickenson D (2009) *Body shopping: converting body parts to profit* (Oxford: Oneworld Publications); and Nuffield Council on Bioethics (2011) *Human bodies: donation for medicine and research*, available at: <http://nuffieldbioethics.org/project/donation/>.

⁶⁶ See, for example, Bordo S (2003) *Unbearable weight: feminism, western culture, and the body* (London: University of California Press).

(‘body projects’ or ‘body work’⁶⁷). Commentators have identified the emergence of the ‘enterprising self’ who needs to be, and is exhorted to be, responsible not only for improving themselves (adding ‘value’ to their body⁶⁸) but for continuous self-monitoring and self-evaluation.⁶⁹

- 1.13 Imagery of all kinds, not limited to formal advertising, broadcasts the message that people (women in particular) have a duty to ‘make the best of themselves’ and take whatever steps are required to conform to particular appearance ideals.⁷⁰ Thus the power of such ideals may extend beyond that of fashion, implying that there is even a duty to achieve the desired look.⁷¹ This implied duty is strengthened through the common conflation between concerns about maintaining good health and an increasing emphasis on taking personal responsibility for one’s health (for example by maintaining a healthy weight, eating a balanced diet, and taking appropriate levels of exercise), and concerns about appearance.⁷²

Box 1.4: Young people’s perceptions of appearance pressures

During three deliberative workshops with young people which explored a range of questions associated with body image and the use of cosmetic procedures,⁷³ participants raised a number of points in relation to both their own and their peers’ experiences. Their views are summarised in brief below.

- **The influence of celebrity:** celebrities, and the homogeneous ‘look’ of some celebrities, play a large part in determining what young people ‘should’ look like. The extensive reach / following of particular celebrities such as Kim Kardashian: “it’s individual people who can reach millions of people. You can’t really control that. You can’t really manage that... it’s a few people who have a huge impact on a lot of others.” Celebrities’ choices influence directly the choices of young people: “Kylie Jenner has her massive lips and all the 14-year-old girls everywhere are drawing on giant lips with their lip liner because they can’t go get implants themselves.” However, although some young people may try to copy how celebrities look, others may focus more on emulating members of their direct circle of peers: “maybe you don’t like the shape of your ears compared to your friend’s, so you change your ears”.
- **Society’s expectations:** societal pressures to look a particular way, to obtain “the perfect body” or to have “the sort of optimal body that people want” can pressurise

⁶⁷ See, for example, Gimlin D (2002) *Body work: beauty and self-image in American culture* (London: University of California Press).

⁶⁸ See, for example, Holliday R, Bell D, Jones M, Probyn E, and Sanchez Taylor, J (2014) *Sun, sea, sand and silicone: mapping cosmetic surgery tourism - final report*, available at: <http://1n1xkd2j1u702vcxsr1pe3h6.wpengine.netdna-cdn.com/files/2012/11/Sun-Sea-Final-Report.pdf> which notes, at 6.3(2), that some cosmetic surgeries convey status and value.

⁶⁹ See, for example, Strathern M (1992) *Reproducing the future: anthropology, kinship and the new reproductive technologies* (Manchester: Manchester University Press), at chapter 2; and Elias A, and Gill R (2016) Beauty surveillance: the digital self-monitoring cultures of neoliberalism *European Journal of Cultural Studies*: [In press].

⁷⁰ See, for example, Mail Online (1 February 2007) *Don’t let yourself go just because you’re the wrong side of 30*, available at: <http://www.dailymail.co.uk/femail/article-432647/Dont-let-just-youre-wrong-30.html>; and YouTube (2016) *Stay beautiful: ugly truth in beauty magazines*, available at: <https://www.youtube.com/watch?v=zIIKTNPP5Ts>. See also: Brooks A (2017) *The ways women age: using and refusing cosmetic intervention* (New York: New York University Press), at page 154, on the expectation that women “ought to do whatever they can with what they have”, including having anti-ageing procedures.

⁷¹ Widdows H (forthcoming) *Perfect me!* (Princeton: Princeton University Press).

⁷² See, for example, the advertisement on “Introducing our “Wow, you look really well” treatments”: R Capital (16 February 2017) *The Harley Medical Group launch London Underground ad campaign*, available at: <https://rcapital.co.uk/harley-medical-group-launch-london-underground-ad-campaign/>.

⁷³ Deliberative workshops were held with self-selecting students from a range of schools across the Edinburgh area as part of the International Association of Bioethics Congress (17 June 2016), members of the Aberdeen Young Persons’ Group (18 June 2016), and members of the Nottingham Young Persons’ Advisory Group (13 August 2016). All participants were between the ages of ten and 20. For further details, see Appendix 1.

people to get cosmetic surgery. Assessments of appearance might be influenced by social opinion, and “what you’re told about how you should look.” These expectations exist because in society there is a large emphasis on image to the extent that how you look “influences people’s opinions of you”.

- **General media:** the presentation of appearance in the media (for example magazines and reality TV) is a source of appearance expectation which gives strong points of reference for what people ‘should’ look like: “magazines post photos of celebrities on the beach in their bikinis... it’s things like that which influence.” However, the media also comments strongly, including criticising explicitly, what people should *not* look like. It may not be the case, however, that these expectations originate from general media; rather traditional media responds to trends set by *social* media.
- **Social media:** images posted on social media, including Instagram, Facebook, and Snapchat, contain large amounts of appearance-related content: “a lot of the time you’re going to see someone like the Kardashian family – they’re famous for plastic surgery. I think they’re so successful because of the idea that they’re the model image”. Participating in posting images to social media requires time, and hours are spent modifying photos before posting to Instagram (“you don’t want to put a bad photo on Instagram”). The influence of social media on appearance is significant; perhaps the most influential of all sources which focus on appearance. This is also the case between ‘friends’, rather than through following celebrities: “you post a picture on Facebook, and someone comments and says, ‘oh your nose is so ugly or so big’.”
- **Changing fashions:** changing fashions mean that new clothes need to be purchased frequently: “you can [but don’t] wear the clothes you wore last year, that fit you perfectly well, look perfectly good, but are in the wrong colour.” Fashions can also affect whether, for example, tanned or pale skin is sought by young people: “people’s idea of what’s perfect changes so much”. However, for trends such as full lips, “the procedure is permanent, the trend is not.”
- **Images in childhood:** the role of how toys are presented, particularly “Barbie dolls that are completely unnatural and boys’ action figures which are over-muscular... set the ideals really early on, and then it’s enforced by celebrities and it makes it so much about [that] this is what people should look like, even though they *can’t* look like that.” Similarly, Disney characters’ bodies may be seen by younger children as the “supposedly perfect ideal”.
- **Responding to peer comments:** young people may be influenced directly by comments from members of their peer groups: “a friend didn’t think she had small lips, but then one person one day told her that she had small, flat lips... now she wants to get a lip filler.” Assessments by others with direct contact with young people have influence over what one ‘should’ look like: “the issue is with other people; their idea of what you should look like, rather than your idea of what you want to look like – they’re two different things.” Bullying may also contribute to these concerns, and “the seriousness of the bullying might affect how much [young people] want cosmetic surgery”.

1.14 The growing body of evidence on how managing one’s appearance is increasingly becoming a matter of anxiety for some people has been accompanied by a similarly dramatic growth in the cosmetic procedures industry. The very limited data available suggests that the use of cosmetic surgery has at least tripled in the UK over the last decade, while non-surgical procedures such as injections of botulinum toxins (botox⁷⁴),

⁷⁴ ‘Botox’ is one trademarked form of botulinum toxin, but the term has become generally used to refer to any form of botulinum toxin used in cosmetic procedures, and is used generically in this report.

dermal fillers, and chemical peels are also growing in popularity and currently represent over 80 per cent of the procedures undertaken (see paragraphs 3.7–3.8).

- 1.15 Virtually all of these procedures are undertaken in the private sector, and hence their provision is subject to the same commercial pressures and marketing practices as any other commercial product or service. While, again, research on the influences directly underpinning this growth in the use of invasive cosmetic procedures is at an early stage, market research for the industry identifies many of the same factors noted above in connection with growing anxiety about appearance, alongside increasing affordability, technological change enabling cheaper and quicker ('lunch hour') procedures, and the coexistence of an ageing population alongside increasing pressures to look young (see paragraph 5.37). The same market research predicts ongoing growth across all sectors of the industry.⁷⁵

Appearance and happiness

- 1.16 Advertisements widely associate the use of cosmetic procedures with happiness or success (see, for example, Box 2.3 and Box 4.8). The explicit or implicit message is that 'better' looks (closer to a prevailing ideal) will increase a person's chances of success, and therefore happiness, in social and romantic relationships and in occupational settings (see also paragraphs 5.5–5.17). The more a person's self-esteem relies on the judgments of their appearance by others, and the more they correlate beauty and success, the more they are likely to heed messages from the media / advertisers, from social media, and from their peers about what they 'should' look like – and the more likely they are to feel dissatisfied and unhappy with their appearance.⁷⁶
- 1.17 There are a number of challenges in examining potential relationships between 'happiness', appearance, and cosmetic procedures, not least owing to the lack of consensus concerning terminology and definitions. Economists, sociologists, psychologists, politicians, and policy-makers use a variety of terms in their work, including 'quality of life', 'well-being', and 'positive adjustment'. There is little consensus about the definitions of any of these constructs, apart from agreement that all of them are multi-factorial – a complex interplay of factors, contexts and processes. The salience of the various factors within this mix depends on each individual's values and belief systems, and their social context.
- 1.18 Despite these challenges, however, the evidence is clear that a person's 'actual' appearance, as judged by others, is *not* predictive of their level of happiness.⁷⁷ Rather,

⁷⁵ Mintel (2014) *Cosmetic surgery - UK*, available at: <http://academic.mintel.com/display/679689/>; and Key Note (2015) *Cosmetic surgery: market update*, available at: https://www.keynote.co.uk/market-update/healthcare-medical-pharmaceuticals/cosmetic-surgery?full_report=true.

⁷⁶ See, for example, Stice E, Spangler D, and Agras WS (2001) Exposure to media-portrayed thin-ideal images adversely affects vulnerable girls: a longitudinal experiment *Journal of Social and Clinical Psychology* **20**(3): 270-88; Fardouly J, Diedrichs PC, Vartanian LR, and Halliwell E (2015) Social comparisons on social media: the impact of Facebook on young women's body image concerns and mood *Body Image* **13**: 38-45; and Fardouly J, and Vartanian LR (2015) Negative comparisons about one's appearance mediate the relationship between Facebook usage and body image concerns *Body Image* **12**: 82-8. See also: Engeln-Maddox R (2006) Buying a beauty standard or dreaming of a new life? Expectations associated with media ideals *Psychology of Women Quarterly* **30**(3): 258-66.

⁷⁷ Feragen KB, Kvaalem IL, Rumsey N, and Borge AIH (2010) Adolescents with and without a facial difference: the role of friendships and social acceptance in perceptions of appearance and emotional resilience *Body Image* **7**(4): 271-9; and Moss T, and Rosser B (2012) Adult psychosocial adjustment to visible differences: physical and psychological predictors of variation, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 21.

research demonstrates a much stronger relationship between happiness and people's *own* judgment about their appearance, which is affected by a number of factors including the extent to which appearance plays a part in their sense of self-worth, the gap they perceive between how they look and certain appearance 'ideals', and levels of sensitivity to messages from their social milieu.⁷⁸ Thus, someone with a severe visible difference or disfigurement can feel happy with their appearance, judging it, for example, to give them a uniqueness and opportunities that others do not have,⁷⁹ while people described by others as beautiful may experience anxiety and insecurity if, as the result of heavy investment in their looks, they view these as their passport to relationships, desirable social groups, or occupational success.⁸⁰ This investment may, for example, lead them to see and scrutinise small imperfections that need 'fixing', or fear the onset of such imperfections in the future, and lead them to consider preventative treatment.

Box 1.5: Psychological theories of happiness: the role of appearance

Psychological theories of happiness do not specifically highlight satisfaction or dissatisfaction with appearance as a contributory factor in happiness, but the increased emphasis on appearance in current society has raised the profile of this possibility in recent years. One influential school of thought in psychology, for example, suggests that approximately 50 per cent of the variance in happiness can be explained by genetics, ten per cent by social circumstances, and 40 per cent by factors under people's own voluntary control, such as their values, beliefs, and how they choose to live their lives.⁸¹ For some, this 40 per cent will include satisfaction or dissatisfaction with their appearance alongside a number of other components.

- 1.19 High levels of concern about the opinions of others, or a preoccupation with the perceived gap between a person's own assessment of their appearance and the ideals portrayed in advertisements, are thus likely to have negative effects on a person's overall level of happiness. In the 2016 *Good childhood report*, unhappiness with appearance and life as a whole are associated with emotional problems such as anxiety and depression in young people aged ten to 15 years' old (with links stronger for girls than boys).⁸² In the 2015 *Good childhood report*, which looked specifically at comparisons between countries, young people in England ranked last out of 15 countries for self-confidence, and in the bottom three countries for happiness with 'your own body' and 'the way that you look'.⁸³

Definitional challenges: parameters of this report

- 1.20 This report is concerned with the provision of 'cosmetic procedures' by third parties in clinical or quasi-clinical surroundings, which constitute one particular means for changing one's appearance in response to the promotion of particular appearance ideals. Such procedures include cosmetic surgery and dentistry, the use of botox and dermal fillers,

⁷⁸ MacLachlan M, Mháille G, Gallagher P, and Desmond D (2012) Embodiment and appearance, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 3.

⁷⁹ As discussed at: Deliberative workshop with Changing Faces, 14 December 2016. See also: Partridge J (1990) *Changing faces: the challenge of facial disfigurement* (London: Penguin).

⁸⁰ See, for example, Vartanian LR (2009) When the body defines the self: self-concept clarity, internalization, and body image *Journal of Social and Clinical Psychology* **28(1)**: 94-126.

⁸¹ Seligman M (2002) *Authentic happiness* (New York: Free Press).

⁸² The Children's Society (2016) *The good childhood report*, available at: http://www.childrenssociety.org.uk/sites/default/files/pcr090_mainreport_web.pdf.

⁸³ The Children's Society (2015) *The good childhood report*, available at: <http://www.childrenssociety.org.uk/sites/default/files/TheGoodChildhoodReport2015.pdf>, at page 53. The research team assessed 'subjective well-being' with measures of ten factors including satisfaction with appearance. Other factors measured included satisfaction with family, health, friends, money, and school.

cosmetic peels, and laser and intense pulsed light (IPL) treatments. However, while it may be straightforward to present a list of interventions that would be widely perceived as ‘cosmetic procedures’ (see Box 1.6 below), it is difficult to produce a clear or stable categorisation of precisely what should be included or excluded within this rubric. This difficulty in categorisation is partly due to the way in which new technologies, techniques and materials are emerging, while others may fall out of favour; but also because of inherent definitional uncertainties.

- 1.21 The distinctions between ‘cosmetic’ and ‘therapeutic’ procedures are themselves fluid and uncertain. In some cases, the same procedure may be undertaken either for therapeutic or for appearance-related purposes, with distinctions therefore drawn in relation to motivation, rather than the nature of the procedure itself (see, for example, paragraph 5.30 on the diverse, and often coexisting, motivations for procedures such as ear-pinning, and breast reduction). There are also a number of mainstream procedures that are undertaken primarily for reasons of appearance, such as breast reconstruction after surgery, or benign mole / blemish removal, but that are nonetheless not generally categorised as ‘cosmetic’.⁸⁴
- 1.22 Similarly, there are no clear dividing lines between cosmetic procedures and what is regarded as ‘routine’ beauty maintenance: laser hair removal or regular nail treatments such as acrylic or gel nails, for example, could be regarded as falling in either, or both, categories.⁸⁵ Some procedures such as fitting braces on teeth in adolescence have become so common that many people would not classify them as ‘cosmetic procedures’, even though they are invasive, provided in a clinical context, and often undertaken solely for appearance rather than functional reasons.⁸⁶ There are also some similarities between cosmetic procedures and other permanent or semi-permanent ways of modifying the body, such as tattoos, scarification, and piercing.
- 1.23 Recognising that it is not possible to draw sharp and consistent distinctions between therapeutic procedures, cosmetic procedures, and beauty practices, for the purposes of this report the umbrella term ‘cosmetic procedures’ will be used for invasive, non-reconstructive procedures that share a number of common features:
- Their purpose is to change a person’s appearance in accordance with perceptions of what is normal or desirable.
 - Their purpose is non-essential with respect to physical function.
 - They are carried out by third parties in a clinical or quasi-clinical environment (while recognising that some of the ethical concerns raised may also arise in the context of procedures or products that people can use without third party involvement).

⁸⁴ Respondents to our various consultative activities, for example, tended to exclude such procedures from the category of ‘cosmetic’ procedures, even where the procedure had no functional aim. In general usage, the term ‘cosmetic’ appears to be applied primarily for a subset of procedures related to appearance, often with questions of motivation in view. We discuss these distinctions, and the basis on which they may be made, further in Chapter 7.

⁸⁵ Nuffield Council on Bioethics (3 May 2016) *Blog: routine vs exceptional cosmetic procedures: a helpful distinction?*, available at: <http://nuffieldbioethics.org/blog/routine-vs-exceptional-cosmetic-procedures-a-helpful-distinction>.

⁸⁶ There are specific criteria that must be met for dental braces to be covered within NHS dentistry: in brief, where there is a sufficient functional need for the teeth to be realigned (e.g., relating to bite). Where the aim is primarily aesthetic, and little or no need with respect to function, treatment is not covered by the NHS. For an overview of orthodontic treatment criteria for under 18s, see: British Orthodontic Society (2014) *What is the IOTN?*, available at: <http://www.bos.org.uk/Public-Patients/Orthodontics-for-Children-Teens/Fact-File-FAQ/What-Is-The-IOTN>. For a brief overview of NHS orthodontic treatment for adults, see: British Orthodontic Society (2014) *Can I have treatment within the NHS as an adult?*, available at: <http://www.bos.org.uk/Public-Patients/Orthodontics-For-Adults/FAQ/Can-I-Have-Treatment-Within-The-NHS-as-an-Adult>.

- They are not ordinarily publicly funded through public health systems such as the UK NHS.

- 1.24 The procedures that were cited most commonly during our project are listed in Box 1.6 below. Inevitably, given the imprecise nature of these distinctions as highlighted above, some of these procedures may at times be offered for functional, rather than cosmetic reasons (in particular, for example, in the case of breast reduction); and indeed people's aims in seeking procedures may combine both functional and cosmetic elements. Moreover, as we explore further later in this report (see Chapter 5), our categorisation of 'cosmetic procedures' draws together a very disparate collection of interventions, undertaken for a wide range of reasons by diverse populations.
- 1.25 Invasive procedures associated with ritual or religious significance, such as FGM (female genital mutilation)⁸⁷ and male circumcision, share characteristics with the cosmetic procedures considered in this report. However, they also raise additional ethical questions that deserve distinct consideration.⁸⁸ They are therefore not included within our umbrella term of 'cosmetic procedures' for the purposes of this report, other than for comparative purposes (see in particular paragraphs 4.49–4.50). We have similarly excluded the procedures associated with gender reassignment, and gender assignment for intersex individuals, on the basis that these interventions raise issues that go beyond questions of appearance, and again these require separate, and fuller, consideration.

⁸⁷ Whilst a full discussion of the very significant issues that arise in the various procedures that fall under the umbrella of FGM is not possible here, it should be noted that the terminology alone is strongly contentious: see, for example, contributors to Hernlund Y, and Shell-Duncan B (2007) *Transcultural bodies: female genital cutting in global context* (New Brunswick, New Jersey: Rutgers University Press); and Boddy J (2007) *Civilizing women: British crusades in colonial Sudan* (Princeton: Princeton University Press).

⁸⁸ The terminology of male circumcision is also contested. From a legal perspective, there is a growing body of literature that is critical of the different ethical and legal responses to male and female forms of non-therapeutic genital cutting, and argues for any such procedures for boys, girls, and intersex individuals to be delayed until they are able to make their own decisions. See, for example, Fox M, and Thomson M (2009) Reconsidering 'best interests': male circumcision and the rights of the child, in *Circumcision and human rights*, Milos M (Editor) (New York: Springer); Earp BD (2016) In defence of genital autonomy for children *Journal of Medical Ethics* **42**(3): 158-63; Earp BD, Hendry J, and Thomson M (2017) Reason and paradox in medical and family law: shaping children's bodies *Medical Law Review*: forthcoming; and Fox M, and Thomson M (2017) Bodily integrity, embodiment, and the regulation of parental choice *Journal of Law & Society*: forthcoming.

Box 1.6: Examples of invasive non-reconstructive cosmetic procedures**Surgical procedures****Breast procedures**

- Breast augmentation (enlargement)
- Breast reduction
- Mastopexy (breast uplift)
- Male breast reduction

Facial procedures

- Blepharoplasty (eyelid surgery)
- Cheek reshaping
- Chin reshaping
- Facelifts
- Otoplasty / pinnaplasty (setting back prominent ears)
- Rhinoplasty ('nose jobs')

Non-surgical procedures

- Dermal fillers (injections to fill-out wrinkles and skin creases, either permanent or impermanent; also used to fill out the lips)
- Laser or IPL hair removal
- Invasive skin-lightening procedures such as IV glutathione
- Hair restoration / transplant

Body procedures

- Abdominoplasty ('tummy tucks')
 - Arm / body / thigh lifts
 - Buttock implants
 - Female genital cosmetic surgeries, including labiaplasty (surgery to reduce the size of the labia minora and / or majora), vaginal tightening, liposuction of the mons pubis, and hoodectomy (removal of the fold of skin around the clitoris)
 - Male genital cosmetic surgeries such as penis enlargement and scrotal sac lifts
 - Lipomodelling (transferring fat from one area of the body to another)
 - Liposuction
-
- Botulinum toxins (generally known as botox)
 - Chemical skin peels
 - Microneedling (puncturing the skin with very small needles to promote a wound-healing response in order to treat skin damage)
 - Cosmetic dental procedures, including teeth whitening

Chapter 2

Emerging ethical
concerns

Chapter 2 – Emerging ethical concerns

Introduction

Chapter 2: overview

Having a cosmetic procedure, like other means of changing or managing appearance, can be experienced by individuals as positive and enabling. However their provision also has the potential for harm at societal level, which can operate alongside unproblematic personal use. A number of significant concerns about such ‘communal harms’ emerged early on in the project, and form the basis for our own ethical analysis in Chapter 7:

- The social and economic factors described in Chapter 1 may combine to exert pressure on people (especially, but not only, on girls and women) to conform to particular expectations with respect to appearance. These standards and ideals are socially, culturally and historically constructed, and socially enforced. Arguments based on ‘choice’ alone are therefore unlikely to be sufficient in enabling us to understand the ethical questions at stake.
- The levels of anxiety arising in the context of pressures to conform to particular appearance ideals, and their impact on mental health, are a matter of public health concern. Moreover, the social expectations and ideals to which we are encouraged to conform and aspire are not necessarily ethically neutral or value free. Many cosmetic interventions both reflect and promote gender, disability and racial norms, and hence may reinforce existing inequalities and discriminatory attitudes, despite countervailing changes in social attitudes towards diversity and inclusion.
- Adolescents may be particularly sensitive to pressures to conform to prevailing peer and social pressures, and are at a vulnerable stage of development with respect to their sense of their own identity. Their access to cosmetic procedures raises particular ethical concerns.
- The cosmetic procedures industry both exploits and generates these appearance insecurities by marketing invasive cosmetic procedures as medicalised ‘solutions’. These are offered in environments that are, or feel, medical – and so which are associated with relationships of trust and concern for patient welfare. These associations raise further ethical concerns with respect to practitioners’ responsibilities towards users / patients.

2.1 During this project, the Working Party heard from many people interested, in some way, in the growth of the cosmetic procedures industry. We heard from people who had had a procedure, would think about doing so, or would never contemplate it; from practitioners, providers, regulators, and insurers; from academics exploring the nature of the increasing pressures in relation to appearance, and the experiences and attitudes of those having procedures; and from those interested in advertising and social media use. Throughout this process, some very clear issues of ethical concern emerged, both echoing and expanding upon concerns set out in the existing ethical and philosophical literature on beauty and beauty practices.⁸⁹ We discuss these in greater detail in Chapter

⁸⁹ See, for example, Bartky SL (1991) *Femininity and domination: studies in the phenomenology of oppression* (New York: Routledge); Morgan KP (1991) Women and the knife: cosmetic surgery and the colonization of women's bodies *Hypatia* 6(3): 25-53; Wolf N (1991) *The beauty myth* (London: Vintage Books); Davis K (1995) *Reshaping the female body: the dilemma of cosmetic surgery* (New York: Routledge); and Bordo S (2003) *Unbearable weight: feminism, western culture, and the body* (London: University of California Press).

7, after presenting and reviewing the evidence that underpins our analysis, but we highlight in this chapter those issues that strike us as particularly crucial to address.

- 2.2 As we suggested in Chapter 1, the use of cosmetic procedures may be seen as part of the wider social practices related to appearance in which many people engage, and from which they derive a sense of dignity and pride. At the same time, we need to acknowledge the wider context: one of an increasingly visual culture, with high levels of use of interactive social media and appearance-related apps, and where social and economic trends may exercise diverse pressures on people (especially, but not only, on girls and women) to conform to particular expectations with respect to appearance. These standards and ideals are socially, culturally, and historically constructed. They are also socially ‘enforced’: there can be both social and economic costs in not conforming to prevailing standards and ideals, and hence it may often be the most rational (and indeed often the most desirable and enjoyable) option to conform to what is expected of ‘people like me’.⁹⁰ This suggests that arguments based on ‘choice’ are unlikely to be sufficient alone in considering the ethical questions at stake.
- 2.3 Moreover, the social expectations and ideals to which we are encouraged to conform and aspire are not themselves necessarily ethically neutral or value free. Appearance ideals interact with other social structures, such as those of gender, race, class, sexuality, and disability; and can perpetuate inequality and hierarchy.⁹¹ Examples of cosmetic procedures that reflect the negative valuation placed on difference from a perceived ideal include: the widespread use of skin-lightening products (see Box 2.1 below); eyelid surgery to achieve the preferred ‘double eyelid’;⁹² facial surgery for people with Down’s syndrome to make them look more like non-disabled people;⁹³ and indeed the whole plethora of procedures designed to limit or disguise the visual effects of ageing, particularly in women (see paragraph 5.6). None of these interventions promotes health: rather they both reflect and promote gender, disability, and racial norms.

Box 2.1: Skin colour and beauty

Skin colour plays a significant role in appearance ideals across the globe. European colonialism brought with it a reverence for all things white that remains powerful, despite important counter movements. There is a continuing focus on femininity and beauty as being the preserve of the lighter-skinned black woman;⁹⁴ and the ideal skin complexion represented in African media, from billboards and print media to television and digital advertising is pale.⁹⁵ Hierarchies of skin shades have emerged within black aesthetics in

⁹⁰ See, for example, Mackie G (1996) Ending footbinding and infibulation: a convention account *American Sociological Review* **61**(6): 999-1017; Chambers C (2007) *Sex, culture, and justice: the limits of choice* (Pennsylvania: The Pennsylvania State University Press); and Khader SJ (2011) *Adaptive preferences and women’s empowerment* (New York: Oxford University Press).

⁹¹ Chambers C (2007) *Sex, culture, and justice: the limits of choice* (Pennsylvania: The Pennsylvania State University Press).

⁹² NPR (18 November 2014) *The many stories behind double-eyelid surgery*, available at:

<http://www.npr.org/sections/codeswitch/2014/11/18/364670361/the-many-stories-behind-the-double-eyelid-surgery>.

⁹³ See, for example, Olbrisch RR (1985) Plastic and aesthetic surgery on children with Down’s syndrome *Aesthetic Plastic Surgery* **9**(4): 241-8, and the discussion in Asch A (2006) Appearance-altering surgery, children’s sense of self, in *Surgically shaping children: technology, ethics, and the pursuit of normality*, Parens E (Editor) (Baltimore: The Johns Hopkins University Press), pp235-7.

⁹⁴ Tate S (2017) Skin: post-feminist bleaching culture and the political vulnerability of blackness, in *Aesthetic labour: rethinking beauty politics in neoliberalism*, Elias A, Gill R, and Scharff C (Editors) (London: Palgrave Macmillan).

⁹⁵ Olumide YM (2016) *The vanishing black African woman: volume one - a compendium of the global skin-lightening practice: 1* (Bamenda, Cameroon: Langaa RPCIG), at page 347.

the post-colonial era in the Caribbean; and skin bleaching by African women and women of African descent has been claimed as 'post-black feminist'.⁹⁶

A preference for pale skin in most East Asian countries predates the introduction of Western images of beauty. Classical Chinese poems, literature and art, for example, are replete with images of flawless pale-skinned beauty and there is evidence that, traditionally, pale skin was associated with refinement and high status, and darker skin with peasantry. During the Maoist era this was reversed as peasants and workers were revered and ideologically valued. Today, a preference for pale skin is facilitated by a large and growing market in skin-whitening products and is associated, in women particularly, with status and sophistication.⁹⁷

The high value placed on what is defined as a 'fair' appearance in India has a long history. Traced by some to early migrations of people across South Asia, and later reinforced by British colonialism, light skin is almost universally valued in India and often associated with higher castes.⁹⁸ Today the value placed on 'fairness', especially for women, is underlined in marriage advertisements, amplified by digital media, and reinforced by the aggressive marketing of skin-lightening products.⁹⁹

There have, however, been strong counter-discourses to the status of white beauty ideals where it is dark skin and black features and hair that are ascribed value. In the 1930s, for example, this was taken up in the context of Jamaica's Rastafarianism, in the 1960s in Black Power in the US and in the 1970s Afro-aesthetics in Brazil.¹⁰⁰ More recently, women in India have used social media as a vehicle to question skin colour bias and discrimination and challenge the careless marketing of skin-lightening products.¹⁰¹

- 2.4 At the same time, it is important to recognise how such forces coexist with other societal changes that have resulted in a *greater* acceptance of diversity: notable changes have occurred over recent decades, for example, in the visibility and rights of people who look different or are disabled.¹⁰² These points were reinforced to the Working Party by participants in a deliberative event convened by the organisation Changing Faces to explore the views and experiences of those living with physical disability and disfigurement.¹⁰³ A particular theme emerging from that event was the apparent contradiction in how significant and welcome changes in social attitudes to disability ("it was only about 30 years ago that they stopped putting people who looked different in an institution"¹⁰⁴) were taking place alongside a trend to promote more homogenous forms of 'celebrity' beauty, and the growing popularity of non-surgical procedures such those which use botox and fillers to combat any perceived facial imperfections.

⁹⁶ Tate S (2017) Skin: post-feminist bleaching culture and the political vulnerability of blackness, in *Aesthetic labour: rethinking beauty politics in neoliberalism*, Elias A, Gill R, and Scharff C (Editors) (London: Palgrave Macmillan).

⁹⁷ Li EP, Min HJ, Belk RW, Kimura J, and Bahl S (2008) Skin lightening and beauty in four Asian cultures *Advances in Consumer Research* 35: 444-9; and Hua W (2013) *Buying beauty: cosmetic surgery in China* (Hong Kong: Hong Kong University Press).

⁹⁸ See, for example, Bétéille A (1967) Race and descent as social categories in India *Daedalus* 96(2): 444-63.

⁹⁹ See, for example, Karnani A (2007) Doing well by doing good - case study: 'Fair & Lovely' whitening cream *Strategic Management Journal* 28(13): 1351-7; and Karan K (2008) Obsessions with fair skin: color discourses in Indian advertising *Advertising & Society Review* 9(2).

¹⁰⁰ Rooks NM (1996) *Hair raising: beauty, culture, and African American women* (New Brunswick: Rutgers University Press).

¹⁰¹ See, for example, Women of Worth (2017) *Dark is beautiful*, available at: <http://womenofworth.in/dark-is-beautiful/>. Similar campaigns have also emerged transnationally: Self (14 March 2016) *The unfair and lovely campaign is embracing darker skin tones*, available at: <http://www.self.com/story/the-unfair-and-lovely-campaign-is-embracing-darker-skin-tones>. See also: Glenn EN (2008) Yearning for lightness: transnational circuits in the marketing and consumption of skin lighteners *Gender & Society* 22(3): 281-302.

¹⁰² Scully JL (2008) *Disability bioethics: moral bodies, moral difference* (Lanham, Maryland: Rowman & Littlefield Publishers).

¹⁰³ Deliberative workshop with Changing Faces, 14 December 2016.

¹⁰⁴ *ibid.*

- 2.5 The concerns noted above point to two specific areas of harm that may potentially arise in connection with the promotion, provision, and use of cosmetic procedures, and that are explored further in this report: public health concerns related to body image and appearance anxiety, and questions of discrimination. These arise both in the wider context of increasing social pressures with respect to appearance, described in Chapter 1, and in the specific context of the use and provision of cosmetic procedures, which represents one of the ways in which people may respond to those pressures. The fact that these procedures are provided within a clinical or quasi-clinical context of trust raises further ethical questions (see paragraphs 2.16–2.17), as does the issue of access to procedures for cosmetic purposes by children and young people (see paragraphs 2.18–2.19).
- 2.6 A troubling feature arising specifically in the context of the use of cosmetic procedures is that of the way in which blame often appears to be apportioned, particularly in the popular press in response to women’s decisions. Women can be vilified if they undergo cosmetic procedures and things go wrong (vividly illustrated, for example, in the public response to the PIP breast implant fraud where victims were castigated as vain and stupid¹⁰⁵); and yet also criticised if they do not, for example through the common accusation of ‘letting themselves go’ (see paragraph 1.13).
- 2.7 Before going on to consider in more detail the points that we have outlined above, it is also critical to recognise that there are clearly many circumstances in which access to cosmetic procedures is experienced by individuals as positive and enabling, for example in dealing effectively with an appearance-related issue that has been a source of longstanding concern.¹⁰⁶ For others, the use of cosmetic procedures may be perceived as relatively unimportant or as a matter of indifference.¹⁰⁷ Our concerns in this report relate to the scope for harm at a societal level, which can operate alongside unproblematic personal use.

Public health issues

- 2.8 The levels of anxiety and distress arising in the context of increasing pressures to conform to particular appearance ideals (see paragraphs 1.6–1.11) and their impact on mental health, are a matter of public health concern.¹⁰⁸ The impact appears to be particularly powerful with respect to girls and young women, but is also increasingly affecting boys and men.
- 2.9 There is constant anecdotal reporting of how women working in sectors such as film, media, fashion and advertising feel pressurised to undergo cosmetic procedures in order

¹⁰⁵ See, for example, The Mass Observation Archive (2012) *Autumn 2012 directive: part 2 - cosmetic surgery* (Brighton: The Keep). These ‘shamings and blamings’ often relate also to class: see Doyle J, and Karl I (2008) Shame on you: cosmetic surgery and class transformation in 10 Years’ Younger, in *Exposing lifestyle television: the big reveal*, Palmer G (Editor) (Abingdon: Routledge).

¹⁰⁶ Deliberative workshop with Changing Faces, 14 December 2016.

¹⁰⁷ For example, as part of a discussion event with members of Stitch in Time, Rossendale, 13 July 2016, one participant notes that changing one’s appearance may be something people ‘do’, just like others garden.

¹⁰⁸ We use the term ‘public health’ to refer to the efforts of society as a whole to improve the health of the population and prevent illness (see the Foreword to Nuffield Council on Bioethics (2007) *Public health: ethical issues*, available at: <http://nuffieldbioethics.org/project/public-health>). Clearly, the questions of body image and use of cosmetic procedures that are the subject of this report affect the health (both physical and mental) of individuals, but our argument is that they are primarily mediated by social pressures, and hence action at the level of society as a whole is needed to address them.

to maintain the image expected of them,¹⁰⁹ and in some circles certain procedures, such as botox, are increasingly regarded as normal or necessary.¹¹⁰ In Chapter 5, we review the research available on how and why people decide to have particular cosmetic procedures, and how these intersect with existing body concerns. For example, while the continuing pressures on older people, especially women, to look younger are certainly not new, these appear to be given renewed force in the promise of cosmetic procedures; as are the desires of women to return their post-pregnant body to what it used to be (see paragraphs 5.6–5.17). There is also evidence to suggest that the promotion of ‘new’ procedures, such as the popular ‘designer vagina’ (see Box 2.2 below) or ‘leg rejuvenation’ (see Box 3.4), helps create new reasons to be anxious about additional parts of the body, as well as generating a new market for a commercially motivated industry.

Box 2.2: The ‘designer vagina’

The ‘designer vagina’ is a term which encompasses a range of procedures which change the appearance of female genitalia. These procedures are offered by a wide range of commercial cosmetic surgery providers, and include:

- labiaplasty: the removal of tissue from the labia minora or labia majora in order to reduce size;
- clitoral hood reduction: reduction of the skin around the clitoris;
- liposuction of the pubic mound (mons pubis); and
- the use of fillers to plumpen the labia majora, or pubic mound.

In the UK, no data are publicly available on either the number of cosmetic vaginal procedures that are performed, or the demography of women who undergo these procedures although there are anecdotal accounts of significant increases in recent years.¹¹¹ International data suggest, however, that the demand for labiaplasty in recent years has grown from negligible to significant. The snapshot data¹¹² on procedures published annually by the International Society of Aesthetic Plastic Surgery (ISAPS), for example, included labiaplasty and vaginal tightening for the first time in 2013, with a total of 114,135 procedures reported.¹¹³ These figures increased to 145,096 by 2015.¹¹⁴ Similar patterns with respect to the emergence and increase in popularity of labiaplasties over the last few years have been reported by the American Society of Plastic Surgeons

¹⁰⁹ See, for example, The Telegraph (22 October 2014) *Celebrities like Renee Zellweger face huge pressure to have plastic surgery*, available at: <http://www.telegraph.co.uk/news/celebritynews/11180071/Celebrities-like-Renee-Zellweger-face-huge-pressure-to-have-plastic-surgery.html>; and The Telegraph (29 November 2009) *Supermodel Erin O'Connor told to have cosmetic surgery*, available at: <http://www.telegraph.co.uk/culture/tvandradio/6636506/Supermodel-Erin-OConnor-told-to-have-cosmetic-surgery.html>. The president of the American Society for Aesthetic Plastic Surgery in a recent interview (see: The Huffington Post (24 April 2017) *Men are getting botox now more than ever. These plastic surgeons explain why.*, available at: http://www.huffingtonpost.com/entry/men-getting-more-botox_us_58ebf37de4b0c89f9120b2aa) emphasised how men, from a wide range of professions, were also feeling the need to have botox and other procedures to ‘compete’, although from the available statistics men still constitute a small percentage of users (see paragraph 3.9).

¹¹⁰ See, for example, Berkowitz D (2017) *Botox nation: changing the face of America* (New York: New York University Press).

¹¹¹ See, for example, Liao LM, and Creighton SM (2007) Requests for cosmetic genitoplasty: how should healthcare providers respond? *BMJ: British Medical Journal* **334(7603)**: 1090-2; and Mail Online (25 February 2017) *The new normal: surge in teens wanting ‘designer vaginas’ is down to taboo-free beauty standards, NOT the prevalence of porn*, available at: <http://www.dailymail.co.uk/health/article-4256832/Surge-women-wanting-designer-vaginas.html>.

¹¹² As with the data published by other surgical membership associations, these figures relate only to procedures carried out by members who responded to the survey, and therefore offer only a snapshot of all procedures undertaken. ISAPS’ survey respondents are from countries including the US, Brazil, South Korea, India, Mexico, Germany, Colombia, France, Spain, Venezuela, Argentina, Iran, and Italy.

¹¹³ International Society of Aesthetic Plastic Surgery (2014) *Procedures performed in 2013*, available at: [https://www.isaps.org/Media/Default/global-statistics/2014%20ISAPS%20Results%20\(3\).pdf](https://www.isaps.org/Media/Default/global-statistics/2014%20ISAPS%20Results%20(3).pdf), at page 2.

¹¹⁴ International Society of Aesthetic Plastic Surgery (2015) *Procedures performed in 2015*, available at: <http://www.isaps.org/Media/Default/global-statistics/2016%20ISAPS%20Results.pdf>, at page 3.

(39% increase between 2015 and 2016)¹¹⁵ and the American Society for Aesthetic Plastic Surgery (23% increase).¹¹⁶ Little data on other types of vaginal cosmetic procedures are available.

The reasons underpinning the emergence of this relatively new area of cosmetic surgery are contested. While some surgeons argue that the procedure is almost always undertaken for reasons of discomfort,¹¹⁷ UK advertising (subsequently criticised by the Advertising Standards Authority) has promoted the surgery as offering a “more natural appearance”¹¹⁸ and links have also been made with the increased accessibility of pornography, and changing fashions in body shaving and waxing (see paragraph 5.29).¹¹⁹ New methods of ‘vaginal rejuvenation’ and associated training programmes are marketed directly to practitioners and providers, and are presented as a valuable opportunity to grow their practice and increase revenue.¹²⁰

- 2.10 A key question for this Working Party to explore therefore is the extent to which the promotion of cosmetic procedures and their uptake is exacerbating the anxiety and distress about appearance experienced by people (especially girls and women) in a way that is detrimental to their well-being. Our exploration of the empirical evidence in later chapters of our report demonstrates that there is indeed justification for being concerned that people are increasingly being encouraged to feel dissatisfied, or even inadequate, with respect to their appearance, and to think that they ‘ought’ to do something about it. While there are many drivers for rising levels of anxiety about appearance (see paragraphs 1.6–1.13), the cosmetic procedures industry (from developers, to providers to promoters) is at the very least complicit in this rhetoric, playing on people’s cultivated sense of dissatisfaction for commercial gain.
- 2.11 Widespread promotion of cosmetic procedures, both directly by the industry (see Box 2.3 below) and more indirectly through pervasive commentary in broadcast, print and social media,¹²¹ and through celebrity endorsement,¹²² contributes to the perception that such procedures offer a straightforward ‘solution’ to the ‘problem’ of one’s failure to live up to prevailing appearance ideals. Yet, as we discussed in Chapter 1, the psychological evidence available suggests little correlation between happiness / general well-being and

¹¹⁵ American Society of Plastic Surgeons (2016) *Plastic surgery statistics*, available at: <https://d2wirczt3b6wjm.cloudfront.net/News/Statistics/2016/2016-plastic-surgery-statistics-report.pdf>. ASAPS’ members reported undertaking 9,138 labiaplasties in 2015, compared with 12,666 in 2016.

¹¹⁶ The American Society for Aesthetic Plastic Surgery (2016) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>. ASAPS’ 2016 statistics indicate, at page 5, a 23% rise in the number of labiaplasties its members reported undertaking compared to the previous year. The total number of labiaplasties reported by members was 10,774 in 2016, and 8,745 in 2015 (at page 11). Of the 10,774 undertaken in 2016, 559 were carried out for users under the age of 18 (at page 16).

¹¹⁷ See, for example, The Independent (24 November 2016) *Why women are getting cosmetic surgery on their vaginas*, available at: <http://www.independent.co.uk/life-style/health-and-families/labiaplasty-why-women-are-getting-cosmetic-surgery-on-their-vaginas-a7436801.html>.

¹¹⁸ Advertising Standards Authority (11 May 2016) *ASA ruling on London Bridge Plastic Surgery Ltd*, available at: <https://www.asa.org.uk/rulings/london-bridge-plastic-surgery-ltd-a16-335126.html>. See also: Liao L-M, Taghinejadi N, and Creighton SM (2012) An analysis of the content and clinical implications of online advertisements for female genital cosmetic surgery *BMJ Open* 2(6).

¹¹⁹ See, for example, Dines G (2010) *Pornland: how porn has hijacked our sexuality* (Boston: Beacon Press), cited in Alberti F (2016) *This mortal coil: the human body in history and culture* (Oxford: Oxford University Press), at page 81.

¹²⁰ See, for example, European College of Aesthetic Medicine & Surgery (2016) *Module 18: master course in aesthetic genital surgery*, available at: <http://ecamedicine.com/component/courses/course/detail/57/module-18:-master-course-in-aesthetic-genital-surgery.html>; and Syneron Candela (2017) *Fractional CO2 technology - Intima*, available at: http://syneron-candela.com/na/node/4427/view/request_url%3Dsyneron-candela.fr/node/7049/view/unik_name%3Dtop_contact.

¹²¹ See, for example, the growing popularity of cosmetic surgery ‘makeover’ shows, as discussed by Doyle J, and Karl I (2008) Shame on you: cosmetic surgery and class transformation in 10 Years’ Younger, in *Exposing lifestyle television: the big reveal*, Palmer G (Editor) (Abingdon: Routledge).

¹²² See, for example, Aesthetics (13 July 2016) *How to use celebrity endorsement to boost business*, available at: <https://aestheticsjournal.com/feature/how-to-use-celebrity-endorsement-to-boost-business>.

'actual' appearance. Moreover, the promotion of cosmetic procedures as a solution to a perceived problem is often unaccompanied by any sense of either the risks, or the limitations and uncertainties of outcome, of both surgical and non-surgical procedures.

- 2.12 There are further public health concerns, where prevailing beauty ideals themselves are potentially physically or mentally harmful. Examples include the promotion of unhealthy thin bodies for women, and the encouragement of steroid use to achieve a 'ripped', or muscled, look for men. These concerns arise even more starkly where beauty standards and ideals can only be achieved through the use of procedures that, even when performed to a high standard, involve a degree of physical risk, as is the case with any invasive cosmetic procedure. In contrast with invasive therapeutic procedures, the risks inherent in procedures undertaken in order to achieve a particular appearance ideal are not counterbalanced by the prospect of clinical benefit.

Potential for discrimination

- 2.13 As we indicated above (see paragraph 2.3), some of the ideals that people are encouraged to aspire to by the beauty, fashion, and media industries are themselves not morally neutral. The lack of diversity in the fashion and beauty industries, for example, sends clear messages about the greater value ascribed to certain kinds of appearance (young, white, and thin models still preferred¹²³) and by implication to certain kinds of people.¹²⁴ Potentially discriminatory practices relating to appearance are not limited to employment areas concerned with fashion or beauty, but are also found much more widely, as illustrated through a recent House of Commons inquiry into the widespread use by employers of discriminatory dress and appearance codes that have a disproportionate and negative effect on women.¹²⁵ High profile cases of employment discrimination against older women in broadcasting,¹²⁶ and against disabled people by employers who wish their frontline staff to present a particular image,¹²⁷ are indicative of the broader scope for such discrimination, despite the requirements of the Equality Act 2010 (see paragraph 4.62). Such discrimination is not limited to the domain of work: the implicit value placed on being, for example, young, white, thin, and able-bodied, has broader discriminatory consequences in the way that those who do not fit within these

¹²³ Harper's Bazaar (10 September 2015) *A new report shows that fashion ads are still overwhelmingly white*, available at: <http://www.harpersbazaar.com/fashion/models/news/a12148/fashion-models-diversity-2015/>. See also: TED Talks (2012) *Looks aren't everything. Believe me, I'm a model.*, available at: https://www.ted.com/talks/cameron_russell_looks_aren_t_everything_believe_me_i_m_a_model?language=en.

¹²⁴ While there have always been ideals of beauty, as seen, for example, in the ideals of divine beauty in the Classical era (see Jenkins I (2015) *Defining beauty: the body in ancient Greek art* (London: British Museum Press)), 'ordinary' humans were not expected to conform to them. What has changed is the expectation that people should now aspire to achieve what is promoted as an ideal, including where those ideals are airbrushed or achieved through invasive procedures. (For a discussion of the rise of 'normality' as a concept, see: Davis LJ (1995) *Enforcing normalcy: disability, deafness, and the body* (London: Verso).)

¹²⁵ House of Commons Petitions Committee and Women and Equalities Committee (2017) *High heels and workplace dress codes*, available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpetitions/291/291.pdf>.

¹²⁶ See, for example, The Independent (12 January 2011) *BBC ageism verdict gives hope to older presenters*, available at: <http://www.independent.co.uk/news/media/tv-radio/bbc-ageism-verdict-gives-hope-to-older-presenters-2182233.html>.

¹²⁷ See, for example, *Dean v Abercrombie & Fitch*, where an employment tribunal considered the case of a young woman who was asked to work in the stockroom rather than on the shop floor of the retailer because she had a prosthetic arm which, if covered with a cardigan during summer months, would breach the company's 'look policy'. The tribunal ruled that she had been wrongfully dismissed. For an overview of the case, see: The Guardian (13 August 2009) *Disabled worker wins case for wrongful dismissal against Abercrombie & Fitch*, available at: <https://www.theguardian.com/money/2009/aug/13/abercrombie-fitch-employee-case-damages>.

categories become less ‘visible’, so that their needs and interests are more likely to be overlooked,¹²⁸ or they are treated less favourably in other ways.¹²⁹

- 2.14 Appearance ideals, and the pressure to conform to them, are thus not simply a matter of taste or fashion but also raise wider issues of discrimination. In the same way, many of the cosmetic procedures discussed in this report are promoted as a response to anxieties that are potentially discriminatory – in particular with respect to age, gender, race, and physical difference. With the rise of technological fixes from airbrushing of images to surgery, people are now increasingly faced with appearance ideals that cannot be achieved without having ‘work done’, creating a self-perpetuating cycle of demand for such procedures.
- 2.15 Moreover, concerns about discrimination are not limited to the issue of what kinds of appearance, and hence by implication what kinds of people, are valued. Even where appearance ideals themselves appear to be morally neutral, the demands of conforming to them impose different burdens on different people: it is much easier for some people to ‘fit in’ and present the desired appearance than it is for others. Social pressures to conform to beauty ideals are thus inherently unequal in their effects. The greater the social pressure to conform to or achieve particular appearance standards and ideals, the greater may be the risk of discrimination against those who are unable, or indeed unwilling, to meet those ideals.

The context within which procedures are offered

- 2.16 One of the main areas of ethical concern arises in connection with the context within which procedures are sought and provided. Many of the cosmetic procedures with which this report is concerned are provided in a clinical setting, either within a private hospital that provides a range of other, health-related, interventions, or in a standalone clinic, and hence in a medicalised environment in which relationships of trust and professional responsibility are embedded and assumed. A further example is the way that botox is increasingly offered in dental surgeries.¹³⁰ Even where non-surgical procedures are provided outside this clinical context, for example in a beauty salon or spa, a similarly medicalised environment may be implied: for example through the name used (such as the ‘medi-spa’); through the information provided (such as the emphasis in marketing materials on the role and qualifications of a medical director and the focus on safety and high professional standards); and through the way staff dress (for example the use of white coats or other uniform conveying a clinical impression).
- 2.17 This strong association with the trust-based nature of clinical practice, where patient welfare is assumed to be at the heart of all interactions, highlights the personal professional responsibility of practitioners providing cosmetic procedures. However, this assumption of trust-based practice, centred around patient welfare, comes into conflict with the way in which cosmetic procedures are advertised and promoted as a desirable consumer good, to be purchased on demand by customers, rather than undertaken, with

¹²⁸ See, for example, Ory M, Hoffman MK, Hawkins M, Sanner B, and Mockenhaupt R (2003) Challenging aging stereotypes: strategies for creating a more active society *American Journal of Preventive Medicine* **25(3)**: 164-71.

¹²⁹ See, for example, Vartanian LR (2010) Disgust and perceived control in attitudes toward obese people *International Journal of Obesity* **34(8)**: 1302-7. See also: Berry B (2007) *Beauty bias: discrimination and social power* (Westport, Connecticut: Praeger Publishers).

¹³⁰ Factfinding meeting with General Dental Council, 12 October 2016. See also: The Telegraph (4 May 2008) *Dentists offering botox alongside fillings*, available at: <http://www.telegraph.co.uk/news/newstoppers/howaboutthat/1925263/Dentists-offering-Botox-alongside-fillings.html>.

advice and support, and after careful consideration of the risks, by patients (see Box 2.3 below). This tension between perceiving the potential user of cosmetic procedures as a patient or consumer, combined with the commercial imperatives of the industry that underpin proactive marketing and sales strategies, reinforces the concern that individual choice, and the protections of traditional consent practice, may be insufficient alone to ensure ethical practice.

Box 2.3: Examples of cosmetic surgery adverts online¹³¹

■ **Cosmetic surgery – The Hospital Group**

Award-winning care, as seen on TV. Book your free consultation today. Nationwide clinics · award winning surgeon · free patient aftercare · over 20 years' experience

■ **Best cosmetic surgery clinic – in London**

Be confident again! Path to a new you – financing available – cosmetic surgery
Great aftercare · award winning surgeon · free consultation – sign up · 1000s of happy clients

■ **MYA cosmetic surgery – welcome to MYA world**

The Celebrities Choice! 0% Finance Available! Book Your Free Consultation Today.

■ **Cosmetic Surgery London – clarenceclinic.co.uk**

Top cosmetic surgery clinic in London. Book a consultation
High-quality · consistent results

■ **Dr Forrester & Ms McEvoy – Plastic Surgery**

Surgical and nonsurgical cosmetic procedures by trusted and experienced doctors.

■ **MyBreast cosmetic surgery – the best surgeons for you**

Surgeon of the Year award winners. Book your consultation with us now!

Access to procedures by children and young people

2.18 Finally, the question arises as to who may access cosmetic procedures, and whether there could be any justification for limiting access in any way. Specific concerns arise in connection with access by children and young people. Adolescents are particularly susceptible to pressures to conform to prevailing peer and social pressures;¹³² and are at a vulnerable stage of development with respect to their sense of their own identity.¹³³ Moreover, appearance dissatisfaction in adolescence has consistently been identified as a risk factor for a variety of practices used to manage appearance and that are associated with long-term consequences, including eating disorders, depression, and low self-esteem.¹³⁴

2.19 While the law increasingly recognises the ability of children and young people to make decisions for themselves (see paragraph 4.46), this recognition is accompanied until

¹³¹ On 5 May 2017, the term 'cosmetic surgery' was entered into the search engine Google.co.uk. The adverts listed in the box correspond to those which appeared on the first three pages of search results, and were 'tagged' as adverts (i.e., with a green box with the word 'Ad' next to the search result).

¹³² Ricciardelli LA, and Mellor D (2012) Influence of peers, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 20.

¹³³ Smollak L (2012) Appearance in childhood and adolescence, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 12.

¹³⁴ *ibid.*

adulthood by an ongoing protective role both on the part of parents and on the part of the state. This protective role is signalled in other areas of law through the absolute prohibition on those under 18 having a tattoo, or using a sunbed other than under medical supervision (see paragraph 4.48). Parents¹³⁵ are explicitly excluded from providing consent on behalf of their children for either of these activities, demonstrating a clear limitation by the state on the role of parents with respect to some of the means by which bodies may be modified and appearance changed. Moreover, in the health context, health professionals would be acting against their ethical codes, and indeed the law, if they provided procedures that they did not believe to be in a child's best interests. The permissibility of carrying out invasive cosmetic procedures on a child or young person, without expectation of therapeutic gain, raises serious ethical concerns.

¹³⁵ Throughout this report, reference to 'parents' includes anyone exercising parental responsibility for a child, including a legal guardian.

Chapter 3

The 'business' of
cosmetic procedures

Chapter 3 – The ‘business’ of cosmetic procedures

Chapter 3: overview

- Most cosmetic procedures are provided in the private sector, and the overlap between cosmetic procedures and the beauty industry makes this sector ‘big business’, driven by commercial interests and proactive marketing. The role of commerce is thus an important factor to take into account in exploring the ethical implications of the use of cosmetic procedures.
- Accurate information about the size and value of the cosmetic procedures market is hard to find in the public domain, because of the fragmented nature of the market, limited reporting requirements, and commercial confidentiality. However, market intelligence assessments suggest sustained growth: one estimate of the UK cosmetic sector (surgical and non-surgical) was £3.6 billion in 2015, up from £720 million in 2005. In the US, the cosmetic surgery market alone was assessed in 2015 as \$20 billion.
- Figures on the number of procedures undertaken are similarly elusive, but one 2009 UK estimate was of 1.2 million procedures a year (92% of which were non-surgical), with significant growth expected since. An association of NHS-qualified plastic surgeons working in the cosmetic sector reported a threefold increase in cosmetic surgeries between 2004 and 2015 undertaken by its members, followed by a 40% drop in 2016. In contrast the large commercial groups report ongoing growth in 2016. While procedures such as breast augmentations and reductions, liposuction, and surgery on the face retain popularity over time both in the UK and beyond, ‘newer’ procedures, such as buttock augmentations, penis enlargements, and female genital cosmetic surgery are also emerging as increasingly popular.
- The development and marketing of new (or, in many cases ‘repurposed’) products and procedures are important drivers of the market, especially where they offer less invasive alternatives to surgery. Developments include:
 - the use of platelet-rich plasma in ‘vampire’ treatments;
 - ‘fat freezing’ as a non-surgical alternative to liposuction; and
 - the use of fillers and botox in new areas of the body, including ears, knees and feet.
- Manufacturers of the products and equipment used in cosmetic procedures similarly compete for market share. In some cases, including in the production and sale of breast implants and dermal fillers, strong commercial competition has led to significant concerns about safety and quality.
- The cosmetic procedures industry is made up of a complex network including: those who develop products, procedures and technologies; ‘provider’ companies and practitioners; financiers; agents; and advertisers. The business models through which cosmetic procedures are offered include:
 - self-employed health professionals;
 - private hospitals and clinics, who also provide mainstream medical care;
 - large commercial ‘group’ providers who specialise in cosmetic procedures; and
 - beauty salons, spas, gyms and other parts of the beauty and ‘wellness’ sector.

Introduction

- 3.1 Challenges arising in connection with cosmetic practice are often conceptualised and discussed primarily in terms of the one-to-one relationships between practitioners and users. This focus has led to an emphasis in public and policy debate on regulating what happens in the consulting room or clinic, looking, for example, at issues such as the quality of informed consent, qualifications and professional standards, and regulatory approaches to safe practice.¹³⁶ While important, this focus contributes to an emphasis on personal responsibility and attitudes of scorn and 'victim-blaming' when things go wrong: media reports about 'botched surgeries' or unwanted outcomes, for example, often present users as making poor choices about treatment, or as having selected the 'wrong' practitioner.¹³⁷
- 3.2 Practitioner standards, safe practice, and questions of informed choice are clearly all important, and we return to them later in this report (see Chapters 4, 7 and 8). However, the fact that most procedures are provided in the private sector, combined with the overlap between cosmetic procedures and the beauty industry, makes this 'big business' driven by commercial imperatives and proactive marketing. This, in turn, draws in many other actors, including those who develop products, procedures and technologies, financiers, agents and facilitators, and advertisers.
- 3.3 In analysing the practice of cosmetic procedures, and its ethical implications, we therefore need to look beyond the immediate one-to-one relationships between users and practitioners, in order to explore both the role of commerce, and the roles and responsibilities of the many different actors involved in the industry.

The cosmetic procedures industry

Value of the cosmetic procedures market

*"Please don't forget that at its heart we are talking business."*¹³⁸

*"The majority of cosmetic procedures are provided by private providers, rather than the NHS, and are thus commercial enterprises."*¹³⁹

- 3.4 Accurate information about the size and value of the cosmetic procedures market is hard to find in the public domain, because of the fragmented nature of the market, limited reporting requirements, and commercial confidentiality. However, analyses of market

¹³⁶ See, for example, the approach of the Keogh report: 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>.

¹³⁷ See, for example, Holliday R (2016) *Cosmetic surgery discourse and cosmetic surgery value: presentation to Beauty Demands seminar: Manchester - 24 March*, which notes that women who had received PIP implants were "spat on by a hostile crowd" as they tried to demonstrate outside Parliament. See also: The Mirror (19 September 2016) *Botched boob job mum told 'you can't pay for a Mini and expect a Ferrari' by plastic surgeon*, available at: <http://www.mirror.co.uk/news/uk-news/botched-boob-job-mum-told-8868941>.

¹³⁸ Respondent to the Working Party's online questionnaire.

¹³⁹ Dr Sara Fovargue, Law School and Lancaster Centre for Bioethics and Medical Law, Lancaster University; and Dr Alexandra Mullock, School of Law and Centre for Social Ethics and Policy, University of Manchester, responding to the Working Party's call for evidence.

value produced by market research companies give some indication of both the scale of the market, and the way in which it is developing.¹⁴⁰

- 3.5 Assessments of the market value of the cosmetic procedures sector in the UK (published in 2010 by market intelligence agency Mintel, and cited by the Department of Health in 2013), rose from £720 million in 2005 to £2.3 billion in 2010, and were estimated to reach a value of £3.6 billion by 2015.¹⁴¹ A market update published in 2015 by business intelligence provider Key Note Ltd., on the other hand, valued the UK cosmetic surgery and cosmetic procedures market much lower, though moving in the same direction: £646 million in 2010 and £725 million in 2014, with further growth forecast to £795 million in 2017 and £913 million in 2019.¹⁴² Key Note highlights, however, that it derives its information from trade sources and from the limited data collected by the British Association of Aesthetic Plastic Surgeons (BAAPS) which covers only one sector of the market (see Box 3.1 below), and comments that the actual number of people undergoing cosmetic operations in the UK will be much higher than is reflected in these figures.
- 3.6 Similar challenges arise in estimating the global value of the cosmetic procedures market; however, analyses published by market research companies emphasise the growing commercial significance of the sector. In 2015, one such company estimated the global market in ‘cosmetic surgery and service’ as worth over \$20 billion, and set to rise to over \$27 billion by 2019.¹⁴³ The American Society of Plastic Surgeons (ASPS) reported that Americans spent over \$15 billion on cosmetic surgery and non-surgical cosmetic procedures in 2016,¹⁴⁴ while the pharmaceutical company Allergan reported global net revenue in 2016 as \$1.97 billion for Botox and \$573 million for fillers.¹⁴⁵ In April 2017, Allergan acquired the medical technology company behind the ‘CoolSculpting’ system (see Box 3.4 below) for \$2.4 billion,¹⁴⁶ and the aesthetic laser market alone is reportedly expected to be worth \$1.8 billion by 2024.¹⁴⁷

Volume of procedures

“I’ve seen more and more people undertake them within the upper / middle-class social circles I’m a member of. Also, the increase in positive reinforcement through the media and growth of the industry in cosmetic procedures that has driven this.”¹⁴⁸

¹⁴⁰ While the market analyses make use of trade information that is not publicly available, the very high cost of market research reports in turn limits the public accessibility to even of the estimates based on this trade information. The statistics cited in this chapter are based on public reporting of market research data, including that made available to the Department of Health during the Keogh report.

¹⁴¹ Mintel market intelligence report on cosmetic surgery (2010), 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>, at paragraph 1.3.

¹⁴² Key Note (2015) *Cosmetic surgery: market update*, available at: https://www.keynote.co.uk/market-update/healthcare-medical-pharmaceuticals/cosmetic-surgery?full_report=true, at pages 20 and 29.

¹⁴³ Bharat Book Bureau (2015) *Global cosmetic surgery and service market report 2015-2019*, available at: <https://www.bharatbook.com/healthcare-market-research-reports-643332/healthcare-industry-healthcare-market-research-reports-healthcare-industry-analysis-healthcare-sector3.html>.

¹⁴⁴ The American Society for Aesthetic Plastic Surgery (2016) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>, at page 5.

¹⁴⁵ Allergan (2017) *Annual report 2016*, available at: <https://allergan-web-cdn-prod.azureedge.net/actavis/actavis/media/allerganinvestors/financial-information/proxy-materials/10-k.pdf>, at page 70.

¹⁴⁶ PR Newswire (28 April 2017) *Allergan successfully completes ZELTIQ aesthetics acquisition*, available at: <http://www.prnewswire.com/news-releases/allergan-successfully-completes-zeltiq-aesthetics-acquisition-300447962.html>.

¹⁴⁷ PR Newswire (21 September 2016) *Aesthetic lasers market analysis by application and segment forecasts to 2024*, available at: <http://www.prnewswire.com/news-releases/aesthetic-lasers-market-analysis-by-application-and-segment-forecasts-to-2024-300332306.html>.

¹⁴⁸ Respondent to the Working Party’s online questionnaire.

"It is becoming more routine to undertake cosmetic procedures and this is largely due to the affordability. This trend is no different to any other commodity that becomes mass produced or mass available."¹⁴⁹

"I know people who've got loads of stuff done. My cousin has had her ears pinned back, my other cousin gets botox, my friend gets electrolysis to get the moles removed from her face."¹⁵⁰

- 3.7 Figures on the total numbers of procedures carried out in the UK, and elsewhere, are similarly elusive. The 2014 figures presented by Key Note are based on an estimated total of 726,633 procedures carried out in the UK, of which 85.3 per cent (620,077) were non-surgical procedures.¹⁵¹ Mintel, in contrast, cited an increase in non-surgical procedures in the UK from a much higher baseline of 950,000 in 2008 to 1.1 million in 2009, and stated that these represented 92 per cent of the market by volume.¹⁵² Mintel figures are thus based on a 2009 total of 1.2 million procedures (of which approximately one million are non-surgical), with significant growth forecast since.
- 3.8 More precise information is, however, available on particular sectors of the industry, providing both a snapshot of how those sectors break down, and how they are changing over time, as set out in Box 3.1 below.

Box 3.1: Published data on numbers of cosmetic procedures

- Figures collected by the BAAPS on the number of cosmetic surgery procedures carried out in the private sector by plastic surgeons who are members of the Association, demonstrated a steady and significant rise over the past decade in the UK: from 16,367 surgeries in 2004¹⁵³ to 51,140 in 2015.¹⁵⁴ A nine per cent dip in 2014 (the first decrease after a decade of increases) was ascribed to a 'post-austerity' boom of double-digit rises in 2013 which were then "returning to a more rational level."¹⁵⁵ 2015 statistics confirmed a return to previous growth patterns with a 13 per cent increase in procedures on the previous year.
- In 2016, by contrast, BAAPS reported a 40 per cent fall in cosmetic surgical procedures undertaken by its members, a fall which BAAPS explained by reference to "a climate of global unrest and 'bad news overload' leaving patients prioritising stability and comfort over big life changes."¹⁵⁶ The fall in people seeking procedures from BAAPS members (NHS trained plastic surgeons working also in the private sector)

¹⁴⁹ Clare McKeaveney, Queen's University Belfast, responding to the Working Party's call for evidence.

¹⁵⁰ Discussion event with members of ScotCRN YPG, Aberdeen, 18 June 2016.

¹⁵¹ Key Note (2015) *Cosmetic surgery: market update*, available at: https://www.keynote.co.uk/market-update/healthcare-medical-pharmaceuticals/cosmetic-surgery?full_report=true, pp18-9.

¹⁵² Mintel (2010) *Non-surgical cosmetic procedures top the million mark for first time*, available at: <http://www.mintel.com/press-centre/beauty-and-personal-care/non-surgical-cosmetic-procedures-top-the-million-mark-for-first-time>.

¹⁵³ See: British Association of Aesthetic and Plastic Surgeons (24 January 2005) *British Association of Aesthetic Plastic Surgeons announce annual audit results* (London: British Association of Aesthetic and Plastic Surgeons).

¹⁵⁴ British Association of Aesthetic Plastic Surgeons (8 February 2016) *Super cuts 'daddy makeovers' and celeb confessions: cosmetic surgery procedures soar in Britain*, available at: https://baaps.org.uk/media/press_releases/38/super_cuts_daddy_makeovers_and_celeb_confessions_cosmetic_surgery_procedures_soar_in_britain. Correlating these statistics with the Key Note data (see paragraph 3.7) suggests that Key Note estimates are based on the assumption that BAAPS members carry out approximately half of all cosmetic surgeries in the UK. However, there is currently no published information on the number of procedures carried out by the large commercial companies who are significant players in this field.

¹⁵⁵ British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: https://baaps.org.uk/media/press_releases/1226/tweak_not_tuck.

¹⁵⁶ British Association of Aesthetic Plastic Surgeons (13 February 2017) *The bust boom busts*, available at: https://baaps.org.uk/media/press_releases/29/the_bust_boom_busts.

may, however, also reflect changes in the cosmetic procedures market, with more people using the services offered by the large commercial ‘group’ providers (see paragraph 3.23). Some of the largest group providers of cosmetic procedures in the UK told us that the numbers of procedures (both surgical and non-surgical) undertaken by their practitioners have continued to rise in the past few years, including in 2016.¹⁵⁷

- The American Society for Aesthetic Plastic Surgery (ASAPS) similarly publishes data on the procedures (both surgical and non-surgical) performed by its members, showing a 19 per cent increase over the last decade: from 11.4 million procedures in 2006 to 13.6 million procedures in 2016.¹⁵⁸ However, this increase was entirely due to growth in non-surgical procedures such as the use of botulinum toxins and dermal fillers: there was minimal change in the number of cosmetic surgeries over the ten-year period (1.92 million in 2006; 1.97 million in 2016).¹⁵⁹
- A similar picture is presented by data from the American Society of Plastic Surgeons (ASPS), which reports a small decrease in cosmetic surgical procedures (1.8 million in 2006; 1.7 million in 2016), but a significant increase in non-surgical procedures (9.1 million in 2006; 15.4 million in 2016).¹⁶⁰
- Worldwide, the International Society of Aesthetic Plastic Surgery (ISAPS) publishes estimated figures based on survey responses, projected to reflect the number of plastic surgeons in respondent countries. According to these estimates, the total number of procedures (both surgical and non-surgical) carried out by plastic surgeons rose from 14.1 million procedures in 2010 to 21 million in 2015, with the US, Brazil, South Korea, India, and Mexico identified as the five countries where most procedures were performed in 2015.¹⁶¹

3.9 While these annual statistics cover only those procedures carried out by particular groups of practitioners and hence present a very partial picture of the market, they do also provide an insight into how fashions and tastes in cosmetic procedures may change, influenced both by wider fashion trends, and by the marketing of technological developments that make new types of procedure available (see paragraphs 3.14–3.17). In 2014, for example, BAAPS reported that people choosing surgery were 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.¹⁶² In 2015, on the other hand, breast augmentation was reported to be up by 12 per cent, and still the most popular treatment for women; however “a more natural, proportionate enhancement” was widely preferred over the artificial look once associated with

¹⁵⁷ Factfinding meeting with Harley Medical Group (10 March 2017); Factfinding meeting with Transform (15 March 2017).

¹⁵⁸ The American Society for Aesthetic Plastic Surgery (2006) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/2006stats.pdf>, at page 3; and The American Society for Aesthetic Plastic Surgery (2016) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>, at page 4.

¹⁵⁹ See: The American Society for Aesthetic Plastic Surgery (2006) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/2006stats.pdf>, at page 2; and The American Society for Aesthetic Plastic Surgery (2016) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>, at page 8.

¹⁶⁰ American Society of Plastic Surgeons (2006) *Cosmetic surgery gender distribution*, available at: <https://d2wirczt3b6wjm.cloudfront.net/News/Statistics/2006/cosmetic-procedures-women-2006.pdf>; and American Society of Plastic Surgeons (2016) *Plastic surgery statistics*, available at: <https://d2wirczt3b6wjm.cloudfront.net/News/Statistics/2016/2016-plastic-surgery-statistics-report.pdf>.

¹⁶¹ 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>; and International Society of Aesthetic Plastic Surgery (2015) *Quick facts: highlights of the ISAPS 2015 statistics on cosmetic surgery*, available at: [http://www.isaps.org/Media/Default/global-statistics/ISAPSQuickFactsMS_V6%20\(1\).pdf](http://www.isaps.org/Media/Default/global-statistics/ISAPSQuickFactsMS_V6%20(1).pdf). ISAPS data do not include survey responses from the UK.

¹⁶² British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: https://baaps.org.uk/media/press_releases/1226/tweak_not_tuck.

implants.¹⁶³ The significant drop in surgical procedures carried by BAAPS members in 2016 was ascribed in part to the increasing availability of non-surgical techniques, especially given that procedures such as abdominoplasty, for which there is no non-surgical alternative, had in fact increased.¹⁶⁴ While, as noted earlier, the commercial group providers do not currently publish routine data on procedures performed, press reports similarly emphasise “a huge rise in ‘lunchtime nip-and-tucks’” after interviewing commercial providers¹⁶⁵ (see also paragraph 3.16). According to the data published by BAAPS, the proportion of procedures with male users has remained steady at around nine per cent of the total.¹⁶⁶

Box 3.2: Most popular cosmetic surgeries carried out by BAAPS members (UK 2016)¹⁶⁷

Women	Breast augmentation:	7,732
	Blepharoplasty (eyelid surgery):	3,584
	Breast reduction:	3,566
	Face / neck lift:	3,328
	Liposuction:	2,879
Men	Rhinoplasty:	529
	Otoplasty (ear pinning):	421
	Liposuction:	339
	Blepharoplasty (eyelid surgery):	321
	Breast reduction:	320

¹⁶³ British Association of Aesthetic Plastic Surgeons (8 February 2016) *Super cuts ‘daddy makeovers’ and celeb confessions: cosmetic surgery procedures soar in Britain*, available at: https://baaps.org.uk/media/press_releases/38/super_cuts_daddy_makeovers_and_celeb_confessions_cosmetic_surgery_procedures_soar_in_britain.

¹⁶⁴ British Association of Aesthetic Plastic Surgeons (13 February 2017) *The bust boom busts*, available at: https://baaps.org.uk/media/press_releases/29/the_bust_boom_busts.

¹⁶⁵ Mail Online (4 January 2017) *Bigger bums, smaller nipples and lunchtime nip-and-tucks: experts reveal the cosmetic surgery trends set to sweep 2017*, available at: <http://www.dailymail.co.uk/femail/article-4084630/Surgeons-reveal-cosmetic-surgery-trends-set-sweep-2017.html>.

¹⁶⁶ According to BAAPS, men had 8% of cosmetic procedures in 2016, 9% in 2015, and 9% in 2014. See, respectively, British Association of Aesthetic Plastic Surgeons (13 February 2017) *The bust boom busts*, available at: https://baaps.org.uk/media/press_releases/29/the_bust_boom_busts; British Association of Aesthetic Plastic Surgeons (8 February 2016) *Super cuts ‘daddy makeovers’ and celeb confessions: cosmetic surgery procedures soar in Britain*, available at:

https://baaps.org.uk/media/press_releases/38/super_cuts_daddy_makeovers_and_celeb_confessions_cosmetic_surgery_procedures_soar_in_britain; and British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: https://baaps.org.uk/media/press_releases/1226/tweak_not_tuck.

¹⁶⁷ British Association of Aesthetic Plastic Surgeons (13 February 2017) *The bust boom busts*, available at: https://baaps.org.uk/media/press_releases/29/the_bust_boom_busts.

Box 3.3: Most popular non-surgical cosmetic procedures (US, 2016)

There are no publicly-available data on the UK's most popular non-surgical procedures. In 2016, the American Society of Plastic Surgeons (ASPS)¹⁶⁸ identified the most popular non-surgical procedures reported by its members as:

- Botox treatments: 7 million
- Dermal fillers: 2.6 million
- Chemical peels: 1.3 million
- Laser hair removal: 1.1 million
- Microdermabrasion: 775,000

- 3.10 While procedures such as breast augmentations and reductions, liposuction, and surgery on the face retain popularity over time both in the UK and beyond,¹⁶⁹ the annual statistics compiled by ISAPS and others highlight how 'newer' procedures, such as buttock augmentations, penis enlargements, and female genital cosmetic surgery (FGCS) are emerging as increasingly popular. Neither penis enlargement nor labiaplasty, for example, appeared in the 2010 ISAPS statistics, in contrast to the estimated 11,700 enlargements and 95,000 labiaplasties reported in 2015.¹⁷⁰ Growing interest in FGCS, including from adolescent girls, is also increasingly reported in the medical and academic press.¹⁷¹ Buttock lifts and augmentations were listed in the 2010 ISAPS survey (83,500 performed), but the introduction of fat-transfer techniques as an alternative to implants for buttock augmentation has accompanied a fourfold surge in popularity with an estimated 320,000 procedures carried out worldwide in 2015.¹⁷²
- 3.11 Research published by Mintel in 2014, exploring trends relevant to the industry, reported that the area of the body with which adults in the UK were most likely to be unhappy was the stomach / waist (cited by nearly a third of those surveyed). This unhappiness, combined with the rising proportion of adults qualifying as obese or overweight, was identified as "beneficial to the cosmetic surgery market", both through interest in liposuction and abdominoplasty and for procedures to remove excess skin after weight-loss surgery.¹⁷³ The same market study explored likely interest in future procedures, finding that half the women surveyed (and 35% of the men) stated that they would potentially be interested in a procedure in the future. Of the nearly 2,000 adults surveyed in total, between 11 per cent and 21 per cent expressed interest in specific procedures such as eyelid lift, nose surgery, liposuction, breast augmentation / reduction, and skin

¹⁶⁸ American Society of Plastic Surgeons (1 March 2017) *New plastic surgery statistics reveal focus on face and fat*, available at: <https://www.plasticsurgery.org/news/press-releases/new-plastic-surgery-statistics-reveal-focus-on-face-and-fat>.

¹⁶⁹ ISAPS figures similarly highlight the popularity of breast augmentation, liposuction and eyelid surgery. See: International Society of Aesthetic Plastic Surgery (2015) *Quick facts: highlights of the ISAPS 2015 statistics on cosmetic surgery*, available at: [http://www.isaps.org/Media/Default/global-statistics/ISAPSQuickFactsMS_V6%20\(1\).pdf](http://www.isaps.org/Media/Default/global-statistics/ISAPSQuickFactsMS_V6%20(1).pdf).

¹⁷⁰ 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>; International Society of Aesthetic Plastic Surgery (2016) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2015*, available at: <https://www.isaps.org/Media/Default/global-statistics/2016%20ISAPS%20Results.pdf>, pp2-3.

¹⁷¹ See, for example, Liao LM, and Creighton SM (2007) Requests for cosmetic genitoplasty: how should healthcare providers respond? *BMJ: British Medical Journal* **334(7603)**: 1090-2. See also: Simonis M, Manocha R, and Ong JJ (2016) Female genital cosmetic surgery: a cross-sectional survey exploring knowledge, attitude and practice of general practitioners *BMJ Open* **6**.

¹⁷² 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>, at page 4; and International Society of Aesthetic Plastic Surgery (2016) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2015*, available at: <https://www.isaps.org/Media/Default/global-statistics/2016%20ISAPS%20Results.pdf>, at page 2.

¹⁷³ Mintel (2014) *Cosmetic surgery: UK - executive summary* (London: Mintel), at page 2.

treatments; however, interest was significantly higher for permanent hair removal (27%) and teeth whitening (40%), indicating the growing importance of the non-surgical sector.¹⁷⁴

- 3.12 A further potential growth area for the cosmetic procedures market is that of the under 18 population. No UK-based figures provide a detailed age breakdown of procedures by age; however, US statistics (based on procedures by surgeons who are members of ASAPS) showed that, in 2016, 7.5 per cent (11,059) of all nose surgeries carried out by ASAPS members were performed on children and young people under the age of 18, while under 18s accounted for 32.3 per cent of ear surgery patients (11,821). For a number of other procedures, the percentage undertaken on under 18s was very low, but the actual numbers still considerable: for example, 3,140 breast augmentations (1%), 3,045 liposuction procedures (0.7%), 32,822 injectables (including botox and fillers - 0.4%), 18,632 chemical peels (3%), and 31,822 microdermabrasion treatments (5.4%).¹⁷⁵ Worldwide figures from 2015 relating to procedures reported to ISAPS further note that 45,116 under 18s underwent breast augmentation (3%), 32,494 liposuction (2.3%), 55,064 rhinoplasty (7.5%), 29,155 botox (0.6%), and 10,633 non-surgical fat reduction (2.5%).¹⁷⁶

Developmental drivers

"... new technologies have made... procedures safer and easier to change aspects of a person's body they may be unhappy with for whatever reason".¹⁷⁷

"Now we have the technology, we can make our bodies change to fit the trends, not just change what we wear."¹⁷⁸

- 3.13 Research and development is clearly an important part of innovation in any field, and in healthcare plays a critical role in improving the options open to patients and professionals. However, new products and procedures do not simply emerge in response to existing patient need or user demand: rather the priorities and pressures that shape innovation, including commercial factors, also act to shape, and even create, demands in the future.¹⁷⁹ The significant role played by those who develop new products and techniques for cosmetic purposes, that can then be marketed as responding to previously unmet need, should be acknowledged when considering the ethical implications, and associated responsibilities, of the growth in use of cosmetic

¹⁷⁴ *ibid.*, pp2-3.

¹⁷⁵ The American Society for Aesthetic Plastic Surgery (2016) *Cosmetic surgery national data bank statistics*, available at: <http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf>, pp16-7.

¹⁷⁶ International Society of Aesthetic Plastic Surgery (2016) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2015*, available at: <https://www.isaps.org/Media/Default/global-statistics/2016%20ISAPS%20Results.pdf>, at page 20. ISAPS data further indicate that, worldwide, 8% of plastic surgeons performed breast augmentation procedures women under the age of 17.

¹⁷⁷ Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester, responding to the Working Party's call for evidence.

¹⁷⁸ User of non-invasive cosmetic procedures, cited in Mail Online (27 April 2017) *The disturbing reason so many young women are obsessed with getting a bigger bottom (to the bewilderment of their mums who always wanted a smaller one)*, available at: <http://www.dailymail.co.uk/femail/article-4449368/Why-young-women-want-bigger-bottom.html>.

¹⁷⁹ In a different context, see the Nuffield Council's earlier discussion of the factors underpinning research priorities in children's healthcare, which may at times have little association with levels of demand and need: Nuffield Council on Bioethics (2015) *Children and clinical research: ethical issues*, available at: <http://nuffieldbioethics.org/project/children-research/>. See also: Nuffield Council on Bioethics (2014) *The culture of scientific research in the UK*, available at: http://nuffieldbioethics.org/wp-content/uploads/Nuffield_research_culture_full_report_web.pdf.

procedures. Also of ethical concern is the strength of the evidence base underpinning developments in procedures, and the manner in which that evidence is presented to prospective users.

‘New’ cosmetic procedures

- 3.14 New cosmetic procedures are constantly emerging and being promoted to potential consumers, often through the re-application of techniques initially developed for other purposes. One of the best-known examples of this ‘re-purposing’ is the use of the prescription medicine botulinum toxin, originally developed to control spasticity and muscle tremors in conditions such as Parkinson’s disease, cerebral palsy and multiple sclerosis, for removing facial wrinkles. Another more recent re-purposing is the cosmetic use of Latisse: a prescription medicine that was originally developed for use in glaucoma but which also increases eyelash length.¹⁸⁰ Examples of other procedures that have emerged more recently and been promoted for their cosmetic effect are set out in Box 3.4 below:

Box 3.4: Examples of new and ‘repurposed’ procedures

So-called ‘**vampire facials**’¹⁸¹ use platelet rich plasma (PRP) injections, a technique developed for therapeutic purposes to aid healing, for example for individuals with shoulder pain.¹⁸² Blood is removed from a person’s arm and then spun in a centrifuge to separate out platelets from the blood’s red and white cells: these are then mixed with autologous fat from the person undergoing treatment, or with a synthetic dermal filler, in order to make a product which is injectable. Very small needles are then used to prick the skin (local anaesthetics can be applied beforehand), before the product is applied over a person’s face.¹⁸³ The same technique has been used for **vampire breast lifts**, marketed as providing “younger-appearing skin” and “increased volume of fatty tissue”.¹⁸⁴ Although vampire procedures have received significant press coverage and are widely available, the underpinning clinical evidence for PRP relates primarily to its use for non-cosmetic purposes, and to date has been held by some of the major UK providers of non-surgical treatments to be insufficient to justify offering it in their clinics.¹⁸⁵

‘**Fat freezing**’ (also known as cryolipolysis) is marketed under the brand of CoolSculpting as “the world’s number 1 non-surgical fat-reduction treatment” for the abdomen, sides, inner or outer thighs, upper arms, or double chin.¹⁸⁶ Cryolipolysis is also used alongside other techniques including ultrasound and radio frequency in ‘3D Lipo’ treatments.¹⁸⁷ The CoolSculpting device, classified by the US Food and Drug

¹⁸⁰ RealSelf (2009) *How to get a Latisse prescription*, available at: <https://www.realself.com/question/latisse-prescription>; and Allergan (2014) *Highlights of prescribing information: Latisse*, available at: http://www.allergan.com/assets/pdf/latisse_pi.pdf.

¹⁸¹ The description ‘vampire facial’ is widely used in the UK, while the term ‘Vampire Facelift’ is trademarked in the US, and its website states that only providers listed on the site own the licence to use the name: Vampire Facelift (2013) *Homepage* available at: <http://vampirefacelift.com>.

¹⁸² Wesner M, Defreitas T, Bredy H *et al.* (2016) A pilot study evaluating the effectiveness of platelet-rich plasma therapy for treating degenerative tendinopathies: a randomized control trial with synchronous observational cohort *PLoS one* **11**(2): e0147842.

¹⁸³ See further description in: Kamakura T, Kataoka J, Maeda K *et al.* (2015) Platelet-rich plasma with basic fibroblast growth factor for treatment of wrinkles and depressed areas of the skin *Plastic and Reconstructive Surgery* **136**(5): 931-9.

¹⁸⁴ See: Vampire Breast Lift (2013) *Vampire breast lift homepage*, available at: <http://vampirebreastlift.com>.

¹⁸⁵ Factfinding meeting with Sk:n (9 March 2017); Factfinding meeting with Transform (15 March 2017).

¹⁸⁶ CoolSculpting (2017) *What is CoolSculpting?*, available at: <http://www.coolsculpting.com/what-is-coolsculpting/>. See also: Manstein D, Laubach H, Watanabe K *et al.* (2008) Selective cryolysis: a novel method of non-invasive fat removal *Lasers in Surgery and Medicine* **40**(9): 595-604.

¹⁸⁷ 3D Lipo (2017) *3D Lipo+ information sheet*, available at: <http://www.3d-lipo.co.uk/wp-content/themes/3dlipo/downloads/lipo-plus-info-sheet.pdf>.

Administration (FDA) in 2010 as a “contact cooling device for aesthetic use”, uses a cooling pad in combination with a vacuum or mechanical massager.¹⁸⁸ This disrupts adipocyte (fat) cells which are then frozen, so that they crystallise and die. Over time, it is reported that the body processes and eliminates the dead fat cells.¹⁸⁹ Research on the device suggests that no significant side effects are reported, satisfaction rates are high, and fat measurements are reduced. However, the research also notes that 96 per cent of users reported minimal-to-tolerable discomfort.¹⁹⁰ The levels of discomfort associated with the procedure have also led to some UK providers of cosmetic procedures to decide not to offer the service to their clients.¹⁹¹

Expanding uses of dermal fillers and botox to treat other parts of the body include fillers for feet¹⁹² presented as a cure for pain from high heels,¹⁹³ and for ears to rejuvenate the earlobe,¹⁹⁴ confusingly badged as ‘eartox’.¹⁹⁵ Botox is also being promoted for the scrotum (‘scrotox’) despite lack of evidence as to its effect.¹⁹⁶ Fillers or botox may be offered in combination with other techniques such as radio frequency procedures or ultrasound: for example in a range of leg rejuvenation procedures¹⁹⁷ responding to concerns such as dislike of ‘kninkles’ (knee wrinkles).¹⁹⁸

Developments in production techniques for dental braces, including customised clear aligners marketed as “near-invisible”,¹⁹⁹ have contributed to greater acceptability of cosmetic dentistry amongst adults.²⁰⁰ The availability of these techniques has in turn led to the promotion of short courses of orthodontic treatment, for example those promising straighter teeth in as little as six months.²⁰¹

New products and techniques in development

3.15 Other new developments are yet to reach the commercial cosmetic procedures market, but their potential future role in this area has been discussed in the scientific press. Such

¹⁸⁸ US Food and Drug Administration (15 September 2010) *Re. K080521 evaluation of automatic class III designation: ZELTIQ dermal cooling device*, available at: https://www.accessdata.fda.gov/cdrh_docs/pdf8/K080521.pdf.

¹⁸⁹ CoolSculpting (2017) *How it works*, available at: <http://www.coolsculpting.com/what-is-coolsculpting/how-it-works/>.

¹⁹⁰ Dierickx CC, Mazer J-M, Sand M, Koenig S, and Arigon V (2013) Safety, tolerance, and patient satisfaction with noninvasive cryolipolysis *Dermatologic Surgery* **39(8)**: 1209-16, at page 1211.

¹⁹¹ Factfinding meeting with Sk:n, 9 March 2017.

¹⁹² Google Patents (2012) *Injectable filler for podiatric and orthopedic uses: US 20120207792 A1*, available at: <https://www.google.com/patents/US20120207792>.

¹⁹³ Mail Online (23 April 2017) *Nip and tuck with Dr Tracy Mountford: is there a way to make high heels less painful?*, available at: <http://www.dailymail.co.uk/femail/article-4437790/Nip-Tuck-Dr-Tracy-Mountford.html>.

¹⁹⁴ Geraghty L (2018) Earlobe rejuvenation, in *Soft tissue augmentation: procedures in cosmetic dermatology series - fourth edition*, Carruthers J, and Carruthers A (Editors) (E-published: printed version forthcoming), pp169-73.

¹⁹⁵ The Telegraph (4 October 2016) *Eartox is the latest cosmetic procedure to experience a surge - so do your ears need attention?*, available at: <http://www.telegraph.co.uk/beauty/skin/eartox-is-the-latest-cosmetic-procedure-to-experience-a-surge/>.

¹⁹⁶ The Independent (30 November 2016) *Scrotox: yes, men are actually botoxing their testicles*, available at: <http://www.independent.co.uk/life-style/scrotox-botox-men-testicles-scrotum-a7447871.html>.

¹⁹⁷ See, for example, Weiss M, Mahoney AM, Gold M, and Lawrence N (2016) Leg rejuvenation: a combination approach: a review and our experience *Dermatologic Surgery* **42**: S131-S8.

¹⁹⁸ Mail Online (17 April 2017) *The £4,000 knee rejuvenator: operation that cures saggy skin becomes the most sought after procedure in Hollywood*, available at: <http://www.dailymail.co.uk/femail/article-4419708/The-4-000-knee-rejuvenator.html>.

¹⁹⁹ Invisalign (2016) *What is Invisalign?*, available at: <http://www.invisalign.co.uk/en/what-is-invisalign/Pages/What-Is.aspx>.

²⁰⁰ A YouGov report commissioned by Oasis Dental Care indicates, for example, that “interest in treatments such as whitening and adult orthodontics is increasing”: YouGov / Oasis Dental Care (2015) *National dental health report: understanding patients' perspective of dentistry in the UK*, available at: <https://www.oasisdentalcare.co.uk/media/2380/annual-dental-report-oasis-dental-care.pdf>.

²⁰¹ Factfinding meeting with the General Dental Council, 12 October 2016. See also: British Orthodontic Society (2011) *Unconfirmed minutes of a meeting of the board of trustees of the British Orthodontic Society held on Saturday 24 September 2011*, available at: <http://www.bos.org.uk/LinkClick.aspx?fileticket=gVP2DqiZu6Y%3D&portalid=0>, at page 2.

developments include both potential cosmetic applications of new products, such as innovative lasers, and new techniques and supporting technologies, such as 3D printing and machine learning, being applied to the field of cosmetic procedures (see Box 3.5).

Box 3.5: New products, techniques and supporting technologies

Picosecond lasers are a new group of lasers which deliver laser energy in picoseconds (one trillionth of a second). Devices which use picosecond lasers can be used for acne scars, pigmented lesions, and to remove tattoos.²⁰² Recent research has also explored the use of picosecond lasers for skin rejuvenation treatments.²⁰³

3D printing – also known as additive manufacturing – is a technology that builds up multiple layers of material and links each layer together to create a 3D object. Potential medical uses include recent success in fabricating “stable, human-scale tissue constructs of any shape” including ears.²⁰⁴ Potential cosmetic uses include building replacement teeth,²⁰⁵ and producing bespoke breast implants for their intended recipient.²⁰⁶ It has also been suggested that 3D printing could be used to model what the outcome of a procedure might look like, thus enabling prospective patients to make more informed choices.²⁰⁷

Machine learning is a sub-field of artificial intelligence in which a computer can ‘learn’ how to do complex tasks itself. Potential applications in cosmetic surgery include ‘training’ an automated classifier for facial beauty (using extracted facial features from female faces deemed attractive by human referees). It is suggested that this application could serve as a predictive tool for estimating users’ perceived beauty following cosmetic surgery, again improving the information about likely outcomes to users in advance of a procedure. The same study noted that “in conjunction with optical head-mounted display technology, machine learning also has the potential to facilitate intraoperative visualization of surgical outcomes [...] optimizing aesthetic results while minimizing trauma and operating time.”²⁰⁸

‘Lunch hour’ procedures and home-based use

3.16 As indicated earlier in our review of the available data on cosmetic procedure use (see Box 3.1 and paragraph 3.9), the cosmetic procedures market is increasingly being dominated by non-surgical (but nevertheless invasive) procedures, often marketed as ‘quick and safe’ alternatives to surgery. The term ‘tweakments’ is becoming popular²⁰⁹ to

²⁰² See, for example, the product overview listed by Cynosure (2017) *PicoSure*, available at: <http://www.cynosure.com/product/picosure/>. Cynosure holds a patent for picosecond laser device: Google Patents (2013) *Picosecond laser apparatus and methods for treating target tissues with same: WO 2013158299*, available at: <https://www.google.co.uk/patents/WO2013158299A1>.

²⁰³ Weiss RA, McDaniel DH, Weiss MA *et al.* (2017) Safety and efficacy of a novel diffractive lens array using a picosecond 755 nm alexandrite laser for treatment of wrinkles *Lasers in Surgery and Medicine* **49(1)**: 40-4.

²⁰⁴ Kang H-W, Lee SJ, Ko IK *et al.* (2016) A 3D bioprinting system to produce human-scale tissue constructs with structural integrity *Nature Biotechnology* **34(3)**: 312-9.

²⁰⁵ See, for example, The Guardian (31 October 2015) *The latest advance in 3D printing: replacement teeth*, available at: <https://www.theguardian.com/technology/2015/oct/31/3d-printing-plastic-replacement-teeth>.

²⁰⁶ International Business Times (22 May 2015) *Fripp Design pioneers 3D printed silicone breast implants that fit perfectly and won't droop*, available at: <http://www.ibtimes.co.uk/fripp-design-pioneers-3d-printed-silicone-breast-implants-that-fit-perfectly-wont-droop-1502588>.

²⁰⁷ Quartz (13 June 2015) *See what you'll look like after plastic surgery with a 3D-printed bust of your head*, available at: <http://qz.com/427157/see-what-youll-look-like-after-plastic-surgery-with-a-3d-printed-bust-of-your-head/>.

²⁰⁸ Kanevsky J, Corban J, Gaster R *et al.* (2016) Big data and machine learning in plastic surgery: a new frontier in surgical innovation *Plastic and Reconstructive Surgery* **137(5)**: 890e-7e, at page 895e.

²⁰⁹ See, for example, #tweakments on Twitter, and headlines such as The Telegraph (3 December 2016) *The teeth-tweakments that will make you look instantly younger*, available at: <http://www.telegraph.co.uk/beauty/face/teeth-tweakments-will-make-look-instantly-younger/>.

describe procedures that can be provided in a short timeframe (for example over a lunch-hour) with little if any recovery time, and which seek to make subtle rather than bold changes to appearance (see Box 3.6 below). Many of these, when carried out in appropriate surroundings and by qualified practitioners, will have lower physical risks than traditional surgical procedures (see Chapter 6 for further discussion of the evidence on risks of physical harm). However, the use of such terminology, and the implied equivalence with non-invasive beauty procedures that 'tweak' appearance, has the potential to encourage users to downplay the physical risks that may still be involved.

Box 3.6: Examples of procedures marketed as alternatives to surgery

In addition to the relatively long-established use of botox and dermal fillers for lines and wrinkles in the face, and more recent applications elsewhere in the body (see Box 3.4), the use of dermal fillers may be marketed specifically as an alternative to major surgical procedures, as for example in the 'non-surgical nose job',²¹⁰ while 'thread lifts' (threads or sutures inserted in the skin under local anaesthetic) are promoted as 'non-surgical facelifts'.²¹¹ Developments in the way that existing treatments can be delivered, such as new injection devices designed to reduce the degree of pain and bruising,²¹² may also lower the threshold for prospective users to consider a treatment.

- 3.17 In parallel with the growth in interest in quicker, cheaper and less-invasive alternatives to surgical procedures, the possibility of purchasing products over the internet without the need for intermediaries (including where this entails circumventing regulatory controls over the supply of particular products), has rendered home use of procedures that would traditionally have been administered in a clinic more feasible. Concerns have been expressed about the dangers of self-injecting botox or fillers,²¹³ and injectable skin-bleaching products such as IV glutathione also appear to be readily available over the internet for home use,²¹⁴ despite concerns about the safety of such products in any setting.²¹⁵ Similarly, while it is not unlawful for groups of friends to have cosmetic injections at home ('botox parties') as long as prescribing requirements are met (see paragraph 4.10), the British Association of Cosmetic Nurses (BACN) has argued that the home is not an appropriate location for such treatments.²¹⁶

Commercial competition between manufacturers

"... prices for cosmetic procedures are generally getting lower as the market is competitive."²¹⁷

²¹⁰ See, for example, Real Self, (2017) *Non-surgical nose job*, available at: <https://www.realself.com/Non-surgical-nose-job/reviews>.

²¹¹ Garvey PB, Ricciardelli EJ, and Gampper T (2009) Outcomes in threadlift for facial rejuvenation *Annals of Plastic Surgery* **62(5)**: 482-5.

²¹² See, for example, Juvapen (2017) *Toxin made simple*, available at: <http://toxinmadesimple.com/>.

²¹³ Safety in Beauty (7 May 2016) *Why self injecting fillers and botox is dangerous*, available at: <http://safetyinbeauty.com/self-injecting-fillers-and-botox-is-dangerous/>.

²¹⁴ See, for example, [skinwhiteninginjections.com](http://www.skinwhiteninginjections.com/) (2017) *Homepage*, available at: <http://www.skinwhiteninginjections.com/>.

²¹⁵ Dadzie OE (2016) Unethical skin bleaching with glutathione *BMJ* **354**.

²¹⁶ Aesthetics (1 February 2016) *The last word: botox parties*, available at: <https://aestheticsjournal.com/feature/the-last-word>.

²¹⁷ Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester, responding to the Working Party's call for evidence.

“Cosmetic surgery is now a profitable niche market of a globalised private medical industry.”²¹⁸

- 3.18 Where cosmetic procedures prove popular, there are clearly commercial reasons why a range of manufacturers will be interested in supplying the products required for those procedures. Manufacturers do not simply respond passively to market demand for cheaper or more innovative products, but actively compete to obtain market share, promoting their products to practitioners and clinics, for example through major trade shows and business-to-business media.²¹⁹ This creates a ‘loop back’ effect, as manufacturers seek to meet consumer and professional demand, and then in turn create more demand as they market more products in competition with one another. Dermal fillers and breast implants provide two examples of where the popularity of particular procedures, and the associated potential for financial gain for those supplying the required products, has led both to strong commercial competition between manufacturers, and subsequently to concerns about quality and safety.
- 3.19 At the time of writing, 27 dermal filler products are licensed by the FDA for use in the US, although not all of these are currently marketed.²²⁰ In the EU and UK, in contrast, dermal fillers used for cosmetic purposes are currently almost entirely unregulated (see paragraph 4.33). The Working Party was told that, as a result of this unregulated approach, there are currently over 160 dermal fillers available in the UK, with new and unproven products constantly entering the market.²²¹ While the composition of many of these products may be broadly the same as those approved by the FDA in the US on the basis of controlled clinical studies, concerns were expressed to the Working Party that some may contain novel ingredients, be ‘cross-linked’ to create a more permanent effect, or be products previously withdrawn from the market and then relaunched under a new name. Users may be unaware of the specific product used in their treatment, and many do not know that only those products licensed by the FDA have necessarily been tested for safety and effectiveness through controlled clinical studies.²²² In the context of the risks associated with the use of dermal fillers (see paragraph 6.12), this competitive manufacturing environment is a matter of concern. Provider websites promoting the availability of dermal fillers rarely make reference to risks inherent in their use, other than to note the possibility of passing redness, swelling, or tenderness.
- 3.20 In contrast to low levels of public awareness about risks associated with dermal filler use, the dangers involved when manufacturers seek to cut costs in the production of breast implants received extensive publicity as a result of the fraudulent behaviour of one

²¹⁸ *ibid.*

²¹⁹ See, for example, easyfairs.com (2017) *CCR Expo: why exhibit*, available at: <http://www.easyfairs.com/ccr-expo-2017/ccr-expo-2017/exhibiting/exhibiting/#c1111266>, where exhibitors are encouraged to “place your products in front of thousands of buyers from across the whole spectrum of aesthetic medicine”. See also: Nuffield Council on Bioethics (10 May 2017) *Blog: beauty and the business*, available at: <http://nuffieldbioethics.org/blog/beauty-business>.

²²⁰ US Food and Drug Administration (2017) *Soft tissue fillers approved by the Center for Devices and Radiological Health*, available at: www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/CosmeticDevices/WrinkleFillers/ucm227749.htm.

²²¹ Factfinding meeting with Mr Niall Kirkpatrick, 6 May 2016. See also: Funt D, and Pavicic T (2013) Dermal fillers in aesthetics: an overview of adverse events and treatment approaches *Clinical, Cosmetic and Investigational Dermatology* 6: 295-316.

²²² Factfinding meeting with Mr Niall Kirkpatrick, 6 May 2016. Similar concerns were raised in 2012 by BAAPS in a survey of surgeons’ experience of treating complications from fillers: respondents highlighted particular concerns about the use of unproven materials, application by unqualified practitioners, and patients’ lack of awareness of the risks: British Association of Aesthetic Plastic Surgeons (24 November 2012) *Two out of three surgeons seeing botched filler ops* (London: British Association of Aesthetic Plastic Surgeons). For further information on the FDA’s approach to controlled clinical studies for fillers, see: US Food and Drug Administration (2017) *Soft tissue fillers approved by the Center for Devices and Radiological Health*, available at: www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/CosmeticDevices/WrinkleFillers/ucm227749.htm. See paragraph 4.33 below for the limited circumstances in which medical devices in the EU are classified as medicines or medical devices.

French manufacturer, Poly Implant Prothèse (PIP). In 2010, it emerged that PIP had cut costs by using substandard (industrial grade) silicone gel in its breast implants, leading to both much greater risk of rupture, and significant anxiety and distress for victims of the fraud who remain fearful of consequential health effects.²²³ PIP itself went bankrupt, while the German company TUV Rheinland (that had awarded EU safety certificates for the implants) was initially ordered by a French court in 2013 to pay compensation to women affected, in recognition of its own failings.²²⁴ Litigation concerning the liability of the various parties in the PIP fraud is still ongoing seven years after the fraud was publicly acknowledged.²²⁵

- 3.21 By comparison with the crowded market in dermal fillers, the Working Party was told that the number of manufacturers of breast implants is relatively small, with around ten currently supplying CE-marked implants (see paragraph 4.34) in the EU and UK.²²⁶ Competition between manufacturers relates not simply to price per implant (since variations in list price may be less significant than the discounts achieved by those purchasing in bulk) but also to technological innovation. There is a longstanding history of concerns about complications associated with various forms of breast implant (see paragraph 6.11), and considerable technological effort is devoted to developing new materials and techniques with lower complication rates. However, concerns were expressed to the Working Party that, under current regulatory requirements in the EU and UK, the evidence underpinning such new innovation is often based on limited studies, small numbers of patients, and only short-term follow-up.²²⁷ In contrast, in the US, the FDA requires five- and ten-year follow-up data for breast implants, thus incorporating monitoring and reporting requirements into the licensing system.

Other stakeholders

- 3.22 Given that the majority of cosmetic surgeries are delivered through private health care facilities, and that there is a substantial overlap between non-surgical cosmetic procedures and other parts of the beauty industry, there are numerous other and less obvious stakeholders who play a significant role in the provision and promotion of cosmetic procedures, alongside developers, manufacturers, providers, and practitioners. These include:

- Individuals or companies who provide financial backing for providers;
- Those concerned in marketing and advertising products, procedures or practitioners, from advertising agencies working directly for providers, to journalists, bloggers, and celebrities who review and comment on procedures in print or online;
- Those acting in a variety of ways as agents or mediators between suppliers / providers and users, such as the emerging consumer websites listing recommended practitioners; agencies specialising in facilitating travel for treatment abroad; and companies or websites providing direct access to online products; and
- Insurance companies who offer insurance products to practitioners and indemnify their practice.

²²³ NHS Choices (2016) *PIP breast implants*, available at: <http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx>; PIP Action Campaign (2016) *About us*, available at: <http://pipactioncampaign.org/sample-page-2/>.

²²⁴ BBC News (14 November 2013) *PIP implant scandal: German firm ordered to pay damages*, available at: <http://www.bbc.co.uk/news/world-europe-24936958>.

²²⁵ Lexology (28 March 2017) *Notified bodies potentially liable to end users of medical devices rules CJEU*, available at: <http://www.lexology.com/library/detail.aspx?g=d9ba78ea-f90b-4b52-bc62-3b9fae6e169d&>.

²²⁶ Factfinding meeting with Peter Cranstone, 6 December 2016.

²²⁷ *ibid.*

- Legal practitioners in various roles, from advising on business practice and contracts, to supporting users in seeking redress if things go wrong
- Professional bodies and regulators, who set standards across the sector
- Organisations and individuals who provide training to practitioners on delivering procedures and the use of particular products.

In turn, the relationships and interactions between these many stakeholders play an important role in how the industry develops and reaches out to its potential users. In addition, for example, to the ‘public’ marketing of procedures through advertising direct to potential users, a parallel industry of promotional activity exists between manufacturers, providers, and practitioners, through trade shows, the trade press, and in professional meetings where clinicians may endorse particular products to their peers.²²⁸

Models of business practice

3.23 We have already noted that an important feature of the cosmetic procedures industry is that the vast majority of procedures are provided within the private, rather than the public health sector. However, the ‘private’ sector itself includes significant diversity of business models, which contribute to the complex and fragmented nature of the business. Cosmetic procedures may be provided in a wide range of premises, by many different kinds of practitioners, and under diverse commercial and contractual arrangements. These include:

- **Self-employed health professionals**, who provide cosmetic procedures to private patients on an individual basis, often as a complement to their work in the NHS, for example as a hospital doctor, GP, dentist or nurse. Where they need access to hospital premises (for example when offering surgery), they may have ‘admitting privileges’ in particular NHS or private hospitals, that enable them to use these hospitals’ facilities. Sometimes a number of such practitioners may work together in partnership.
- **Private hospitals or clinics** (either stand-alone or owned as part of a chain) that offer cosmetic procedures alongside a range of other procedures. While nursing and other staff will generally be employed directly by the hospital, doctors tend to be self-employed, and contract with the company to provide medical services. Some ‘private’ hospitals are, in fact, not-for-profit organisations.
- **Large commercial ‘group’ providers** who specialise in cosmetic procedures, rather than offering these alongside medical services. Some groups offer only non-surgical procedures (for example through a chain of clinics), while others offer both non-surgical and surgical procedures. While groups usually own and run the hospitals where they provide surgical services, this is not invariably the case: they may run their own clinics, but contract with other hospitals for in-patient services, ‘booking’ operating space and beds as required. Employment models in these group providers tend to be similar to those in private hospitals: medical staff are self-employed, and contract to treat a certain number of patients or provide a certain number of sessions, while nursing and other staff are directly employed.
- **Beauty salons, spas and gyms, and many other parts of the beauty and ‘wellness’ sector** appear to be an increasingly significant supplier of non-surgical

²²⁸ See, for example, Nuffield Council on Bioethics (10 May 2017) *Blog: beauty and the business*, available at: <http://nuffieldbioethics.org/blog/beauty-business>.

procedures, although, as described earlier, there are no published data on precise numbers of procedures. Providers of cosmetic procedures in this sector vary from single practitioners in stand-alone beauty parlours to chains of salons; practitioners may be self-employed or employed, and may come from a variety of professional backgrounds.

- 3.24 The complex and fragmented nature of the industry itself helps explain some of the difficulties highlighted at the start of this chapter in obtaining comprehensive and authoritative data even with respect to how many procedures are performed, let alone with respect to the characteristics (such as age) of those using procedures, or to changing demand for different types of procedure. It also highlights some of the regulatory challenges in the sector, an issue to which we now turn in Chapter 4.

Chapter 4

Current regulation of
cosmetic procedures

Chapter 4 – Current regulation of cosmetic procedures

Chapter 4: overview

The complex network of stakeholders engaged in the production, provision and marketing of cosmetic products and procedures is governed by a patchwork of regulatory measures, in which a series of reports in the last decade has identified significant gaps and flaws. Action in response to the 2013 Keogh report has remedied some, but not all, of these. There are ongoing challenges of enforcement, and limited means of redress for adverse outcomes, unless negligence can be demonstrated.

- **Controls on practitioners:** There are few statutory limits on who may provide cosmetic procedures. In particular, there are no controls on who may provide non-surgical procedures, other than limitations on access to prescription medicines, and on procedures in the mouth. Professional regulation therefore plays an important role. Developments since the Keogh report include updated guidance for doctors by both the General Medical Council (GMC) and the Royal College of Surgeons (RCS); a voluntary certification scheme for surgeons working in the cosmetic sector; and progress in establishing a voluntary register of practitioners who meet required standards to perform non-surgical procedures.
- **Controls over premises:** The Care Quality Commission (CQC) regulates private clinics and hospitals in England that provide cosmetic surgery, but not those that provide only non-surgical procedures. The CQC's remit extends to how clinics are run (for example with respect to recruitment, record-keeping and equipment), but not to direct measures of the quality of care provided.
- **Controls over products:** Devices and equipment marketed for non-medical purposes, such as many dermal fillers and implants, have historically been excluded from regulation within the EU but will be included from May 2020 under the Medical Devices Regulation 2017. How they will be regulated in the UK after Brexit, and what assessment criteria will be used in either the UK or EU member states, is unknown.
- **Limits on access to procedures:** There are no statutory controls over access to cosmetic procedures by young people, although statutory minimum age-limits of 18 apply for other appearance-related procedures such as tattoos and sunbed use. There is legal uncertainty as to the extent to which some of the procedures marketed as female genital cosmetic surgery may be prohibited by the Female Genital Mutilation Act 2003.
- **Advertising and marketing** is subject to self-regulation by the Advertising Standards Authority (ASA) and the Committee of Advertising Practice (CAP) which require marketing communications to be “legal, decent, honest and truthful”, and “prepared with a sense of responsibility to consumers and to society”. The ASA's remit extends to commercial advertising online and in social media, but does not cover unsolicited endorsements in tweets or blogs or to images shared by social media users.
- The **Equality Act 2010** prohibits discrimination on the grounds of “protected characteristics” such as age, gender and disability (including severe disfigurement). Appearance-related discrimination could fall under the Act if it were related to a protected characteristic.

Introduction

- 4.1 The provision of cosmetic procedures in the UK is currently regulated through a patchwork of requirements, relating to the roles and responsibilities of individual practitioners, the products used in cosmetic procedures, and the premises on which procedures are provided.²²⁹ A series of official reports over the past decade, including the 2005 Cayton review,²³⁰ the 2010 report of the National Confidential Enquiry into Patient Outcome and Death,²³¹ the 2012 expert group report on PIP implants,²³² and the 2013 Keogh report,²³³ have highlighted significant gaps and flaws in these regulatory frameworks, prompting a number of professional and governmental initiatives in response.
- 4.2 This chapter outlines the current regulatory position, including developments emerging as a result of the 2013 Keogh report, together with other relevant areas of regulation such as those relating to advertising and the promotion of particular appearance ideals. It goes on to identify areas where significant regulatory questions appear to remain, including the question of the extent to which current regulatory approaches are suited to the highly commercial nature of the cosmetic procedures industry, the way in which these procedures are marketed more as consumer goods than as invasive procedures, with associated risks, and the complex network of relationships between those involved in the industry, as described in the previous chapter.

Who can provide cosmetic procedures?

- 4.3 There are relatively few statutory limits on who is permitted to offer cosmetic procedures. It is an offence for a person to imply that they are a registered medical practitioner if they are not (for example by taking the title of physician, doctor of medicine, or licentiate in medicine and surgery, without the necessary qualifications and registration),²³⁴ but there is no legally defined set of activities constituting ‘the practice of medicine’ that may only be performed by a doctor. Concern has been expressed that there is therefore nothing to prevent a person without appropriate qualifications treating patients under the title of, for example, ‘aesthetic surgeon’.²³⁵ In contrast, any procedures within the mouth are held to constitute the practice of dentistry and may only be carried out by registered dental professionals.²³⁶

²²⁹ For a critical review, see: Latham M (2008) The shape of things to come: feminism, regulation and cosmetic surgery *Medical Law Review* **16**(3): 437-57.

²³⁰ 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.

²³¹ 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/2010report2/downloads/CS_report.pdf.

²³² 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>.

²³³ 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>.

²³⁴ See section 49 of the Medical Act 1983.

²³⁵ British Association of Aesthetic Plastic Surgeons (15 July 2012) *A surgeon by any other name would (not) cut as sweet* (London: British Association of Aesthetic Plastic Surgeons). See also: BBC News (15 July 2012) *Surgeons ‘seek to protect title’*, available at: <http://www.bbc.co.uk/news/health-18828208>.

²³⁶ General Dental Council (2016) *Focus on standards: the 9 principles*, available at: <http://standards.gdc-uk.org/pages/principle1/faq.aspx>. See also: sections 37 and 38 of the Dentists Act 1984.

- 4.4 Prescription medicines such as botulinum toxin (botox) may only be prescribed by doctors, dentists, and other health professionals who have qualified to become independent prescribers.²³⁷ However, there are no specific statutory controls over who can *administer* botox, and its prescription-only status can be circumvented through direct purchase over the internet.²³⁸ Similarly, there are currently no legal restrictions with respect to the skills or qualifications required for practitioners offering procedures such as dermal fillers, cosmetic peels, micro-needling, and treatments using laser, intense pulsed light (IPL) and light-emitting diodes (for discretionary powers over the use of lasers, see paragraph 4.28). These and other non-surgical cosmetic procedures may therefore be offered by health professionals, such as doctors, dentists and nurses, by non-health professionals such as beauty therapists, and indeed by anyone else who wishes to do so.²³⁹

Governance of non-surgical procedures through professional regulation

“... there is a need for regulation to ensure that professionals are suitably qualified and provide sufficient counselling and guidance for patients as to the risks and psychological impact of procedures.”²⁴⁰

- 4.5 In the absence of specific statutory requirements with respect to the skills or qualifications required to offer a range of non-surgical cosmetic procedures, professional regulation plays an important governance role. Health professionals are subject to regulation by the relevant regulatory body, such as the General Medical Council (GMC), the General Dental Council (GDC), the Nursing and Midwifery Council (NMC), and the Health and Care Professions Council (HCPC): registration with the appropriate body, and ongoing compliance with its requirements, is necessary in order to be permitted to practise one’s profession. Professional regulatory regimes within the health sector include the general requirement to recognise and act within one’s competence, and to observe professional codes of practice and ethics.²⁴¹ Thus, while there are no statutory requirements to have developed particular skills, or obtained particular qualifications, in order to offer non-surgical cosmetic procedures, action for misconduct could potentially be taken by the relevant regulatory body if a health professional offered services that they were not competent to perform.
- 4.6 In the light of the 2013 Keogh report, the GMC published updated guidance to doctors on cosmetic procedures in 2016, after a public consultation on its content. The guidance

²³⁷ Section 58, Medicines Act 1968.

²³⁸ See, for example, Beauty Treatment Expert (10 June 2013) *DIY Botox kits: how safe are they?*, available at: <http://www.beautytreatmentexpert.co.uk/diy-botox-kits-how-safe-are-they.html>. While both the MHRA and the CQC exercise a regulatory role with respect to online pharmacies (see, for example, Care Quality Commission (3 March 2017) *Care Quality Commission advises people to take care when using online primary care services*, available at: <http://www.cqc.org.uk/content/care-quality-commission-advises-people-take-care-when-using-online-primary-care-services>), the global reach of internet services makes effective policing of such online purchases very difficult. See also: The Independent (11 March 2017) *UK medicines regulatory says it is ‘completely impossible’ to control illegal online pharmacies*, available at: <http://www.independent.co.uk/life-style/health-and-families/health-news/uk-medicines-regulator-mhra-completely-impossible-illegal-online-pharmacies-antibiotic-resistance-a7623546.html>.

²³⁹ 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 page 14.

²⁴⁰ Respondent to the Working Party’s online questionnaire.

²⁴¹ See, for example, General Medical Council (2013) *Good medical practice*, available at: http://www.gmc-uk.org/static/documents/content/GMP_.pdf; General Dental Council (2013) *Standards for the dental team*, available at: <https://www.gdc-uk.org/professionals/standards/team>; and Nursing & Midwifery Council (2015) *The code: professional standards of practice and behaviour for nurses and midwives*, available at: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>.

covers both non-surgical and surgical procedures (see also paragraphs 4.11–4.15 regarding the governance of surgery). The GMC’s website notes that “In some cases, [this guidance] sets a higher standard than in our other guidance to address the specific safety issues and ethical concerns particular to the cosmetic sector,”²⁴² and makes clear to doctors that “serious or persistent failure to follow this guidance will put your registration at risk”.²⁴³ Key points covered by the guidance are set out in Box 4.1 below.

Box 4.1: GMC Guidance for doctors who offer cosmetic interventions

Doctors offering cosmetic interventions must:

- recognise and work within the limits of their competence, seeking advice when necessary;
- discuss with their patient what they hope to achieve by having the intervention, and not provide treatment that they believe will not be of overall benefit to the patient;
- make sure patients have the information they want or need, including clear accurate information about side effects, complications and other risks, together with written information after the procedure to ensure that other doctors, if necessary, could take over their care, including relevant information about the medicines or devices used;
- make sure patients are given enough time before they decide whether to have an intervention;
- consider patients’ psychological needs and whether referral to another experienced professional colleague is appropriate;
- tell prospective patients if alternative interventions are available that could meet their needs with less risk, including from other practitioners;
- seek patients’ consent to the procedure themselves rather than delegate;
- take particular care when considering requests for interventions on children and young people; and
- explain charges clearly, and market their services responsibly, without making unjustifiable claims about interventions, trivialising the risks involved, or using promotional tactics that might encourage people to make ill-considered decisions.²⁴⁴

In addition to these requirements relating to the doctor / patient relationship and decision-making around specific interventions, the guidance makes clear doctors’ wider responsibilities to monitor patient outcomes and share insights and concerns with colleagues, contribute to national programmes monitoring quality, and ensure any safety concerns are reported to the relevant regulator.

To support the implementation of the guidance, the GMC has also published on its website ‘guidance in practice’ case studies for doctors, and information for patients, setting out “some things to consider, questions you may want to ask, and... giv[ing] you an idea of what to expect from your doctor”.²⁴⁵ Further work is planned, exploring how

²⁴² General Medical Council (2016) *Homepage: guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/guidance/ethical_guidance/28687.asp.

²⁴³ General Medical Council (2016) *Guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf, at page 2.

²⁴⁴ *ibid.*

²⁴⁵ See resources available at: General Medical Council (2016) *Homepage: guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/guidance/ethical_guidance/28687.asp.

best to encourage implementation and evaluate how effective the guidance has been in improving practice.²⁴⁶

- 4.7 Given the role of the GMC, its guidance is necessarily limited to doctors, and hence cannot be binding on non-medical professionals. This limits its effectiveness where non-medical professionals (for example clinic owners or managers who are not also doctors) are responsible for the overall running of a clinic, and practices such as marketing. The guidance does, however, address the role of managers who are also doctors, by specifically referring doctors to its broader guidance on leadership and management for doctors.²⁴⁷ In particular, doctors are reminded of their responsibilities to make sure systems are in place to give early warning of any patient safety concerns, and that the colleagues for whom they are responsible are appropriately supported and developed.²⁴⁸
- 4.8 Other than with respect to prescribing (see below), there is no equivalent guidance on cosmetic practice issued by the other health regulators.

Guidance on prescribing

“it is essential that only registered doctors, dentists and independent nurse prescribers should be permitted to administer cosmetic agents that are delivered by injection... and then only those who have undergone structured and assessed training which is accredited by an established professional body... and who also have professional indemnity insurance cover which specifically covers the procedure.”²⁴⁹

- 4.9 Regulatory bodies also issue general guidance on the responsibilities that accompany the entitlement to prescribe: in particular that prescribers retain responsibility for their decisions to delegate administration of the prescribed substance.²⁵⁰ Thus, although there is no statutory requirement with respect to the expertise required for practitioners injecting substances such as botox, the doctor, dentist, or other health professional prescribing it, retains professional accountability for its safe administration.
- 4.10 Both the GMC and the GDC set out very clearly that doctors and dentists are expected to take this responsibility seriously. The 2016 GMC guidance states that “you must carry out a physical examination of patients before prescribing injectable cosmetic medicines. You must not therefore prescribe these medicines by telephone, video link, online or at the request of others for patients you have not examined.”²⁵¹ The GDC similarly states that “dentists must not remote prescribe (for example via telephone, email, or a website) for non-surgical cosmetic procedures such as the prescription or administration of Botox

²⁴⁶ mytenders.org (2016) *General Medical Council: design, deliver and evaluate a new partnership model for implementing cosmetic practice guidance*, available at: http://www.mytenders.org/search/show/search_view.aspx?ID=OCT133671; and Factfinding meeting on regulatory and governance perspectives (15 April 2016).

²⁴⁷ General Medical Council (2012) *Leadership and management for all doctors*, available at: http://www.gmc-uk.org/guidance/ethical_guidance/management_for_doctors.asp.

²⁴⁸ General Medical Council (2016) *Guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf, at page 15.

²⁴⁹ Faculty of General Dental Practice, UK, responding to the Working Party's call for evidence.

²⁵⁰ See, for example, Nursing & Midwifery Council (2006) *Standards of proficiency for nurse and midwife prescribers*, available at: <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-proficiency-nurse-and-midwife-prescribers.pdf>, practice standard 14; and General Medical Council (2013) *Good practice in prescribing and managing medicines and devices*, available at: http://www.gmc-uk.org/static/documents/content/Prescribing_guidance.pdf, at paragraph 13.

²⁵¹ General Medical Council (2016) *Guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf, at paragraph 11.

or injectable cosmetic medicinal products”.²⁵² Thus while there are frequent reports of unsupervised access to botox, for example through ‘botox parties’ conducted without a prescriber present, such access falls clearly outside responsible professional conduct as established by the relevant regulatory bodies.²⁵³ We discuss later in this chapter the challenges of enforcement of professional and other forms of regulation (see paragraph 4.63).

The role of professional regulation: governance of surgery

- 4.11 Within the system of self-governance of the medical profession, each area of medical practice is subject to professional oversight by the relevant Royal College.²⁵⁴ Most surgical procedures come within the remit of the Surgical Royal Colleges of the UK and Ireland,²⁵⁵ although female genital surgery falls under the remit of the Royal College of Obstetricians and Gynaecologists (RCOG), and some GPs may also develop a ‘special interest’ in minor surgical procedures.²⁵⁶ Moreover, surgery is not considered a single area of specialist practice, but is divided into a number of distinct surgical specialties which are overseen separately.
- 4.12 ‘Cosmetic surgery’ is not a single surgical specialty, but may be practised by surgeons from a number of specialties, including general surgery, plastic (reconstructive) surgery, oral and maxillofacial surgery, and otolaryngology (ear, nose and throat) surgery. As a result, there has historically been nothing to prevent surgeons in the private sector from undertaking cosmetic procedures that fall outside their own direct area of surgical expertise. There has also been a lack of national training programmes and clear practice standards for those wishing to specialise in cosmetic surgery, since the educational and supervisory role of the surgical Royal Colleges is primarily exercised through recognised specialties. As noted above (see paragraph 4.3), there is also nothing in law to prevent other practitioners providing surgery too, as long as they do not imply that they are registered medical practitioners.
- 4.13 The Keogh report identified how this situation had contributed to a lack of professional oversight of cosmetic surgeons, and recommended that the Royal College of Surgeons (RCS) should establish a “Cosmetic Surgery Interspecialty Committee” (CSIC) to set standards across surgical specialties for training and practice of cosmetic surgery. Once such standards were in place, it would then be possible to make arrangements for certification, so that prospective patients could be confident that a surgeon offering particular cosmetic procedures was indeed competent to do so.²⁵⁷ Keogh also identified a role for the GMC, recommending that only surgeons listed on the GMC’s Specialist Register should be permitted to offer cosmetic surgery, and then only for those procedures that fall within the scope of their specialty-specific training.²⁵⁸ Further recommendations included the establishment of an audit database, and the development

²⁵² General Dental Council (2013) *Guidance on prescribing medicines* (London: General Dental Council).

²⁵³ See, for example, Lexology (27 March 2017) *Nurse who faked botox prescriptions struck off for putting lives at risk*, available at: <http://www.lexology.com/library/detail.aspx?g=85885cad-96e1-4ad9-87a1-d20b603d0453>.

²⁵⁴ For information about the medical and surgical Royal Colleges in the four nations of the UK, see: Academy of Medical Royal Colleges (2017) *Academy members*, available at: <http://www.aomrc.org.uk/about-us/academy-members/>.

²⁵⁵ The Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, and the Royal College of Surgeons in Ireland.

²⁵⁶ See, for example, the minor surgery training courses offered by: Royal College of General Practitioners (2017) *Minor surgery courses*, available at: <http://www.rcgp.org.uk/learning/minor-surgery-courses.aspx>.

²⁵⁷ 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>, recommendation 1.

²⁵⁸ *ibid.*, recommendation 2.

of outcome measures for cosmetic surgery to be published at both surgeon and provider level on the NHS Choices website.²⁵⁹ Developments since the Keogh report by the Royal College of Surgeons are summarised in Box 4.2 below:

Box 4.2: Response by the Royal College of Surgeons to the Keogh report

- Establishment of a time-limited Cosmetic Surgery Interspecialty Committee (CSIC) with partner organisations concerned with cosmetic practice and healthcare standards. CSIC's terms of reference covered training and practice standards, inspection models, the development of outcome measures and audit databases, and the development of standardised patient information.²⁶⁰ CSIC has now been stood down.
- Publication of updated (2016) *Professional standards for cosmetic surgery*,²⁶¹ adding additional guidance for surgeons to that provided by the GMC's 2016 *Guidance for doctors who offer cosmetic interventions* (see Box 4.1).
- Launch (January 2017) of a voluntary 'certification' system, which aims to enable patients to check that individual surgeons have the appropriate experience and qualifications to offer particular cosmetic procedures. In addition to being on the GMC's Specialist Register in a relevant specialty, as recommended by the Keogh report (see paragraph 4.13), applicants for certification will be required, through a web portal, to demonstrate their competence both in professional behaviours and in their clinical skills and experience. They will further be required to attend a mandatory masterclass on professional behaviours for cosmetic surgery (under development at time of writing).²⁶²
- Publication of information for prospective patients, including information sourced from the NHS Choices website about specific surgical procedures, general advice about cosmetic surgery, suggested questions to ask, and advice on how to choose a surgeon and hospital.²⁶³
- Development and publication of a set of outcome measures for cosmetic surgery, to facilitate audit and review, and to provide patients with more reliable information about quality and care standards.²⁶⁴ Some, but not all, of these data requirements are now mandated by the Competitions and Markets Authority, and hence provider hospitals are obliged to collect them and submit them to the Private Healthcare Information Network (PHIN).²⁶⁵ 'Patient-reported outcome measures' (PROMs) have also been developed for a number of surgical procedures, with the aim of making it possible to

²⁵⁹ *ibid.*, recommendations 1 and 3.

²⁶⁰ Royal College of Surgeons (2016) *About the project*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/about-the-project/>.

²⁶¹ Royal College of Surgeons (2016) *Professional standards for cosmetic surgery*, available at: <https://www.rcseng.ac.uk/publications/docs/professional-standards-for-cosmetic-surgery/>.

²⁶² Royal College of Surgeons (12 January 2017) *RCS urges surgeons to apply for cosmetic surgery certification to improve patient safety*, available at: <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/apply-for-cosmetic-surgery-certification/>; and Royal College of Surgeons (2016) *Certification*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/certification/>.

²⁶³ Royal College of Surgeons (2016) *Cosmetic surgery: are you thinking about having cosmetic surgery?*, available at: <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/>.

²⁶⁴ Royal College of Surgeons (2017) *Clinical quality indicators for cosmetic surgery*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/clinical-quality-and-outcomes/dataset-of-clinical-quality-indicators/>.

²⁶⁵ See: Private Healthcare Information Network (2017) *About PHIN and changes to private healthcare*, available at: <https://portal.phin.org.uk/Factsheets/About%20PHIN%20and%20changes.pdf>. During 2017, PHIN will start to publish both hospital and consultant-level information on its public website. The Competition and Markets Authority mandates private hospitals to provide information to support 11 specific performance measures: Competition and Markets Authority (2014) *Private Healthcare Market Investigation Order 2014*, available at: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf.

collect more rigorous data on patients' own perceptions of how their health-related quality of life has been affected by their surgical procedures.²⁶⁶

- Development of the specifications for a future national audit of cosmetic practice, to be passed to 'relevant stakeholders'.²⁶⁷ The RCS has not as yet, however, taken up the recommendation in the Keogh report that it should take responsibility for establishing and overseeing an audit database itself, in partnership with the Healthcare Quality Improvement Partnership.

4.14 Further initiatives being developed to improve surgical practice, covering issues such as access to training, recognition of skills, and the introduction of risk management standards in order to access professional insurance, are summarised in Box 4.3:

Box 4.3: Other initiatives to improve surgical standards

Training initiatives

The Joint Committee on Surgical Training (an advisory body to the four surgical Royal Colleges of the UK and Ireland) has established a 'Training Interface Group' (TIG) on Reconstructive & Aesthetic Surgery to oversee and set standards for training across a number of surgical specialties.²⁶⁸ The aims of the TIG are twofold: first, "to protect the population by the 'normalisation' of cosmetic surgery – i.e., its practice to the same standards of governance as mainstream NHS or private practice"; and second "to inform the majority of surgeons in non cosmetic practice and enable cosmetic surgery to become a recognised part of mainstream surgical practice."²⁶⁹

Given that most cosmetic surgery takes place in the private sector (while medical and surgical training is mainly provided through NHS structures), proposals are being developed to create a 'plastic surgery training provider' which will be controlled by senior plastic surgeons who fully support this initiative. The provider would set up contractual arrangements with consultant trainers, NHS Trusts, and the private hospitals providing the facilities; act as a link with patients; book consultants and trainees' time; and make arrangements with private hospitals for surgery to be carried out. Such a system would provide doctors wishing to specialise in cosmetic surgery with similar opportunities for supervised training and practice to those available within the NHS for specialties provided within the NHS.²⁷⁰

Recognition of doctors' credentials

The GMC has consulted on proposals to introduce a new system of 'credentialing' in order to provide "a framework of standards and accreditation in areas outside recognised specialties where regulation may be absent or weak".²⁷¹ Such a system

²⁶⁶ Royal College of Surgeons (2016) *Patient reported outcomes measures*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/clinical-quality-and-outcomes/patient-reported-outcome-measures/>.

²⁶⁷ Royal College of Surgeons (2016) *Requirements for a future national audit of cosmetic surgical practice*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/clinical-quality-and-outcomes/recommendations/>.

²⁶⁸ Joint Committee on Surgical Training (2017) *Training interface groups: reconstructive & aesthetic surgery*, available at: <http://www.jcst.org/training-interface-groups/reconstructive-aesthetic-surgery>. A review of the 'TIG' system was published in 2016: Joint Committee on Surgical Training (2016) *Review of training interface groups (TIGs): final report*, available at: <http://www.jcst.org/key-documents/docs/TIGreviewFINALREPORT.pdf>.

²⁶⁹ Joint Committee on Surgical Training (2017) *Training interface groups: reconstructive & aesthetic surgery*, available at: <http://www.jcst.org/training-interface-groups/reconstructive-aesthetic-surgery>.

²⁷⁰ Personal communication, Mark Henley, 7 June 2017.

²⁷¹ General Medical Council (2016) *Credentialing consultation: results and next steps*, available at: http://www.gmc-uk.org/06___Credentialing_consultation___results_and_next_steps.pdf_65711404.pdf, at paragraph 2.

could provide one way of reinforcing the Royal College of Surgeons' voluntary certification scheme,²⁷² and in a report to the GMC's Council on the outcomes of the consultation it was noted that cosmetic practice was the field most often identified by respondents as suitable for credentialing.²⁷³ It was suggested in the report that the approach should be piloted and evaluated before being implemented more widely: at the time of writing, firm proposals had not yet been published.

Insurance-related standards

A dedicated professional indemnity scheme for plastic surgeons, the Plastic, Reconstructive and Aesthetic Surgeons Indemnity Scheme (PRASIS), has been established, with its own Code of Practice, with the aim of ensuring affordable insurance cover to plastic surgeons through the maintenance of high standards of practice.²⁷⁴

- 4.15 As noted above in the context of the GMC's guidance on both surgical and non-surgical cosmetic procedures, one of the limitations of the role of professional self-regulation is that it focuses on the responsibility of the individual doctor (see paragraph 4.7). Given the commercial nature of virtually all cosmetic surgery, this raises questions as to the extent to which those responsible for the business and financial decisions that affect how a business is run are regulated. We return to this issue below, in the context of the regulation of premises (see paragraphs 4.23–4.31).

Practitioners who are not health professionals

“A large proportion of these treatments will be carried out in salons and beauty parlours by people with limited training in injections, human anatomy and dermatology, rather than by medical professionals with specialist skills. Such practitioners may be unaware of potential risks in the procedures they are carrying out.”²⁷⁵

“The non-medical provision by amateur beauty therapists frequently minimise problems... by selling procedures whether or not they are age or condition appropriate.”²⁷⁶

“A correctly trained beauty therapist is just as skilled and safe to use as a medically trained doctor for more invasive cosmetic surgery.”²⁷⁷

“... there has been an increase in the number of places offering procedures. If you go to a beauty salon there are a lot of things you can have done straight away. Access is easier.”²⁷⁸

²⁷² As identified in the Private Members' Bill presented by Kevan Jones MP in October 2016: Hansard (2016) *Cosmetic Surgery (Standards of Practice) Bill - debate*, available at: [https://hansard.parliament.uk/Commons/2016-10-19/debates/E0F674CF-760C-45B8-BCDA-A0E0ECF8E74F/CosmeticSurgery\(StandardsOfPractice\)#contribution-B1526800-5B94-44AF-A9B6-1C1845D8C75C](https://hansard.parliament.uk/Commons/2016-10-19/debates/E0F674CF-760C-45B8-BCDA-A0E0ECF8E74F/CosmeticSurgery(StandardsOfPractice)#contribution-B1526800-5B94-44AF-A9B6-1C1845D8C75C); and supported by: Royal College of Surgeons (19 October 2016) *Change in the law 'urgently needed' to protect patients undergoing cosmetic surgery*, available at: <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/rcs-calls-for-change-in-the-law-to-protect-patients-undergoing-cosmetic-surgery/>.

²⁷³ General Medical Council (2016) *Credentialing consultation: results and next steps*, available at: http://www.gmc-uk.org/06___Credentialing_consultation___results_and_next_steps.pdf_65711404.pdf, at page A2.

²⁷⁴ Plastic Reconstructive and Aesthetic Surgeons Indemnity Scheme (2017) *Homepage*, available at: <http://prasis.co.uk/>.

²⁷⁵ Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians, responding to the Working Party's call for evidence.

²⁷⁶ Anonymous respondent to the Working Party's call for evidence.

²⁷⁷ Respondent to the Working Party's online questionnaire.

²⁷⁸ Respondent to the Working Party's online questionnaire.

- 4.16 Non-health professionals providing non-surgical cosmetic procedures, such as beauty therapists, are not regulated in any statutory manner, although non-compulsory National Occupational Standards are set by the Hair and Beauty Industry Authority (HABIA),²⁷⁹ and other good practice standards exist or are in development, such as those set by the European Committee on Standardization.²⁸⁰ The Keogh report expressed great concern that this meant, in practice, that there was nothing to prevent completely unskilled practitioners from offering invasive treatments, and recommended that a new system of compulsory registration of practitioners providing cosmetic procedures should be introduced.²⁸¹ Under such a system, only practitioners who had achieved accredited qualifications and kept up to date, whose premises met specified requirements, and who adhered to a code of practice, would be permitted to provide non-surgical cosmetic procedures.²⁸² Moreover, “the supervision of an appropriate qualified clinical professional” should be required for non-health professionals who had qualified under this route.²⁸³ Keogh further suggested that a programme of work to develop accreditation requirements, and accredited qualifications, should be undertaken by Health Education England (HEE), the body responsible for education and training for the healthcare workforce.²⁸⁴
- 4.17 The English Department of Health was not convinced that a new statutory registration system of this magnitude was required, although it promised in its response to the Keogh report to “explore” legislative options.²⁸⁵ However, other elements of the Keogh recommendations were accepted: in particular, HEE was commissioned to undertake a review of the qualifications required for delivery of non-surgical cosmetic interventions, which it carried out with the involvement of a wide range of practitioner and regulatory stakeholders.²⁸⁶ The final recommendations set out in detail the specific knowledge and skills required for five distinct ‘modalities’ of cosmetic practice: botulinum toxins; dermal fillers; lasers, intense pulsed light (IPL), and light-emitting diode (LED) treatments; chemical peels and skin rejuvenation treatments; and hair restoration surgery.²⁸⁷ The report also identified a number of generic areas of knowledge and skills, required for all modalities, including:

²⁷⁹ HABIA (2017) *National Occupational Standards (NOS)*, available at: <https://www.habia.org/national-occupational-standards-nos/>; Factfinding meeting with professional regulators (30 September 2016); Factfinding meeting with Cheryl Cole, 21 February 2017.

²⁸⁰ Factfinding meeting with Cheryl Cole, 21 February 2017. The European Standard on aesthetic medical services: non-surgical medical treatments is due to be published in June 2017. See: European Committee for Standardization (2017) *CEN/TC 403 - aesthetic surgery and aesthetic non-surgical medical services*, available at: https://standards.cen.eu/dyn/www/f?p=204:110:0:::FSP_PROJECT,FSP_ORG_ID:41115,766801&cs=17E95975378BB00B12165A5BBA3A6A111. A new European Standard for beauty salon services is under development, although not as yet published. See: Deutsches Institut für Normung (2013) *Beauty salon services: requirements and recommendations for the provision of service*, available at: <http://www.din.de/en/getting-involved/standards-committees/nadl/projects/wdc-proj:din21:150130773>; and National Standards Authority of Ireland (10 March 2014) *New European standard for beauty salon services*, available at: <https://www.nsai.ie/Special-Pages/News/EN-standard-for-Beauty-Salon-Services.aspx>.

²⁸¹ 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>, recommendation 7.

²⁸² *ibid.*, recommendation 8.

²⁸³ *ibid.*, recommendation 5.

²⁸⁴ *ibid.*, recommendation 6.

²⁸⁵ 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, at page 9.

²⁸⁶ 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> [add in refs to the two reports directly, and ref to initial publication of Part I in Sept 2014]

²⁸⁷ Treated as a ‘non-surgical procedure’, despite its name, although carried out only by doctors.

- understanding of, and adherence to, evidence-based practice
- effective multidisciplinary team working
- working in partnership with patients / clients to support shared decision-making, informed consent, and shared agreement on outcome expectations
- accurate record keeping, and appreciation of the value of audit
- knowledge of relevant law and ethics, including the principles of informed consent, the law on mental capacity, and the principles of medical negligence
- health and safety requirements relating to premises, equipment and staff.

4.18 The HEE report emphasises that “it is not HEE’s intention to exclude any practitioners from delivering cosmetic procedures or to deny training to any industry sectors”, and the recommended training requirements are therefore designed to apply to *all* practitioners, regardless of previous training or professional background.²⁸⁸ In line with the Keogh report recommendations, concerns about patient safety in connection with more complex or invasive procedures have been addressed by recommending oversight by appropriately qualified health professionals for specified procedures. Box 4.4 below summarises the HEE’s recommended approach to training and recognition of existing qualifications and experience.

Box 4.4: HEE approach to qualifications, experience, and implementation

‘Stepladder’ approach to qualifications

Qualifications for different aspects of practice range from level 4 (equivalent to the first year of a foundation degree) to level 7 (postgraduate level), and the report sets out clearly what procedures may be offered, with or without clinical oversight, at different levels. Thus, for example, the relevant level 4 qualification would be sufficient to enable practitioners to offer laser treatments for hair removal, while a level 7 qualification, combined with oversight from a clinical professional, would be required to deliver laser treatments within the periorbital rim. For some types of cosmetic procedure, practitioners may thus ‘step off’ the training programme at different points, or choose to progress to higher levels. However, the highest level of qualification, combined with oversight by an independent prescriber, is required for the administration of botox and temporary or semi-permanent dermal fillers, and it is recommended that only doctors with the appropriate qualification may perform hair restoration surgery, administer permanent fillers, or deliver fully ablative skin treatments.²⁸⁹

Exemptions and recognition of existing qualifications / experience

Reflecting the very different professional backgrounds of cosmetic practitioners, from beauty therapists to doctors, the HEE requirements set out exemptions from specific areas of study depending on professional background. They also make arrangements for existing qualifications or experience to be appropriately recognised within the new system. Thus health professionals, including doctors, dentists, and nurses, will be exempted from many of the generic requirements, as these will be covered in professional training, while there is scope for vocational qualifications, such as those accredited by the Hair and Beauty Industry Authority, to be recognised as equivalent to relevant elements of the new study programme.

Implementation

²⁸⁸ Health Education England (2015) *Part one: qualification requirements for delivery of cosmetic procedures - non-surgical cosmetic interventions and hair restoration surgery*, available at: <https://hee.nhs.uk/sites/default/files/documents/HEE%20Cosmetic%20publication%20part%20one%20update%20v1%20final%20version.pdf>, at page 32.

²⁸⁹ *ibid.*, at page 11 (Table 1).

In a follow-up report, drawing on consultation with stakeholders over effective implementation of its recommendations, the HEE identified the need for a joint professional council to take 'ownership' of these standards, take lead responsibility for accreditation of training programmes leading to such qualifications, and also to keep oversight of new and emerging treatments.²⁹⁰ While regretting the absence of mandatory controls on those offering procedures,²⁹¹ the report recommends that the qualification requirements should be adopted by the industry as best practice, and that existing practitioners should seek to comply with them by September 2018.²⁹²

- 4.19 While the Department of Health rejected the idea of a statutory register of practitioners qualified to provide non-surgical treatments, it has supported the development of the voluntary and independent Joint Council for Cosmetic Practitioners (JCCP), recommended by the HEE in November 2015, and initiated by the British Association of Cosmetic Nurses and the British College of Aesthetic Medicine in January 2016.²⁹³ Other professional bodies, including the British Association of Dermatologists, the British Association of Aesthetic Plastic Surgeons (BAAPS), the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), and HABIA have since signed memoranda of understanding to work together with the JCCP.²⁹⁴
- 4.20 The JCCP plans to establish two registers covering England and Wales:²⁹⁵ one of practitioners who meet the clinical standards required to provide non-surgical treatments (regardless of their original professional background); and one of accredited education providers offering qualifications in line with the HEE requirements. While registration will remain voluntary for practitioners, the JCCP is seeking to enhance the status of registration through accreditation with the Professional Standards Authority (PSA), a statutory body that accredits voluntary registers that meet its standards.²⁹⁶ Once such accreditation has been secured, practitioners registered with the JCCP will be able to use the PSA's 'quality mark' logo to enable members of the public to identify them as registered and qualified practitioners.
- 4.21 The JCCP has also established a separate Cosmetic Practice Standards Authority (CPSA) in order to separate out regulatory and standard-setting functions. The CPSA will be responsible for setting standards for clinical practice (using the framework developed by the HEE), collecting data (including patient experience and outcome measures), and monitoring developments in the field so that standards are kept up to date. Practitioners who wish to be registered with the JCCP will need to meet the

²⁹⁰ Health Education England (2015) *Part two: report on implementation of qualification requirements for non-cosmetic procedures - non-surgical cosmetic interventions and hair restoration surgery*, available at: <https://hee.nhs.uk/sites/default/files/documents/HEE%20Cosmetic%20publication%20part%20two%20update%20v1%20final%20version.pdf>, recommendation 6.

²⁹¹ *ibid.*, at page 23.

²⁹² *ibid.*, recommendations 1 and 2.

²⁹³ Aesthetics (11 July 2016) *The future of the JCCP*, available at: <https://aestheticsjournal.com/feature/the-future-of-the-jccp/>; and Joint Council for Cosmetic Practitioners (2017) *Homepage*, available at: <http://www.jccp.org.uk/>.

²⁹⁴ Joint Council for Cosmetic Practitioners (2016) *Joint Council for Cosmetic Practitioners (JCCP) and Clinical Standards Authority*, available at: [http://www.jccp.org.uk/content/large/joint_council_for_cosmetic_practitioners_\(jccp\)-__presentation_-_generic_september_2016_v3.pdf](http://www.jccp.org.uk/content/large/joint_council_for_cosmetic_practitioners_(jccp)-__presentation_-_generic_september_2016_v3.pdf).

²⁹⁵ Personal communication with respect to the extent of the JCCP's work: Nigel Mercer, 16 May 2017.,

²⁹⁶ Professional Standards Authority (2017) *How we work*, available at: <http://www.professionalstandards.org.uk/about-us/how-we-work>.

standards set by the CPSA, and will also be required to abide by a code of conduct, have indemnity, practise from safe premises, and be of ‘good character’.²⁹⁷

- 4.22 The Keogh report, and the work of HEE, related specifically to cosmetic practice in England. However, the Scottish Government, in a separate review, stated its desire to ensure that regulation “if at all possible, [...] should be introduced in a coordinated manner across the UK, to reduce the chance of ‘cross-border tourism’”.²⁹⁸ While recent legislative change in Scotland has affected health professionals providing non-surgical cosmetic services, who are now subject to regulation as ‘independent clinics’ (see paragraph 4.31), this does not affect non-healthcare practitioners such as beauty therapists.²⁹⁹

Regulation of premises

“People who are medical professionals have to have training, display competence to practice, regulations and insurance. People who do tattoos have to at least have licenses, abide by some safety regulations, and have their premises inspected. I am concerned that the safety risks of non-surgical procedures have not been truly ascertained.”³⁰⁰

“The market for cosmetic procedures [is]... becoming more normalised and available on the high street.”³⁰¹

- 4.23 All health and social care providers in England, including private hospitals and clinics, must be registered with the Care Quality Commission (CQC) if they carry out one or more “regulated activities” as described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulated activity of surgical procedures includes cosmetic surgery performed by a registered healthcare professional where the procedure involves instruments or equipment being inserted into the body. However, there are explicit exemptions to registration, for example, the subcutaneous injection of botulinum toxin or fillers for the purpose of enhancing a person’s appearance.³⁰²
- 4.24 The CQC inspection process includes assessment of whether providers are meeting fundamental standards of safety and quality relating, for example, to equipment, record-keeping, consent processes, the competency of staff, medicines management, and risk management. It does not have a remit to make direct judgments about the quality or safety of clinical care provided by individual practitioners within a service, unless those providers are registered and operate as individuals³⁰³ (see paragraphs 4.3–4.22). CQC requirements are legally binding on the “registered person (individual, partnership or

²⁹⁷ Aesthetics (11 July 2016) *The future of the JCCP*, available at: <https://aestheticsjournal.com/feature/the-future-of-the-jccp>; Joint Council for Cosmetic Practitioners (2017) *JCCP news update - February 2017*, available at: http://www.jccp.org.uk/content/large/news/jccp_news_update_feb_2017.pdf.

²⁹⁸ Scottish Cosmetic Interventions Expert Group (2015) *Scottish Cosmetic Interventions Expert Group: report*, available at: <http://www.gov.scot/Resource/0048/00481503.pdf>, pp5-6.

²⁹⁹ Healthcare Improvement Scotland (2016) *Regulation of independent clinics: frequently asked questions*, available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/regulation_of_clinics/regulation_of_clinics_faqs.aspx.

³⁰⁰ Respondent to the Working Party’s online questionnaire.

³⁰¹ Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester, responding to the Working Party’s call for evidence.

³⁰² See: Care Quality Commission (2017) *About us*, available at: <http://www.cqc.org.uk/content/about-us>. The statutory basis of the CQC’s role is found in the Health and Social Care Act 2008, as amended, and subsequent regulations.

³⁰³ For example, as a single-handed GP where the ‘provider’ is the GP.

organisation)” providing the health or social care services: that is the owner, and in some cases the manager, of those services.³⁰⁴

- 4.25 The CQC has welcomed the publication of the GMC and RCS guidance documents on cosmetic practice (see paragraph 4.6 and Boxes 4.1 and 4.2 above), and noted that it will take these standards “into account during our inspections and when making a judgement about the quality and safety of services being provided.”³⁰⁵ Updated guidance on the inspection of hospitals offering cosmetic surgery was published by the CQC in November 2016.³⁰⁶
- 4.26 Equivalent monitoring and inspection responsibilities for health care premises in the other countries in the UK are borne by Healthcare Improvement Scotland (see paragraph 4.31), the Care and Social Services Inspectorate Wales, and the Regulation and Quality Improvement Authority in Northern Ireland.
- 4.27 The regulations setting out the responsibilities of the CQC with respect to cosmetic procedures specify that its remit is limited to “surgical procedures (including all pre-operative and post-operative care associated with such procedures) carried on by a healthcare professional for cosmetic purposes”.³⁰⁷ Procedures that “do not involve a cut to the body or if there is no equipment inserted”, such as botox, dermal fillers, chemical peels or laser hair removal, are excluded, although laser lipolysis (which uses the heat from lasers to remove body fat) is included within the definition of surgery.³⁰⁸ The CQC does not, therefore, have a role with respect to non-surgical cosmetic procedures, nor to any services provided by non-health professionals. Clinics where surgical consultations take place *do* come within its remit, even if the surgery itself takes place elsewhere, unless exemptions apply. In practice, this means that clinics offering non-surgical services and surgical consultations on the same premises may be subject to registration.³⁰⁹ However, only the surgical consultation element is subject to registration and regulation – the CQC has no remit to look at any of the non-surgical services in that clinic in its inspections.
- 4.28 Similarly, GP and dental practices are subject to CQC registration and inspection requirements with respect to their mainstream clinical practice,³¹⁰ with very limited exceptions for some private GPs.³¹¹ Local authorities have the discretion, but not

³⁰⁴ Care Quality Commission (2017) *What is registration?*, available at: <http://www.cqc.org.uk/content/what-registration>.

³⁰⁵ Care Quality Commission (19 April 2016) *CQC welcomes new standards for cosmetic surgery*, available at: <http://www.cqc.org.uk/content/cqc-welcomes-new-standards-cosmetic-surgery>.

³⁰⁶ Care Quality Commission (2016) *Inspection framework: independent acute hospitals - service: surgery (cosmetic surgery only)*, available at: <http://www.cqc.org.uk/sites/default/files/Inspection%20framework%20-%20independent%20hospitals%20cosmetic%20surgery.pdf>.

³⁰⁷ Paragraph 6(1)(c) of Schedule 1 to the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. See also: Care Quality Commission (2016) *Choosing cosmetic surgery*, available at: <http://www.cqc.org.uk/content/choosing-cosmetic-surgery>.

³⁰⁸ Care Quality Commission (19 April 2016) *CQC welcomes new standards for cosmetic surgery*, available at: <http://www.cqc.org.uk/content/cqc-welcomes-new-standards-cosmetic-surgery>.

³⁰⁹ Factfinding meeting with Harley Medical Group, 10 March 2017.

³¹⁰ See: Care Quality Commission (2016) *NHS GP practices and GP out-of-hours services: provider handbook*, available at: http://www.cqc.org.uk/sites/default/files/20160127_gp_practices_provider_handbook_jan16.pdf; and Care Quality Commission (2015) *Primary care dental services: provider handbook*, available at: http://www.cqc.org.uk/sites/default/files/20150611_dental_care_provider_handbook.pdf.

³¹¹ See: Care Quality Commission (2014) *Scope of registration: independent medical practitioners working in private practice (changes from October 2013)*, available at: https://www.cqc.org.uk/sites/default/files/20150428_scope_of_registration_independent_medical_practitioners_working_in_private_practice.pdf; and Department of Health (2012) *Response to a consultation on proposed changes to regulations for Care Quality Commission registration*, available at:

obligation, to license practitioners who use IPL or lasers for exclusively non-surgical cosmetic purposes: however, very few local authorities in England are reported as doing so (these currently include the London boroughs, Nottingham, and Leicester).³¹²

- 4.29 In addition to its monitoring and inspection role, the CQC has, since 2014, been required to carry out regular performance assessments, and publish the resulting ratings, of hospitals and GP services.³¹³ In August 2016, the Department of Health initiated a consultation on whether this assessment and rating approach should be extended to other services covered by the CQC's remit, including cosmetic surgery providers.³¹⁴ Noting that "there have been significant concerns about safety and quality of providers in the cosmetic surgery sector", the consultation document suggests that extending the rating system to the premises providing these services would provide fuller information to prospective patients on the "safety and quality of services provided". The proposals were welcomed by BAAPS and BAPRAS, although spokespeople for both organisations noted that rating clinics was only one part of patient safety, highlighting the importance of properly accredited surgeons.³¹⁵
- 4.30 These proposals would apply only to those cosmetic procedures that fall within the existing remit of the CQC, and hence would not include ratings of the providers of non-surgical procedures. Parallel proposals for regulatory change that might affect the non-surgical cosmetic sector include the recommendations published in 2016 by the PSA: that the regulation of healthcare professionals operating on the 'high street' (for example, GPs and dentists) should in future include the regulation of their premises.³¹⁶ Such a proposal, if accepted, would remove responsibility from the CQC for inspecting doctors' and dentists' premises, and merge the regulation of "people and premises" as is already the case, for example, for pharmacists.³¹⁷ At the time of writing, no formal response to either of these sets of recommendations has been published.

Scotland

- 4.31 Independent hospitals, including those providing cosmetic surgery, are regulated in Scotland under the Regulation of Care (Scotland) Act 2001, and inspected by Healthcare Improvement Scotland for compliance with National Care Standards.³¹⁸ However, a report published in 2015 by the Scottish Cosmetic Interventions Expert Group (SCIEG) highlighted how the provisions within the 2001 Act, intended to include independent

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133428.pdf.

³¹² Health Education England (2015) *Part one: qualification requirements for delivery of cosmetic procedures - non-surgical cosmetic interventions and hair restoration surgery*, available at:

<https://hee.nhs.uk/sites/default/files/documents/HEE%20Cosmetic%20publication%20part%20one%20update%20v1%20final%20version.pdf>, paragraphs 4.13-17; Factfinding meeting with Dr Samantha Hills, Clinical Director, Lynton Lasers, 24 January 2017. London boroughs have the power to establish licensing requirements under the London Local Authorities Act 1991, while non-London local authorities may choose to adopt licensing / registration powers under the Local Government (Miscellaneous provisions) Act 1982.

³¹³ Care Quality Commission (Reviews and Performance Assessments) Regulations, SI 2014/1788.

³¹⁴ Department of Health (2016) *Scope of performance assessments of providers regulated by the Care Quality Commission*, available at:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/547103/Scope_of_CQC_ratings_Con_Doc_A.pdf, pp8-9.

³¹⁵ O'Dowd A (2016) Cosmetic surgery will be regulated more closely in England *BMJ* **354**.

³¹⁶ Professional Standards Authority (2016) *Regulation rethought: proposals for reform*, available at:

<http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=10>.

³¹⁷ The Royal Pharmaceutical Society of Great Britain, and the Royal Pharmaceutical Society of Northern Ireland currently include pharmacists' premises within their regulatory remit. This is not the case for other high street practitioners, such as doctors and dentists: see *ibid.*, Annex B.

³¹⁸ These standards are currently under review. See: Scottish Government (2017) *National Care Standards: consultation*, available at: <http://www.gov.scot/Topics/Health/Support-Social-Care/Regulate/Standards/NCSreview>.

clinics within this regulatory framework, had never been brought into effect.³¹⁹ Following the SCIEG recommendations, all such clinics (defined as premises that are not part of a hospital, and from which non-NHS services are provided by doctors, dentists and other dental professionals, nurses and midwives) have been required since April 2016 to register with Healthcare Improvement Scotland, and will be regularly inspected.³²⁰ As in England, these requirements do not, however, apply to non-surgical cosmetic procedures provided by non-health professionals such as beauty therapists. Healthcare Improvement Scotland notes that “further information will be available in due course from the Scottish Government” on an “appropriate regulatory framework” for these practitioners.³²¹

Regulation of products and devices

“Maybe dermal fillers etc. have garnered popularity and acceptance due to the ease in acquisition / non-regulated way in which they can be carried out.”³²²

- 4.32 Cosmetic procedures frequently make use of both medicines and medical devices. Medicines are substances used to treat or diagnose illness or health conditions through pharmacological or other interaction with the body.³²³ Medicines may be licensed either for sale to the general public, or for use only with a prescription from a qualified health practitioner.³²⁴ Botox, for example, is a prescription only medicine (see paragraph 4.4).
- 4.33 Medical devices cover a wide range of products used in healthcare, from sterile bandages to pacemakers, and stethoscopes to magnetic resonance imaging (MRI) scanners. UK legislation relating to medical devices is currently based on a number of EU Directives.³²⁵ A key criterion in the definition of a medical device under these Directives is that its intended use must be for a diagnostic or therapeutic purpose. This means that products designed for use *only* for cosmetic purposes are not defined as medical devices, and fall outside the medical regulatory framework (see paragraph 4.34). As a result, while breast implants are defined as medical devices – presumably because of their role in breast reconstruction – other implants, such as those used to enhance calves and buttocks, are not. Dermal fillers are not currently defined as either medical devices or medicines, unless they are marketed for medical purposes, such as lipoatrophy in people with HIV, or are pre-mixed with other substances such as anaesthetic that do fall within medicines regulations.³²⁶ They also fall outside the 2001 EU General Product Safety Directive, as this excludes products used as part of a

³¹⁹ Scottish Cosmetic Interventions Expert Group (2015) *Scottish Cosmetic Interventions Expert Group: report*, available at: <http://www.gov.scot/Resource/0048/00481503.pdf>, pp18-20.

³²⁰ Healthcare Improvement Scotland (2016) *Regulation of independent clinics: frequently asked questions*, available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/regulation_of_clinics/regulation_of_clinics_faqs.aspx.

³²¹ *ibid.*

³²² Respondent to the Working Party's online questionnaire.

³²³ See: Legislation.gov.uk (2012) *The Human Medicines Regulations 2012*, available at: <http://www.legislation.gov.uk/ukxi/2012/1916/contents/made>.

³²⁴ See, for example, NHS Choices (2014) *Medicines information*, available at: <http://www.nhs.uk/conditions/Medicinesinfo/Pages/Introduction.aspx>.

³²⁵ Directive 90/385/EEC relating to active implantable medical devices (AIMD); Directive 93/42/EEC concerning medical devices (MDD); Directive 98/79/EC on *in vitro* diagnostic medical devices (IVDD); and EU General Product Safety Directive.

³²⁶ See, for example, Merz (2016) *Merz receives CE mark for Radiesse (+) lidocaine*, available at: <https://www.merz.com/blog/news/merz-receives-ce-mark-radiesse-lidocaine/>.

'professional service'.³²⁷ Their contents are therefore potentially *less* regulated than other consumer products,³²⁸ and there is no restriction at all on who may purchase them, or provide them as treatment.

4.34 The Medicines and Healthcare products Regulatory Agency (MHRA) and the European Medicines Agency (EMA) are responsible for licensing medicines: in order to be permitted to sell their products, manufacturers must obtain a marketing authorisation, based on data on safety and effectiveness gathered through clinical trials.³²⁹ The MHRA is also responsible for regulating medical devices, and in borderline cases can offer advice to manufacturers as to whether a product is indeed a medical device, as distinct from, for example, a cosmetic product such as make-up or face cream, or a food supplement.³³⁰ Manufacturers may affix a CE mark on their device and place it on the market once they have demonstrated that it has met EU-defined safety and quality standards and fulfils its stated purpose. In particular, guidance issued by the European Commission on how the "essential requirements" set out in the Directives should be interpreted states that:

- "the clinical evaluation demonstrates that any risks which may be associated with the intended purpose are minimised and acceptable when weighed against the benefits to the patient and are compatible with a high level of protection of health and safety; and
- the IFU [information for use] correctly describe the intended purpose of the device as supported by sufficient clinical evidence".³³¹

4.35 The EU system has been compared unfavourably by some to the licensing system operated by the FDA in the US, although this is contested.³³² A key difference between the EU approach and the centralised approval system operated by the FDA in the US is that the approval system in the EU is dispersed. Manufacturers can apply to any one of the designated independent 'notified bodies' operating in EU member states to confirm that devices comply with the CE mark requirements: this includes assessing in a manner "appropriate to the device" the clinical data submitted by manufacturers.³³³ The MHRA, as the UK's 'competent authority' for this area of EU law, is responsible for designating and auditing the work of these bodies in the UK.

4.36 Following the Poly Implant Prothèse (PIP) fraud (see paragraph 3.20), it was evident that the system of monitoring the safety and quality of devices was seriously flawed: breast

³²⁷ Legislation.gov.uk (2005) *The General Product Safety Regulations 2005*, available at: <http://www.legislation.gov.uk/ukksi/2005/1803/contents/made>. The Keogh report states, at paragraph 4.4, that: "Furthermore, when a product such as a filler is used as part of a 'professional service' it is currently exempt from the EU General Product Safety Directive."

³²⁸ See, for example, a comment from Sir Bruce Keogh that "most dermal fillers have no more controls than a bottle of floor cleaner": NHS Choices (24 April 2013) *Cosmetic treatments need new regulation report finds*, available at: <http://www.nhs.uk/news/2013/04April/Pages/Cosmetic-treatments-need-stricter-regulation-report-concludes.aspx>.

³²⁹ Medicines and Healthcare products Regulatory Agency (2008) *My medicine: licensing (marketing authorisation)*, available at: <http://www.mhra.gov.uk/home/groups/comms-ic/documents/websitesresources/con025908.pdf>.

³³⁰ See: Medicines and Healthcare products Regulatory Agency (2017) *Decide if your product is a medicine or a medical device*, available at: <https://www.gov.uk/guidance/decide-if-your-product-is-a-medicine-or-a-medical-device> for discussion of 'borderline products' where categorisation may not be obvious.

³³¹ European Commission (2016) *Guidelines on medical devices: clinical evaluation - a guide for manufacturers and notified bodies under Directives 93/42/EEC and 90/385/EEC*, available at: <http://ec.europa.eu/DocsRoom/documents/17522/attachments/1/translations/>, at Annex 7.2.

³³² See, for example, contributions by MEPs in: The European Files (2013) *Clinical trials and medical devices in Europe: innovation and harmonization*, available at: <http://www.ealth.org/images/speak-about-us/european-files-magazine-march-2013.pdf>.

³³³ Detailed guidance is issued to notified bodies by the European Commission. See: European Commission (2016) *Guidelines on medical devices: clinical evaluation - a guide for manufacturers and notified bodies under Directives 93/42/EEC and 90/385/EEC*, available at: <http://ec.europa.eu/DocsRoom/documents/17522/attachments/1/translations/>.

implants using substandard (industrial) grade silicone had been manufactured by the company PIP for several years before they were detected. As a result, in 2012, the European Commission launched an action plan based on existing legislation to improve safety.³³⁴ This included the introduction in October 2013 of mandatory audits of all notified bodies, undertaken jointly by two other competent authorities and the European Commission, in addition to the host competent authority responsible for ‘designating’ them.³³⁵ As a result of these changes, the number of notified bodies in the UK has reduced since 2012 from around 80 to 55.³³⁶

- 4.37 Further changes have also been introduced in EU legislation through the development of a new Regulation to replace the current Directives. The Medical Devices Regulation which was formally adopted in April 2017³³⁷ is intended to provide greater patient safety by, amongst other things, the inclusion of a number of previously excluded products marketed for cosmetic purposes, including dermal fillers, implants used for cosmetic purposes, equipment for liposuction, invasive laser equipment, and IPL equipment within its remit. Since by definition these products are not being marketed for ‘medical’ purposes, the Regulation does not attempt to define them as ‘medical devices’, but rather states that they are regulated ‘as if they were’ medical devices. How clinical assessments will be made of these products, however, is yet to be agreed. One of the general principles for assessment of medical devices within the Regulation is that the medical benefit offered must outweigh the risks;³³⁸ if taken literally, this would prevent any device deemed not to have medical benefit from obtaining a CE marking. “Common specifications” for clinical assessment by notified bodies will be developed by member states before the Regulation is applied across EU member states in May 2020.³³⁹
- 4.38 The Regulation also seeks to improve transparency, both with respect to information for individual patients, and for the wider public. Patients must be given an ‘implant card’ containing information about implanted devices;³⁴⁰ a comprehensive database is to be established which will allow devices to be traced from the manufacturer through the supply chain to the final user;³⁴¹ and the clinical data submitted by manufacturers to notified bodies for assessment will be made publicly available.³⁴² These requirements at EU level have been accompanied by the launch in England of a new breast and cosmetic implant registry in October 2016 to which all providers of breast implants, both NHS and

³³⁴ European Commission (2012) *PIP action plan*, available at: https://ec.europa.eu/growth/sectors/medical-devices/pip-action-plan_en.

³³⁵ *ibid.*

³³⁶ As of May 2017: Factfinding meeting with MHRA, 2 May 2017. See: European Commission (2017) *NANDO (new approach notified and designated organisations) information system*, available at: <http://ec.europa.eu/growth/tools-databases/nando/> for current totals.

³³⁷ Official Journal of the European Union (2017) *Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices*, available at: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32017R0745&from=EN>. See also: Lexology (12 April 2017) *EU Medical Devices Regulation and In-Vitro Medical Devices Regulation adopted by European Parliament*, available at: <http://www.lexology.com/library/detail.aspx?g=2f80bf1f-ceb2-4b84-9797-ffa0cdf6bb52>.

³³⁸ Official Journal of the European Union (2017) *Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices*, available at: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32017R0745&from=EN>, at annex 1, chapter 1, paragraph 1 states that “any risks which may be associated with their use [should] constitute acceptable risks when weighed against the benefits to the patient”.

³³⁹ The Regulation itself states at Article 2(1): “The common specifications for each of the groups of products listed in Annex XVI [i.e., the six groups of products newly included within the remit of the Regulation] shall address, at least, application of risk management as set out in Annex I for the group of products in question and, where necessary, clinical evaluation regarding safety”: *ibid.*

³⁴⁰ *ibid.*, at Article 18.

³⁴¹ *ibid.*, at Article 28.

³⁴² *ibid.*, at Article 73.

private, are expected to contribute data.³⁴³ A similar database had been maintained by the MHRA between 1993³⁴⁴ and 2005 but was closed down, reportedly because too few women wished to take part.³⁴⁵

4.39 The Government has not indicated how it will deal with new EU Regulation after the UK leaves the EU, although the MHRA has emphasised the need for ongoing cooperation with EU regulatory procedures in the lead up to Brexit.³⁴⁶ However, in its response to the Keogh report the Department of Health notes that the UK has been a strong proponent of the inclusion of dermal fillers and other cosmetic products and equipment within the new Regulation. It also notes that the Department of Health “support[s] the principle that dermal fillers and other non-surgical cosmetic products should be prescription only, or otherwise that there should be control over who may administer them.”³⁴⁷ No further announcements about prescription-only status have yet been made, and the Working Party was told that there are significant technical difficulties in designating all dermal fillers as medicines (a necessary first step to make them prescription-only under the current regulatory system), because the mode of action of many fillers on the market falls outside the definition of a medicine (see paragraph 4.33).

Access to redress if things go wrong

4.40 How, and whether, patients / users may be able to seek redress if they suffer medical complications or are dissatisfied with the outcome of their procedure will depend on a complicated combination of the law of contract, the tort of negligence, and the policies of the clinic or practitioner who provided their treatment.³⁴⁸ Patients would not ordinarily be expected to pay for additional treatment required to respond to medical complications arising out of their procedure, and some providers (particularly those running their own hospitals) are able to offer 24-hour emergency cover and a rapid response to any post-operative or post-treatment problems. However, not all providers have the necessary facilities themselves, particularly where serious adverse consequences arise, and instead may refer such cases to the NHS, whether through a formal arrangement in which the provider reimburses the costs incurred by the NHS, or simply by telling the patient to go to A&E.

4.41 Treatment available through the NHS, however, will be limited to dealing with the medical complications, without reference to the original cosmetic aims of the procedure. Patients / users are then left with the option to go back to the original provider, or seek treatment elsewhere, which will inevitably incur extra cost. The Working Party was told that the

³⁴³ NHS Digital (2016) *Breast and Cosmetic Implant Registry*, available at: <http://content.digital.nhs.uk/bcir>.

³⁴⁴ Shakespeare PG, Bazire N, and Whitworth IH (2005) The UK breast implant registry - ten years on *British Journal of Plastic Surgery* **58(3)**: 283-5.

³⁴⁵ See, for example, BBC News (3 January 2012) *Implant statistics warning*, available at: <http://www.bbc.co.uk/news/mobile/health-16401016>.

³⁴⁶ Medicines and Healthcare products Regulatory Agency (2017) *Medicines and Healthcare products Regulatory Agency business plan 2017-18*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/609967/Agency_Business_Plan_2017-18_v1.0_-_final_.pdf. For summary and links, see: Lexology (12 May 2017) *UK's regulator announces its top priorities in the lead up to Brexit*, available at: <http://www.lexology.com/library/detail.aspx?g=4c355bec-bbe8-48d3-bcb2-6cca3e4b16e3>.

³⁴⁷ 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, at page 10.

³⁴⁸ Exceptionally the tort of misrepresentation may also be relevant: see, for example, Lexology (31 July 2014) *Cosmetic clinicians' denial of liability for misleading statements in product manufacturer's promotional material raises a few eyebrows in the court of appeal*, available at: <http://www.lexology.com/library/detail.aspx?g=9cbf2ba6-c242-43eb-908b-de402fc8017d>. Where a faulty product or medical device is thought to have caused harm, product liability legislation is also relevant, although as the PIP litigation demonstrates, questions of liability are complex and long-drawn out (see paragraph 3.20).

degree of follow-up offered after a procedure, and what is, or is not, included in that follow-up, varies considerably, not least when treatments are provided abroad.³⁴⁹

- 4.42 If a patient subsequently wished to obtain compensation through the courts for harms they had suffered, they would need to demonstrate that the practitioner carrying out their procedure had been guilty of negligence, whether with respect to the performance of the procedure itself, or with respect to the information provided when seeking consent. In either case, the patient would need to convince a court that the harm they had suffered was directly related to the negligence of the practitioner: for example that the practitioner's conduct of the procedure fell below the requisite standard of care, causing damage to the patient; or that, had they been advised of a particular risk, they would have chosen not to go ahead with the procedure.³⁵⁰ The question of the information to which a prospective patient is entitled before undertaking a medical procedure was the subject of the landmark Supreme Court judgment in 2015 of *Montgomery* (see Box 4.5 below), in which it was held that doctors are under a duty to declare to patients "any material risks" involved in the proposed treatment, and of reasonable alternatives.³⁵¹ The *Montgomery* judgment has been described as a "radical move away from English law's traditional respect for clinical expertise", although the extent to which this promotes patient autonomy has been disputed.³⁵²

Box 4.5: The case of Montgomery

Mrs Montgomery's baby was born with serious disabilities associated with shoulder dystocia during delivery (the baby's shoulders being too wide to pass through the mother's pelvis). Women with diabetes are more likely to have large babies, and have a 9-10% risk of shoulder dystocia during vaginal delivery. Although Mrs Montgomery, a diabetic, had raised concerns about vaginal delivery, she was not advised of the risks of shoulder dystocia because in her doctor's view the risks to the mother from a caesarean section were greater than those to the baby from shoulder dystocia. Mrs Montgomery claimed damages, on the basis that had she been warned of the risks, she would have chosen a caesarean section.

The lower courts rejected Mrs Montgomery's claim, on the basis that the doctor's decision not to warn her of the risks of shoulder dystocia was compatible with a responsible body of medical opinion, which could not be rejected as irrational. Moreover, Mrs Montgomery had not asked specifically about the risk of shoulder dystocia.

However, the Supreme Court ruled in her favour, holding that the paradigm of the doctor-patient relationship in past case law had ceased to reflect reality: "Societal and legal changes point towards an approach to the law which treats patients so far as possible as adults capable of understanding that medical treatment is uncertain of success and may involve risks, of accepting responsibility for risks affecting their lives, and of living with the consequences of their choices."

The Court went on to hold that doctors are under a duty to take reasonable care to ensure that patients are aware of any material risks involved in proposed treatments,

³⁴⁹ Factfinding meeting on consumer perspectives, 5 February 2016.

³⁵⁰ *Bolam v Friern HMC* [1957] 2 All ER 118; *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771. For an overview, see: Brazier M, and Cave E (2016) *Medicine, patients and the law* (Manchester: Manchester University Press), at chapter 7.

³⁵¹ The Supreme Court (2015) *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* [2015] UKSC 11: press summary, available at: https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_PressSummary.pdf. The quotations in Box 4.5 are taken from the Supreme Court's press summary.

³⁵² *Montgomery J, and Montgomery E* (2016) *Montgomery on informed consent: an inexpert decision?* *Journal of Medical Ethics* 42(2): 89-94.

and of reasonable alternatives. A risk is held to be material if “a reasonable person in the patient’s position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it”.

- 4.43 Where the patient / user has not suffered physical harm but is dissatisfied with the aesthetic outcome of their procedure, the situation becomes even more complicated. While some providers may have a policy of offering a revision of a procedure if the results fall short of expectations, this will generally be on the basis of a good will gesture, and could only be enforced if offered as part of the original contract terms. While in theory it could be open to a dissatisfied patient or user to seek compensation for breach of contract (on the basis that they had actually been promised something that had not been delivered), or on the basis of a form of negligence as described above, the Working Party was advised that in practice it is very difficult to succeed in such claims.³⁵³ A further challenge may arise for patients in seeking compensation under any of these legal routes, in that doctors providing cosmetic procedures are normally self-employed (including where the patient has arranged treatment through one of the large group providers – see paragraph 3.23), and hence legal liability rests with the doctor, and not with the company.³⁵⁴ Where the doctor is not resident in the UK, as in a widely reported case cited by Kevan Jones MP in his 2016 Private Members’ Bill advocating further regulation,³⁵⁵ initiating proceedings may be particularly difficult.³⁵⁶
- 4.44 In the light of the difficulties (and costs) of seeking redress through the courts, effective complaints systems operated by provider companies clearly have an important role to play, particularly where the provider accepts lead responsibility for resolving the patient’s concerns, even where in law liability rests with the individual practitioner (as is the case where doctors are not directly employed by providers). The Keogh report recommended that the role of the Parliamentary and Health Service Ombudsman (PHSO) should be extended to cover complaints about private sector health services, including cosmetic services;³⁵⁷ however to date no change has been made to the PHSO’s remit to enable it to oversee the quality of complaints handling in the private sector. Some private providers are members of the Independent Sector Complaints Adjudication Service (ISCAS), a voluntary membership scheme for the independent healthcare sector which offers binding arbitration on complaints about its members.³⁵⁸

³⁵³ Factfinding meeting on consumer perspectives, 5 February 2016. See also: Lexology (29 March 2017) *Cosmetic surgery - knowing your rights if things go wrong*, available at: <http://www.lexology.com/library/detail.aspx?g=8f9ec4ce-eac4-40a2-aaa6-865db486725d>. We also note that such situations may also be very difficult for the practitioner.

³⁵⁴ However, in the ongoing case relating to breast surgeon Ian Paterson, the court will be asked to consider whether private healthcare providers have a “non-delegable duty of care to private patients”. See: One Crown Office Row (19 January 2017) *Paterson case listed in The Lawyer top 20 cases for 2017*, available at: <http://www.1cor.com/news/-Paterson-case-listed-in-The-Lawyer-Top-20-Cases-for-2017>.

³⁵⁵ First reading of Cosmetic Surgery (Standards of Practice Bill, HC Hansard, 19 October 2016, c818, available at: [https://hansard.parliament.uk/Commons/2016-10-19/debates/E0F674CF-760C-45B8-BCDA-A0E0ECF8E74F/CosmeticSurgery\(StandardsOfPractice\)#contribution-B1526800-5B94-44AF-A9B6-1C1845D8C75C](https://hansard.parliament.uk/Commons/2016-10-19/debates/E0F674CF-760C-45B8-BCDA-A0E0ECF8E74F/CosmeticSurgery(StandardsOfPractice)#contribution-B1526800-5B94-44AF-A9B6-1C1845D8C75C).

³⁵⁶ There are no statistics on how many such ‘fly in fly out’ surgeons operate in the UK. It was estimated in 2005 that of 800 surgeons operating in the UK, 600 were non-resident surgeons: Safer Cosmetic Surgery (2013) *The insurance issue with ‘FIFO’ [fly-in fly-out] surgeons*, available at: <http://www.safercosmeticsurgery.co.uk/news/14-safercosmeticsurgery/442-the-insurance-issue-with-fifo-surgeons>. However, this estimate is disputed, and no more up-to-date estimates are available. See also: The Sunday Times (20 January 2013) *They fly in, nip and tuck, fly out*, available at: <https://www.thetimes.co.uk/article/they-fly-in-nip-and-tuck-fly-out-fzpxc5mgvrv>.

³⁵⁷ 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>, recommendation 34.

³⁵⁸ Independent Healthcare Sector Complaints Adjudication Service (2017) *Homepage*, available at: <http://www.iscas.org.uk/>.

Limitations on access to procedures

4.45 One of the issues that the Working Party was asked to consider in its terms of reference was whether any limits should be placed on access to cosmetic procedures, either in terms of groups of people who should not be permitted access; or specific procedures that should not be made available. At present, no such controls exist explicitly in terms of access to cosmetic procedures: however, there are some related legal restrictions, first in connection with children and young people, and second in connection with female genital procedures, and these are outlined below.

Controls on access to procedures by children and young people

4.46 There are no specific legal restrictions limiting children's access to cosmetic procedures. A legally valid consent can be provided on a child's behalf by parents in the same way as for a medical procedure, and those over 16 are presumed to be competent to provide their own consent, unless the opposite can be demonstrated.³⁵⁹ Following the *Gillick* judgment, children under 16 can also consent for their own medical treatment if judged by health professionals to be competent to do so: however, this is based on the presumption that the proposed treatment is in their best interests, and that it is not possible to persuade them to involve their parents.³⁶⁰

4.47 The GMC guidance to doctors on cosmetic procedures (see paragraph 4.6 and Box 4.1) requires doctors to "take particular care if you consider providing cosmetic interventions for children or young people", including by ensuring the environment is appropriate for paediatric care, and where necessary by working with multidisciplinary teams with expertise in working with children and young people.³⁶¹ The guidance emphasises that doctors may only provide interventions that are in the best interests of the child or young person; that where young people have the capacity to consent for themselves it is still good practice to encourage them to involve their parents; and that if a child does not want a procedure, doctors should not provide it, regardless of the wishes of the parent.³⁶²

4.48 While children's access to cosmetic procedures is currently left to the discretion of professionals, there are specific statutory controls over access to other appearance-related procedures. In particular, it is against the law to allow anyone under 18 to access commercial sunbeds³⁶³ or to have a tattoo,³⁶⁴ regardless of whether or not their parents are willing to consent. The Working Party was told that restrictions are also in place (although as a matter of good practice, rather than law) with respect to intimate waxing.³⁶⁵ It has been argued that similar controls should be in place for cosmetic procedures, with the exception of those held by health professionals to be therapeutically necessary for a

³⁵⁹ Sections 1 and 2, Mental Capacity Act 2005.

³⁶⁰ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112.

³⁶¹ General Medical Council (2016) *Guidance for doctors who offer cosmetic interventions*, available at: http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf, at paragraph 32.

³⁶² *ibid.*, paragraphs 33-4.

³⁶³ Sunbeds (Regulation) Act 2010 (covering England and Wales); and The Public Health etc. (Scotland) Act 2008.

³⁶⁴ Tattooing of Minors Act 1969.

³⁶⁵ Factfinding meeting on regulation and governance perspectives, 15 April 2016. Intimate waxing services for women include the 'Brazilian' (the removal of hair from the pubic area, leaving a strip of hair over the pubic mound), and the 'Hollywood' (the removal of all pubic and anal hair). Intimate waxing services for men include the removal of hair from the lower back, penis, buttocks, scrotum, and anal area. See: HABIA (2007) *Code of practice: waxing services*, available at: https://www.habia.org/PDF/standards-quals/Waxing_code_of_practice_Booklet.pdf, at 6.5.

particular child.³⁶⁶ As we noted in Chapter 3, there are no published statistics within the UK on current use of cosmetic procedures by children and young people under 18, and leading private providers told us that they only accepted people 18 and above for treatment.³⁶⁷ However, there are anecdotal accounts of increasing interest in procedures by those under 18, and figures from the US suggest not inconsiderable usage (see paragraph 3.12). A number of jurisdictions have introduced bans or partial bans on cosmetic surgery for those under 18, including the Australian state of Queensland,³⁶⁸ and Italy.³⁶⁹ In Colombia, however, such a ban has reportedly been challenged in the constitutional courts, and the age-limit for breast augmentation reduced from 18 to 14.³⁷⁰

Female genital procedures

4.49 The use of female genital cosmetic surgery (FGCS) is reported to be rising worldwide, although authoritative statistics for the UK are not available (see paragraph 3.10 and Box 2.2). However, the provision of these types of surgeries is complicated by the fact that many of the procedures described as FGCS are anatomically identical to the procedures explicitly prohibited by the Female Genital Mutilation Act 2003 (see Box 4.6 below).³⁷¹ It has been argued that “the FGM Act on its face prohibits... any form of FGCS that involves the cutting away of tissue,”³⁷² and both academic and activist commentators have highlighted what appears to be a race-based double standard in the regulation of genital cutting.³⁷³

Box 4.6: The Female Genital Mutilation Act 2003 and its relationship with FGCS

Female circumcision or female genital mutilation (FGM) was first outlawed in the UK in 1985 and the current law is contained in the Female Genital Mutilation Act 2003. This Act provides that an offence is committed when a person “excises, infibulates or otherwise mutilates the whole or any part of a girl’s labia majora, labia minora or clitoris”. For the purposes of the Act, references to a ‘girl’ includes adult women. The legislation provides for exceptions where genital surgery is needed for the physical or mental health of the girl or woman, or is associated with childbirth.

The *Explanatory Notes*, published when the FGM Act (then the FGM Bill) was being debated in Parliament, provide the following commentary on when surgery might be permissible for reasons of mental health: “Operations necessary for mental health could

- ³⁶⁶ McHale JV (2015) Children, cosmetic surgery and perfectionism: a case for legal regulation?, in *Inspiring a medico-legal revolution: essays in honour of Sheila McLean*, Ferguson PR, and Laurie GT (Editors) (Abingdon: Routledge), at chapter 12.
- ³⁶⁷ Some leading providers state that they do not treat people under the age of 18. See, for example, The Harley Medical Group (2016) *Book your free consultation*, available at: <https://www.harleymedical.co.uk/contact-us/book-your-free-consultation?v2-aug16>.
- ³⁶⁸ Queensland Government (2008) *Health Legislation (Restriction on Use of Cosmetic Surgery for Children and Another Measure) Amendment Act 2008*, available at: <https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2008/08AC057.pdf>.
- ³⁶⁹ Noticieros Televisa (24 May 2012) *Italia prohíbe cirugías estéticas a menores de edad*, available at: <http://noticierostelevisa.esmas.com/especiales/447966/italia-prohibe-cirugias-esteticas-menores-edad>. See also: Endangered Bodies (11 December 2012) *Blog: Italy bans plastic surgery for minors*, available at: http://www.endangeredbodies.org/italy_bans_plastic_surgery_for_minors.
- ³⁷⁰ Colombia Reports (3 May 2017) *Colombia sets minimum age for breast implants at 14*, available at: <http://colombiareports.com/colombia-sets-minimum-age-breast-implants-14/>.
- ³⁷¹ See, for example, the discussion in Kelly B, and Foster C (2012) Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *BJOG: An International Journal of Obstetrics & Gynaecology* **119**(4): 389-92, at page 391.
- ³⁷² Avalos LR (2015) Female genital mutilation and designer vaginas in Britain: crafting an effective legal and policy framework *Vanderbilt Journal of Transnational Law* **48**: 621-706, at page 637.
- ³⁷³ See, for example, Sheldon S, and Wilkinson S (1998) Female genital mutilation and cosmetic surgery: regulating non-therapeutic body modification *Bioethics* **12**(4): 263-85; Sullivan N (2007) “The price to pay for our common good”: genital modification and the somatechnologies of cultural (in) difference *Social Semiotics* **17**(3): 395-409; and contributors to Hernlund Y, and Shell-Duncan B (2007) *Transcultural bodies: female genital cutting in global context* (New Brunswick, New Jersey: Rutgers University Press).

include, for example, cosmetic surgery resulting from the distress caused by a perception of abnormality or gender reassignment surgery. However, subsection (5) provides that in assessing a girl's mental health no account is taken of any belief that the operation is needed as a matter of custom or ritual. So an FGM operation could not legally occur on the ground that a girl's mental health would suffer if she did not conform with the prevailing custom of her community.³⁷⁴ The *Notes* have been criticised on the basis that they appear to allow operations on the grounds of *perception* of abnormality, even where no such abnormality exists,³⁷⁵ even though it is good practice within the NHS to educate prospective patients about the wide diversity of normal labia, rather than simply to offer surgery.³⁷⁶

4.50 Medical organisations have raised concerns about the legal ambiguity of some of the procedures marketed as FGCS,³⁷⁷ and the Home Affairs Select Committee has recommended that the Government should amend legislation to “make it very clear that female genital cosmetic surgery would be a criminal offence.”³⁷⁸ While, to date, no one has been successfully prosecuted for FGM in the UK, it was reported in November 2016 that police were investigating three cases of FGCS (‘designer vagina’ procedures provided by private clinics in London and Cheshire) as possible breaches of the FGM Act.³⁷⁹ At the time of writing, no further information has emerged as to whether these cases will proceed to court.

Regulation of images and advertising

Regulating advertising

“Marketing and sales techniques would benefit from some regulation, though it is important not to fall into the trap of assuming that patients are passive ‘victims’ easily seduced by advertising.”³⁸⁰

“Commercial organisations, including private providers of cosmetic interventions can... utilise powerful marketing techniques to encourage people to use their services.”³⁸¹

4.51 Advertising in the UK is, for the most part, subject to self-regulation for non-broadcast advertising, and to co-regulation (with Ofcom) for broadcast advertising. Two industry

³⁷⁴ Parliament.UK (2002) *Female Genital Mutilation Bill: explanatory notes*, available at: <https://www.publications.parliament.uk/pa/cm200203/cmbills/021/en/03021x-.htm>, at paragraph 6.

³⁷⁵ Chambers C (2017) *Normal bodies: cultural, cosmetic, and clinical surgery* (working paper). See also: Dustin M (2010) Female genital mutilation/cutting in the UK: challenging the inconsistencies *European Journal of Women's Studies* 17(1): 7-23; and Kelly B, and Foster C (2012) Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *BJOG: An International Journal of Obstetrics & Gynaecology* 119(4): 389-92.

³⁷⁶ NHS Choices (2014) *Labiaplasty*, available at: <http://www.nhs.uk/conditions/labiaplasty/Pages/Introduction.aspx>. See also: The Labia Library (2017) *Homepage*, available at: <http://www.labialibrary.org.au/>.

³⁷⁷ See, for example, Royal College of Surgeons (2016) *Cosmetic surgery standards scope FAQ: is female genital cosmetic surgery (FGCS) covered?*, available at: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/faq/#femalesurg>.

³⁷⁸ House of Commons Home Affairs Committee (2015) *Female genital mutilation: follow-up - sixteenth report of session 2014-15*, available at: <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/961/961.pdf>, at paragraph 14.

³⁷⁹ Aesthetics (5 January 2017) *Why is labiaplasty being compared to female genital mutilation?*, available at: <https://aestheticsjournal.com/feature/why-is-labiaplasty-being-compared-to-female-genital-mutilation>.

³⁸⁰ Dr David Bell, University of Leeds, and Professor Ruth Holliday, University of Leeds, responding to the Working Party's call for evidence.

³⁸¹ British Medical Association, responding to the Working Party's call for evidence.

committees, the Committee of Advertising Practice (CAP), and the Broadcast Committee of Advertising Practice (BCAP), are responsible for writing and updating the UK Advertising Codes: the *UK Code of Non-broadcast Advertising and Direct & Promotional Marketing* (the CAP Code), and the *UK Code of Broadcast Advertising* (BCAP).³⁸² Membership of the committees is made up of representatives of advertisers, agencies, media owners and other industry groups, and the stated aims of the Codes include ensuring that marketing communications are “legal, decent, honest and truthful”, and that they are “prepared with a sense of responsibility to consumers and to society”.³⁸³ CAP provides both general and bespoke advice to advertisers as well as undertaking monitoring to check compliance levels and taking enforcement action where necessary. A number of rules in the advertising codes are underpinned by and reflect legislation, including those that prohibit advertising prescription medicines, such as botox, directly to the public,³⁸⁴ and controls on adverts contributing to misleading or unfair trading practices.³⁸⁵

- 4.52 An independent body, the Advertising Standards Authority ((ASA) also funded at arms-length by industry), is responsible for investigating complaints and administering the Codes. The majority of TV and radio advertisements must be ‘pre-cleared’ before being aired, and UK broadcasters are required by Ofcom to comply with BCAP, and with ASA rulings, as part of their licence conditions.³⁸⁶ For non-broadcast adverts (a category that encompasses all forms of marketing communications, including tweets and blogs by or on behalf of suppliers), there is no mandatory pre-clearance system, but advertisers are encouraged to take advantage of the CAP Copy Advice service before they launch their ad campaigns. If an advertisement is found to have breached the CAP Code, the ASA can rule that it be amended or withdrawn. While the ASA cannot directly enforce its rulings on non-broadcast adverts, it can exercise a number of sanctions through the trade associations which are members of its industry committees, including withholding access to advertising space, and requiring pre-vetting of marketing material before publication, in addition to bad publicity and exclusion from industry awards.³⁸⁷ Where the requirements of the Code derive from consumer protection legislation, further enforcement action is possible through Trading Standards.³⁸⁸

Advertising cosmetic procedures

“I was contacted by a company – they offered me free liposuction in return for some Instagram posts, and you think, ‘Oh my god’, it

³⁸² Advertising Standards Authority (2016) *CAP committees, panels and executive*, available at: <https://www.asa.org.uk/about-asa-and-cap/people/cap-panels-and-committees.html>.

³⁸³ Committee of Advertising Practice (2015) *The CAP code: the UK code of non-broadcast advertising and direct & promotional marketing: edition 12*, available at: <https://www.asa.org.uk/asset/47EB51E7-028D-4509-AB3C0F4822C9A3C4/>, at page 11. The BCAP code states that “advertisements must be prepared with a sense of responsibility to the audience and society.” See: Committee of Advertising Practice (2010) *The BCAP code*, available at: <https://www.asa.org.uk/asset/846F25EB-F474-47C1-AB3FF571E3DB5910/>, at 1.2.

³⁸⁴ Legislation.gov.uk (2012) *The Human Medicines Regulations 2012*, available at: <http://www.legislation.gov.uk/ukxi/2012/1916/contents/made>.

³⁸⁵ Legislation.gov.uk (2008) *The Consumer Protection from Unfair Trading Regulations 2008*, available at: <http://www.legislation.gov.uk/ukxi/2008/1277/contents/made>. See also: Department for Business Enterprise & Regulatory Reform and the Office of Fair Trading (2008) *The Consumer Protection from Unfair Trading Regulations: a basic guide for business*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284446/oft979.pdf.

³⁸⁶ Advertising Standards Authority (2017) *Self regulation and co-regulation*, available at: <https://www.asa.org.uk/about-asa-and-cap/about-regulation/self-regulation-and-co-regulation.html>.

³⁸⁷ Advertising Standards Authority (2017) *Sanctions*, available at: <https://www.asa.org.uk/codes-and-rulings/sanctions.html>.

³⁸⁸ Advertising Standards Authority (2017) *Self regulation and co-regulation*, available at: <https://www.asa.org.uk/about-asa-and-cap/about-regulation/self-regulation-and-co-regulation.html>.

*was ridiculous... Obviously I didn't do it, and I wouldn't want to do that.*³⁸⁹

*"A worrying concern are e-voucher companies which advertise treatments – usually non-surgical [...] reducing prices from between 90 per cent and 64 per cent."*³⁹⁰

- 4.53 Specific guidance on the interpretation of the CAP and BCAP Codes, as these apply to surgical and non-surgical cosmetic interventions, is provided through advertising guidance on *Cosmetic interventions*, updated in 2013 in the light of some of the concerns expressed in the Keogh report.³⁹¹ In general, it is emphasised that advertisements must be prepared with a sense of responsibility (see Box 4.7 below); that they “must not materially mislead or be likely to do so”; and that particular care must be taken when advertising on social media sites likely to have particular appeal to a younger audience. Specific guidance is provided on when it is acceptable to describe practitioners as ‘qualified’ or ‘experienced’; the importance of not misleading consumers as to what an advertised intervention is likely to achieve, and when obvious exaggeration (‘puffery’) is acceptable. Thus, they argue that claims such as ‘a new you’ or ‘feel fantastic’ are likely to be acceptable as unlikely to be taken literally, while the description of procedures as ‘revolutionary’ or as ‘turn[ing] back time’ are considered objective claims that must be substantiated. When pre- or post-production techniques such as re-touching are used, “marketers should ensure that they do not manipulate an image to the point that it goes beyond the look which the treatment alone can achieve”.³⁹²

Box 4.7: Extracts from the guidance on ‘responsibility’ in CAP guidance *Cosmetic Interventions* (paras 32-6)

“Responsibility

32. Ads must be prepared with a sense of responsibility to consumers and to society.
33. Ads should not trivialise cosmetic interventions or suggest that they be undertaken lightly. Creative treatments should not detract from the seriousness of the interventions offered.
34. Marketers should not play on consumers’ insecurities. They should not irresponsibly imply that a cosmetic intervention will be able to solve a consumer’s personal or emotional problems or improve their situation after a difficult life event.
35. Marketers should avoid irresponsibly describing cosmetic interventions as “safe” or “easy”, because it is likely that all such interventions will carry some level of risk to the patient.
36. Colloquial terms such as “boob job”, “tummy tuck” etc. should not have the effect of detracting from the seriousness of the intervention/s offered.”³⁹³

³⁸⁹ Mail Online (20 February 2017) *Furious Gemma Atkinson spurns offer of free liposuction as she condemns beauty company for ‘ridiculous’ bribe*, available at: <http://www.dailymail.co.uk/tvshowbiz/article-4241226/Gemma-Atkinson-spurns-offer-free-liposuction.html#ixzz4ZJ6W3r16>.

³⁹⁰ British Association of Cosmetic Nurses, responding to the Working Party’s call for evidence.

³⁹¹ Committee of Advertising Practice (2016) *Cosmetic interventions: advertising guidance (non-broadcast and broadcast)*, available at: <https://www.asa.org.uk/asset/06D92630-75DE-4DDC-81F365D94E7BA21C/>.

³⁹² *ibid.*, at paragraph 22. Further advertising guidance is published on ‘cosmetic production techniques’. See: Committee of Advertising Practice (2011) *Cosmetic production techniques: advertising guidance (non-broadcast and broadcast)*, available at: <https://www.asa.org.uk/asset/DADFC0E7-DEDC-4198-8F4E1EF7D3F74461/>.

³⁹³ Committee of Advertising Practice (2016) *Cosmetic interventions: advertising guidance (non-broadcast and broadcast)*, available at: <https://www.asa.org.uk/asset/06D92630-75DE-4DDC-81F365D94E7BA21C/>.

- 4.54 In addition to the CAP / BCAP guidance offering interpretation on how the Codes should be applied to the marketing of cosmetic interventions, the ASA website offers more informal advice, highlighting particular points that advertisers should take into account and giving examples of adverts that have been held to fall short of the requirements of the Codes (see Box 4.8 below).

Box 4.8: ASA advice and examples of inappropriate adverts

“Consider your target audience”

Young people are likely to interpret ads differently to adult viewers, for instance, by being more likely to identify with negative feelings about their appearance. Ads depicting people being unhappy with their appearance, followed by a dramatic or significant positive change in their emotional well-being after a procedure, could be socially irresponsible. Recently, a TV ad featuring a fashion blogger was considered harmful to those under 18, despite appearing late at night. It didn't explicitly link surgery with popularity or success but the ASA considered the ad suggested these were related.

“More natural appearance”

The claims “Achieve a more natural appearance” and “Relieve the discomfort caused by enlarged Labia” in an ad for labiaplasty were considered irresponsible because they implied that labia might be unnatural in appearance pre-surgery, and while there might be medical reasons for surgery to reduce discomfort, large labia were not necessarily abnormal and would cause discomfort. Depending on the context, stating that a treatment can result in a “natural appearance” can be acceptable.

Promotional marketing

The issue of conducting promotions responsibly can be tricky, not least because these are usually time-limited. Avoid providing a short response time and including text like “offer ends midnight” and “Give the Buy Now button a cheeky wink before the lids close on today's deal”. If some consumers are likely to see an ad towards the end of a promotion and will only have a few days to respond, this will be problematic, even if the promotion has been available for some time.

Given the risks involved with cosmetic interventions, CAP and the ASA take a strict view. Consumers should be given enough time to research and give the matter serious consideration prior to responding to any type of promotion for a cosmetic intervention, whether this involves committing to buy a voucher for treatment or otherwise, and despite cancellation periods and stringent consultations, post advertising.

Marketers should note that the Royal College of Surgeons suggests that surgeons should not offer services as a prize or use promotional tactics and financial inducements that could influence a patient's decision to have cosmetic surgery. This builds on the GMC guidance for all doctors who offer cosmetic interventions.

Avoid trivialisations

The ASA has previously ruled that a number of ads were irresponsible for implying procedures could be undertaken lightly, or were quick and simple: A ‘Sex and the City’ style ad for the casual way it described a fat transfer; an ad which implied consultations could be slotted into Christmas festivities; a “Medical tourism” ad prominently stating, “Boob job”; and an ad which stated, “The incisions are tiny... you recover within hours... Had my breasts done at MYA, loved them... no second thoughts about going back”.³⁹⁴

³⁹⁴ Advertising Standards Authority (18 August 2016) *Advertising surgical and non-surgical interventions: cutting edge advice*, available at: <https://www.asa.org.uk/news/advertising-surgical-and-non-surgical-interventions-cutting-edge-advice.html>.

Advertising and its effect on body image and body confidence

- 4.55 The ASA website also includes informal advice on “body image and social responsibility” with a particular focus on the thinness of models used in adverts.³⁹⁵ However, one of the issues raised during the Working Party’s inquiry was the limitations of the ‘one advert at a time’ approach which is the mainstay of the current regulatory system (see paragraphs 4.51–4.52).³⁹⁶ An approach that considers on a case-by-case basis whether or not a particular advert has met the standards set in the Codes does not allow for consideration of the cumulative effect of images that may seem unexceptional in themselves, but that may contribute to the body image pressures identified in Chapter 1 (see paragraphs 1.6–1.13).
- 4.56 However, in addition to its role in policing the Code in response to complaints, the ASA emphasises that it will take a proactive role in working with others to identify and tackle problems, and make sure that adverts are responsible.³⁹⁷ In 2016, the ASA identified “the presentation of an idealised or unrealistic body image” as one of a number of concerns linked with equality issues and gender stereotyping that had generated considerable public interest, and launched a call for evidence to help shape possible action in this field.³⁹⁸ The Working Party was told that questions of ‘cumulative effect’ were likely to be considered as part of this process, and that the ASA was aiming to publish a report on its findings in 2017.³⁹⁹

Additional controls by those hosting advertising

- 4.57 Within the parameters of the industry-wide system operated by the ASA and the CAP / BCAP Codes, it is also open to those organisations that provide advertising space (whether hard copy, online or broadcast) to set their own policies with respect to the adverts that they will accept. When he became Mayor of London, Sadiq Khan asked Transport for London (TfL) to update its advertising policy, and in June 2016 announced that TfL would no longer accept advertisements that “could reasonably be seen as likely to cause pressure to conform to an unrealistic or unhealthy body shape, or as likely to create body confidence issues, particularly among young people.”⁴⁰⁰ He further requested TfL to establish an Advertising Steering Group to monitor TfL’s approach to advertising and to keep its policies under regular review.⁴⁰¹ In the Group’s first meeting in February 2017, members commended TfL and the London Mayor for including explicit

³⁹⁵ Advertising Standards Authority (17 June 2015) *Body image and social responsibility*, available at: <https://www.asa.org.uk/news/body-image-and-social-responsibility.html>.

³⁹⁶ Factfinding meeting with professional regulators (30 September 2016).

³⁹⁷ Advertising Standards Authority (2017) *Our purpose and strategy*, available at: <https://www.asa.org.uk/about-asa-and-cap/about-regulation/our-purpose-and-strategy.html>.

³⁹⁸ Advertising Standards Authority (6 June 2016) *Our call for evidence: gender stereotyping in ads*, available at: <https://www.asa.org.uk/news/our-call-for-evidence-gender-stereotyping-in-ads.html>. The strong public response to the weight loss advert asking “Are you beach-body ready?” was one of the prompts behind the initiation of this project: Factfinding meeting with professional regulators (30 September 2016); and The Guardian (28 April 2016) *ASA launches investigation into gender stereotyping of women in adverts*, available at: <https://www.theguardian.com/media/2016/apr/28/asa-probe-gender-stereotyping-women-adverts>.

³⁹⁹ Factfinding meeting with professional regulators (30 September 2016). At the time of writing, the report was not yet available.

⁴⁰⁰ Mayor of London (13 June 2016) *Mayor in crackdown on body image advertisements on the TfL network*, available at: <https://www.london.gov.uk/press-releases/mayoral/mayor-in-crackdown-on-body-image-advertisements>. See further: Transport for London (2016) *Advertising policy*, available at: <http://content.tfl.gov.uk/advertising-policy-july-2016.pdf>, at paragraph 2.3(d).

⁴⁰¹ Mayor of London (13 June 2016) *Mayor in crackdown on body image advertisements on the TfL network*, available at: <https://www.london.gov.uk/press-releases/mayoral/mayor-in-crackdown-on-body-image-advertisements>.

reference to body image, and were also interested in finding ways to encourage greater diversity, for example by reference to sexuality and disability.⁴⁰²

- 4.58 Some social media companies also have their own internal policies on acceptable advertising, as illustrated in Box 4.9 below:

Box 4.9: Social media policies on advertising relevant to body image

Facebook's / Instagram's advertising policies state that advertisements should not contain 'before-and-after' images, or "unexpected or unlikely results," and that "advert content must not imply or attempt to generate a negative self-perception in order to promote dietary, weight loss or other health-related products".⁴⁰³ Users' personal data should not be used to enable advertisements to be targeted to reflect "the personal beliefs, characteristics or values of the people who use Facebook or Instagram,"⁴⁰⁴ and adverts which focus on health, fitness, or weight loss products must be targeted to people aged 18 and over.⁴⁰⁵

YouTube's policy on advertising rules for its YouTube Kids app prohibits products related to external personal care, fitness, exercise, weight loss, diet, and nutrition.⁴⁰⁶ However, YouTube's general site does not include an advertising policy relating to these products.

Snapchat – an instant multimedia messaging app – does not explicitly highlight products or services relevant to body image in its own advertising policies.⁴⁰⁷

Twitter's editorial guidelines for advertising state that advertisements should not include exaggerated or sensationalised language.⁴⁰⁸ Its keyword policy also states that advertisers must not target users' timelines through selecting words that target sensitive categories, one of which is health.⁴⁰⁹ Twitter also prohibits advertisers from creating tailored audiences based on sensitive information associated with users' health.⁴¹⁰

Controls over the sharing of images, outside commercial advertising

- 4.59 While the CAP Code has a wide reach, encompassing the many different media used by companies to market their products or services, it does not extend to material shared on a non-commercial basis between individuals. Thus, for example, the Code does not cover blogs or tweets by celebrities praising or endorsing particular cosmetic procedures, unless the celebrity has actually been commissioned to do so by the supplier. Such

⁴⁰² Transport for London (2017) *Advertising Steering Group: draft minutes for meeting of 17 February 2017, 10.00-11.30*, available at: <http://content.tfl.gov.uk/mayors-advertising-steering-group-minutes-february-2017-draft.pdf>.

⁴⁰³ Facebook (2017) *Advertising policies: personal health*, available at: https://www.facebook.com/policies/ads/prohibited_content/personal_health.

⁴⁰⁴ Facebook (2017) *The advert review process*, available at: <https://www.facebook.com/policies/ads>, at point 13(3).

⁴⁰⁵ Facebook (2017) *Advertising policies: personal health*, available at: https://www.facebook.com/policies/ads/prohibited_content/personal_health.

⁴⁰⁶ See: YouTube Help (2017) *Advertising on YouTube Kids*, available at: https://support.google.com/youtube/answer/6168681?hl=en-GB&ref_topic=30084. YouTube Kids is an app which is aimed at children, and provides parents with a range of "family-friendly videos": YouTube Kids (2017) *Homepage*, available at: <https://kids.youtube.com/>. YouTube is owned by Google: BBC News (2006) *Google buys YouTube for \$1.65bn*, available at: <http://news.bbc.co.uk/1/hi/business/6034577.stm>.

⁴⁰⁷ Snap Inc. (2017) *Snap Inc. advertising policies*, available at: <https://www.snap.com/en-GB/ad-policies/>.

⁴⁰⁸ Twitter (2017) *Quality policy for advertising*, available at: <https://support.twitter.com/articles/20170421>.

⁴⁰⁹ Twitter (2014) *Policies for keyword targeting*, available at: <https://support.twitter.com/articles/20170368>.

⁴¹⁰ Twitter (2017) *Policies for conversion tracking and tailored audiences*, available at: <https://support.twitter.com/articles/20171365>.

content is thus largely unregulated, unless it is found to breach the policies of the particular social media or website company.

- 4.60 As a general rule, social media companies do not actively intervene with respect to the content posted on their sites, with the exception of initiatives (sometimes involving collaboration across the sector) to combat dangerous and illegal content, such as that relating to child abuse or extremism.⁴¹¹ Concerns about the scope for social media use to influence body image, and the associated impact on mental health, appear at present to have received relatively little attention, although social media companies may include body image issues in their educational and campaigning programmes. One example drawn to the Working Party's attention, for example, in Instagram's '#perfectlyme' campaign undertaken in partnership with Seventeen magazine.⁴¹² A campaign seeking to persuade companies to create policies that would prohibit the downloading of cosmetic surgery apps and games by children, on the other hand, has so far proved unsuccessful.⁴¹³
- 4.61 In most cases, companies take a reactive, rather than proactive, approach to implementing their policies, relying on users to report alleged breaches before taking action: for example, there are no systems in place to enforce the minimum age limits set for many social media sites, other than to delete accounts in response to complaints. In a 2017 report on children's digital use, the Children's Commissioner highlighted "repeated but futile" attempts by young people to report offending content or bullying; and criticised the strategies employed by social media to respond to complaints about particular content as "not sufficiently proactive or responsive".⁴¹⁴ She also described as "totally unacceptable" delays by Facebook in removing inappropriate images of children that had been reported to them as part of a BBC investigation.⁴¹⁵ Similarly strongly-worded criticism of the failures on the part of social media companies to act effectively with respect to dangerous or illegal content have been made by the Home Affairs Select Committee.⁴¹⁶

Role of equality law

- 4.62 As we noted in Chapter 2, some of the appearance ideals associated with demand for cosmetic procedures are discriminatory in nature (see paragraph 2.13–2.15). In Great Britain, discrimination on the grounds of a number of 'protected characteristics', such as

⁴¹¹ See, for example, Facebook (5 December 2016) *Partnering to help curb spread of online terrorist content*, available at: <https://newsroom.fb.com/news/2016/12/partnering-to-help-curb-spread-of-online-terrorist-content/>; and The Guardian (22 July 2013) *Twitter to introduce PhotoDNA system to block child abuse images*, available at: <https://www.theguardian.com/technology/2013/jul/22/twitter-photodna-child-abuse>.

⁴¹² Video meeting with Facebook / Instagram, 16 December 2016. See also: The Huffington Post (18 October 2016) *The simple way Instagram is combating self-harm and body image issues*, available at: http://www.huffingtonpost.com/entry/instagram-perfectly-me-initiative-body-image_us_58051efbe4b0e8c198a99a14.

⁴¹³ Endangered Bodies (30 January 2017) *Cosmetic surgery games for kids? No thanks.*, available at: http://www.endangeredbodies.org/cosmetic_surgery_games_for_kids_no_thanks.

⁴¹⁴ Children's Commissioner (2017) *Growing up digital*, available at: www.childrenscommissioner.gov.uk/sites/default/files/publications/Growing%20Up%20Digital%20Taskforce%20Report%20January%202017_0.pdf, at page 14. See also: The Guardian (21 May 2017) *Facebook moderators: a quick guide to their job and its challenges*, available at: <https://www.theguardian.com/news/2017/may/21/facebook-moderators-quick-guide-job-challenges>.

⁴¹⁵ Children's Commissioner *Facebook and other social media providers must act responsibly and protect children*, available at: <https://www.wired-gov.net/wg/news.nsf/articles/Facebook+and+other+social+media+providers+must+act+responsibly+and+protect+children+07032017154600?open>.

⁴¹⁶ House of Commons Home Affairs Committee (2017) *Hate crime: abuse, hate and extremism online*, available at: <https://www.publications.parliament.uk/pa/cm201617/cmselect/cmhaff/609/609.pdf>.

age, race, gender, and disability, is prohibited by the Equality Act 2010.⁴¹⁷ While discrimination on the grounds of appearance alone is not prohibited, the Act may still be relevant where appearance-related discrimination also relates to one of the protected characteristics. Moreover, “severe disfigurement” is treated under the Act as a disability.⁴¹⁸ The Equality and Human Rights Commission, which is responsible both for enforcing the protections in the 2010 Act, and for providing guidance and advice to support compliance, has, for example, issued advice on sexist dress codes at work, and when these might breach equality law.⁴¹⁹

Challenges of enforcement

4.63 Given the complex nature of the cosmetic procedures industry, and the multiple stakeholders concerned, it is perhaps unsurprising that the regulatory landscape sketched out in this chapter is so broad and complicated; or indeed that, despite repeated regulatory reviews, concerns remain as to whether potential users of cosmetic procedures are adequately protected. A common theme that emerges across a number of the disparate domains reviewed above, from the regulation of individual practitioners to the regulation of advertising and the sharing of information and images over social media, is that of the enormous challenge of enforcement and the limitations of a reactive approach. While considerable work has been done in recent years in setting standards and policies, these alone may be insufficient to protect users if they are not adopted consistently across the sector and cannot be effectively policed.

⁴¹⁷ Legislation.gov.uk (2010) *Equality Act 2010*, available at: <http://www.legislation.gov.uk/ukpga/2010/15/contents>. The 2010 Act applies in England, Wales, and Scotland. Separate legislation applies in Northern Ireland. See: Equality Northern Ireland (2017) *Legislation*, available at: <http://www.equalityni.org/Footer-Links/Legislation.aspx>.

⁴¹⁸ Schedule 1, paragraph 3, of the Equality Act 2010.

⁴¹⁹ Equality and Human Rights Commission (2017) *Sexist dress codes at work: what you can do*, available at: <https://www.equalityhumanrights.com/en/equality-act/know-your-rights/sexist-dress-codes-work-what-you-can-do>.

Chapter 5

Having a cosmetic procedure: influences and motivations

Chapter 5 – Having a cosmetic procedure: influences and motivations

Chapter 5: overview

The research available at the moment exploring the motivations and influences that lead people to consider cosmetic procedures is disparate and variable in quality; and further, more robust, evidence is needed to provide a more thorough understanding of the field than is presently possible. This chapter draws on the published literature and the Working Party's own evidence-gathering to summarise what is known about the motivations and influences that prompt people to consider using cosmetic procedures.

Different cohorts of prospective users of cosmetic procedures are attracted to particular procedures for different reasons, although very often linked through a common thread of wishing to 'fit in' with a particular peer group. Reasons cited in the published literature and in the Working Party's own evidence gathering for having a cosmetic procedure include:

- wanting to look younger;
- aiming to achieve 'normality', often defined with reference to peer group preferences regarding appearance, rather than in response to disfigurement;
- hoping to improve self-esteem, or responding to body dissatisfaction;
- hoping to achieve, or maintain, professional success; and
- rejecting or conforming to social and cultural ideals.

However, only a minority of people who share one or more of these aims will decide to use cosmetic procedures in order to try to achieve them. A number of role models and influences have been identified as potentially significant in encouraging people to consider (or not to consider) cosmetic procedures. These include: the influence and attitudes of family, friends and peers; the influence of celebrity, media, social media, and pornography; concerns with respect to sex and relationships; experience of being bullied or teased; physical discomfort (as a contributory factor); changes in the body post-pregnancy; and affordability.

While these influences seem disparate, a common feature of some of them is that they make procedures seem more 'available' as they become more familiar, appropriate or affordable. Others arise out of particular events or personal histories.

Introduction

- 5.1 This chapter focuses on what is known about what motivates and influences people to undergo cosmetic procedures, and should be read in conjunction with the following chapter exploring what is known about user satisfaction and outcomes. We draw on published literature;⁴²⁰ contributions to the Mass Observation project;⁴²¹ our consultation responses from academics, professionals, practitioners and other individuals with

⁴²⁰ For an extended review of the literature on what might motivate people to undergo cosmetic procedures, see: Nuffield Council on Bioethics (2016) *Literature review: cosmetic procedures - demand, motivations, and influencing factors*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Motivations-review.pdf>. This review includes studies from within and outside the UK.

⁴²¹ The Mass Observation project currently gathers views from approximately 450 UK-based volunteer participants who are members of its writing panels. Participants respond to directives (open-ended questionnaires that are sent to them three times a year). For further details, see: Mass Observation (2015) *The Mass Observation Project, 1981-ongoing*, available at: <http://www.massobs.org.uk/the-mass-observation-project-1981-ongoing>. In 2012, the project issued a directive to gather participants' views of cosmetic surgery: Mass Observation (2012) *The Mass Observation Project: autumn 2012 directive - part 2: cosmetic surgery*, available at: http://www.massobs.org.uk/images/Directives/Autumn_2012_directive.pdf.

specific interests in cosmetic procedures; online questionnaire responses from the wider public; face-to-face factfinding meetings around particular themes (both in groups and through interview-style meetings with individuals); and deliberative events with young people, with the general public through Café Scientifique-style events, and with older women through an informal community group (see Appendices 1 and 2 for further detail of these consultative activities).

- 5.2 In what follows, we use quotations from the literature and from our own evidence-gathering activities to indicate, in people's own words, their understandings and experiences of cosmetic procedures. In doing so our intention is not to privilege any one view, but to illustrate the diversity of views, perspectives and opinions on cosmetic procedures. We are also aware that different social and demographic groups within the population have different reasons for using specific cosmetic procedures.
- 5.3 The published literature exploring the influences, motivations and experiences of those having cosmetic procedures is also disparate and varying in quality: some studies, for example, draw broad conclusions from small sample sizes, while other research is conducted by practitioners or commercial providers interviewing or surveying their own clients, raising concerns about methodology or bias. There is also a preference for anonymity on the part of many people undergoing cosmetic procedures which contributes to difficulties in research recruitment. Research results may be further affected by the psychological need, recognised in many fields, for people retrospectively to justify their decisions, particularly when these involve high cost, whether financial or emotional.⁴²²
- 5.4 Taking these limitations into account, some clear themes nevertheless emerge, not least with respect to the diverse nature of the reasons and influences that underpin individuals' decisions to have a cosmetic procedure. This chapter provides an overview of the empirical evidence available to the Working Party, starting with the question of what people aim to achieve in having a cosmetic procedure, and then turning to the influences that shape decisions to undergo certain procedures. The following chapter then considers the available evidence with respect to the outcomes of cosmetic procedures. In reviewing the available evidence and in identifying shortcomings in some existing research, we also note that further and more robust evidence is needed to provide a more thorough and nuanced understanding of the field than we have at present.

Having a cosmetic procedure: what people aim to achieve

- 5.5 As we note in paragraph 5.2, different cohorts of prospective users of cosmetic procedures are attracted to particular procedures for different reasons, although linked through a common thread of wishing to 'fit in' with a particular peer group. For example, young women may use botox or dermal fillers for reasons that differ significantly from those of older women who undergo the same procedure. Below, we present an overview of the motivations most often cited in the published literature, alongside those that emerged in our own consultative activities. We note that the reasons people give for undergoing cosmetic procedures are multi-faceted, and although we present them below

⁴²² See, for example, the theory of 'cognitive dissonance' which suggests that there is a tendency for individuals to seek consistency among their beliefs and opinions. When there is an inconsistency between attitudes or behaviours (dissonance), something must change to eliminate the dissonance: Festinger L, and Carlsmith JM (1959) Cognitive consequences of forced compliance *The Journal of Abnormal and Social Psychology* **58(2)**: 203-10.

as discrete motivations in separate sections, in practice they are likely to overlap. Given the complexity of the messages conveyed about the ideal body and body modification, it is likely that people will be motivated by more than one of the issues identified here.⁴²³

Age: looking younger (or older)

“There’s such emphasis on looking young and looking attractive and, I mean everything in society pushes you toward that.”⁴²⁴

“Fears about becoming less attractive due to ageing. Aware of societal pressure on women to look young. Concerns that if I didn’t have botox at this point I may be leaving it too late.”⁴²⁵

“We all have vanity – particularly women – the pressure to look young is immense.”⁴²⁶

5.6 The significance of the pressure to look young as a motivating factor for people, particularly women, to consider a cosmetic procedure has been reported in a number of empirical studies,⁴²⁷ and ‘ageing anxiety’ among middle-aged women is associated with generally positive attitudes to cosmetic surgery.⁴²⁸ Widespread interest in mitigating or disguising the effect of ageing on appearance is indicated by the size of the market in anti-ageing products and procedures,⁴²⁹ and the ageing population has been identified by market analysts as a significant driver in demand for anti-ageing cosmetic procedures now and over the next few years.⁴³⁰ It has also been suggested that, among younger women, botox is being used as an ageing ‘prophylactic’ in order to forestall the signs of ageing.⁴³¹ Concerns about the appearance of ageing are not limited to self-perceptions of attractiveness or self-esteem, but may also relate to concerns about the possible consequences of visible ageing, emerging for example in connection with employment prospects (see paragraph 5.15) or concerns about future relationships (see paragraph 5.35).

⁴²³ See, for example, Sorice SC, Li AY, Canales FL, and Furnas HJ (2017) Why women request labiaplasty *Plastic and Reconstructive Surgery* **139(4)**: 856-63, which reported that of 50 women who had received a labiaplasty, nearly all cited four or more reasons for requesting the procedure.

⁴²⁴ Nora, 57, who had liposuction, botox, dermal fillers, and dermabrasion procedures: Adams J (2010) Motivational narratives and assessments of the body after cosmetic surgery *Qualitative Health Research* **20(6)**: 755-67, at page 760.

⁴²⁵ Respondent to the Working Party’s online questionnaire.

⁴²⁶ Mass Observation Archive (2012) *Autumn 2012 directive: part 2 - cosmetic surgery* (Brighton: The Keep).

⁴²⁷ See, for example, Darisi T, Thorne S, and Iacobelli C (2005) Influences on decision-making for undergoing plastic surgery: a mental models and quantitative assessment *Plastic and Reconstructive Surgery* **116(3)**: 907-16, at page 912, which reports that a quarter of its 644 survey respondents cited age as a motivating factor for having a cosmetic procedure; 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 which explores older women’s attitudes to ‘natural’ and ‘unnatural’ ageing; and Hurd Clarke L, Repta R, and Griffin M (2007) Non-surgical cosmetic procedures: older women’s perceptions and experiences *Journal of Women & Aging* **19(3-4)**: 69-87, which involved 44 women between the ages of 55 and 70, and indicated that an awareness of ageing may be a motivating factor.

⁴²⁸ Slevic J, and Tiggemann M (2010) Attitudes towards cosmetic surgery in middle-aged women: body image, ageing anxiety, and the media *Psychology of Women Quarterly* **34(1)**: 65-74.

⁴²⁹ One estimate suggests the global market in such products and procedures will grow from \$140 billion in 2015 to \$216 billion by 2021. See: GlobeNewswire (2 August 2016) *Anti-aging market poised to surge from USD 140.3 billion in 2015 to USD 216.52 billion, globally by 2021 - ZionMarketResearch.com*, available at: <https://globenewswire.com/news-release/2016/08/02/860902/0/en/Anti-Aging-Market-Poised-to-Surge-from-USD-140-3-Billion-in-2015-to-USD-216-52-Billion-Globally-by-2021-ZionMarketResearch-Com.html>.

⁴³⁰ Key Note (2015) *Cosmetic surgery: market update*, available at: https://www.keynote.co.uk/market-update/healthcare-medical-pharmaceuticals/cosmetic-surgery?full_report=true.

⁴³¹ See, for example, the discussion of ‘preventive botox’ in Berkowitz D (2017) *Botox nation: changing the face of America* (New York: New York University Press), pp53-5.

- 5.7 Less commonly, perceptions of looking immature, or perceiving an attribute as ‘childlike’ or androgynous may also motivate people to seek cosmetic surgery. For example, one respondent in a US study of women who had received various types of breast surgery explained her decision to have breast augmentation: “I looked like a little boy, completely flat-chested. I didn’t feel feminine. Not just a little boy, also a kid.”⁴³² As this example illustrates, questions of age and gender can be interrelated in decisions to undertake a cosmetic procedure.

Achieving ‘normality’

*“I wanted to be normal.”*⁴³³

*“I don’t look ‘normal’ as my breasts are very small.”*⁴³⁴

*“My labia did not look like those shown in textbooks or porn. I therefore mistakenly believed I was abnormal.”*⁴³⁵

- 5.8 The value placed on ‘normality’ as an important motivating factor in decisions to have cosmetic procedures is well-documented in the literature.⁴³⁶ It emerged frequently throughout the Working Party’s evidence-gathering activities, particularly in response to its online questionnaire, where a number of respondents stated that they had been prompted to have, or would seriously consider having, cosmetic procedures in order to achieve what they perceived as normality for a particular part of their body. As the quotation above citing “very small” breasts suggests, perceptions of what is ‘normal’ may relate to narrow boundaries with respect to acceptable appearance, or to particular peer group preferences, rather than to the absence of abnormality or disfigurement.
- 5.9 The importance ascribed to achieving what is perceived as a more normal appearance emerges in empirical studies not only from the UK, but also from France, Italy, the US, and Brazil. These include concerns about genital appearance for women undergoing female genital cosmetic surgery (FGCS),⁴³⁷ otoplasty,⁴³⁸ male breast reduction,⁴³⁹ other types of breast surgeries,⁴⁴⁰ and cosmetic procedures such as body contouring after

⁴³² Borelli F, and Casotti LM (2012) The before and after: a study of plastic surgery consumption with young women in Brazil *Advances in Consumer Research* **40**: 379-85. See further: 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, at page 822, where a 21-year-old user of breast augmentation states: “I felt like I was getting older... but I still looked like I was 12 years old.”

⁴³³ User of breast augmentation and abdominoplasty, aged 32, in de Andrade DD (2010) On norms and bodies: findings from field research on cosmetic surgery in Rio de Janeiro, Brazil *Reproductive Health Matters* **18(35)**: 74-83.

⁴³⁴ Respondent to the Working Party’s online questionnaire.

⁴³⁵ *ibid.*

⁴³⁶ See, for example, Davis K (1995) *Reshaping the female body: the dilemma of cosmetic surgery* (New York: Routledge).

⁴³⁷ Bramwell R, Morland C, and Garden AS (2007) Expectations and experience of labial reduction: a qualitative study *BJOG: An International Journal of Obstetrics & Gynaecology* **114(12)**: 1493-9; and 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.

⁴³⁸ See, for example, Horlock N, Vögelin E, Bradbury ET, Grobelaar AO, and Gault DT (2005) Psychosocial outcome of patients after ear reconstruction: a retrospective study of 62 patients *Annals of Plastic Surgery* **54(5)**: 517-24, at page 518, where 36% of children who had undergone ear reconstruction indicated that they “wanted to be like everyone else.”

⁴³⁹ See, for example, the account of a plastic surgeon in: Greco C (2015) Shining a light on the grey zones of gender construction: breast surgery in France and Italy *Journal of Gender Studies*: 1-15, at page 6. The surgeon notes, on one patient who had gynaecomastia, that when he “goes to the beach everybody teases him... [so] you operate on him and you make him normal”.

⁴⁴⁰ See, for example, Rubin LR, Klassen A, Cano SJ, Hurlley K, and Pusic AL (2009) Motivations for breast surgery: a qualitative comparison study of breast reconstruction, augmentation, and reduction patients *The Breast Journal* **15(6)**: 666-7.

bariatric (weight loss) surgery.⁴⁴¹ A rather different desire for ‘normality’, in the sense of a person wanting to regain their past appearance, may also arise at points in life where bodies undergo a period of rapid and significant change, most notably in the case of pregnancy (see paragraph 5.31).⁴⁴²

Happiness: self-esteem and confidence

“I was unhappy.”⁴⁴³

“There are a significant group of people that must not be forgotten; for whom, if they don’t have something done, and they become socially withdrawn, that ruins their life. So just as much as there are people who feel that they can have the perfect life if they get something done, if you’re affected by something to the extent where it affects your social life, it affects your family life, it affects your work life, because you don’t have something done, and you become withdrawn, those people mustn’t be forgotten.”⁴⁴⁴

“Life is better as [my] self-esteem increased.”⁴⁴⁵

5.10 A number of respondents to the Working Party’s online questionnaire stated that they had undergone, or considered having, a cosmetic procedure in the hope that cosmetic procedures might improve their self-esteem: for example, they suggested that their aim in having a procedure would be “to feel more confident”, or “to feel better about myself”. From a 2014 survey, the market intelligence agency Mintel reported that “boosting self-esteem” was the most common reason given by respondents who had had, or would consider having, cosmetic procedures, with 51 per cent citing this as an influencing factor.⁴⁴⁶ The hope of feeling better about oneself, or enhancing one’s self-esteem, likewise frequently emerges in the literature: for example, in a study with women who have undergone a specific procedure such as FGCS,⁴⁴⁷ and hypothetically with respect

⁴⁴¹ See, for example, Klassen AF, Cano SJ, Scott A, Johnson J, and Pusic AL (2012) Satisfaction and quality-of-life issues in body contouring surgery patients: a qualitative study *Obesity Surgery* **22(10)**: 1527-34, at page 1532.

⁴⁴² Darisi T, Thorne S, and Iacobelli C (2005) Influences on decision-making for undergoing plastic surgery: a mental models and quantitative assessment *Plastic and Reconstructive Surgery* **116(3)**: 907-16, which includes the observation, at page 911, that: “I wanted to restore my body to the way it looked before I had children.” See also: 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; Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: a cross-cultural analysis of women’s narratives *Body & Society* **13(1)**: 41-60; and Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80.

⁴⁴³ Respondent to the Working Party’s online questionnaire.

⁴⁴⁴ Participant, deliberative workshop with Changing Faces, 14 December 2016.

⁴⁴⁵ Respondent to the Working Party’s online questionnaire.

⁴⁴⁶ Mintel (2014) *Cosmetic surgery: UK - executive summary* (London: Mintel), at page 3. Mintel surveyed 1,225 adult internet users who had indicated that they had had, or would be interested in having, surgical or non-surgical procedures. Participants were asked: “You have indicated that you have had, or would be interested in having surgical or non-surgical procedure(s). Which of the following factors, if any, influenced / would influence your decision? Please select all that apply.” Other options available for participants to select were: to be more attractive (36%); I wanted / want a quick fix to an area of my appearance I was / am unhappy with (27%); to look younger (22%); for medical reasons (19%); I wanted / want to save money in the longer term (12%); I wasn’t / am not happy with the results from conventional products (10%); it’s more socially acceptable these days (9%); I knew / know people who have had the same procedure (7%); I did it / would do it for my partner (7%); to boost my career prospects (6%); I was / am inspired by a celebrity (3%). However, 12% of respondents indicated that none of these options applied.

⁴⁴⁷ 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, at page 1568, where 32% of women who had undergone FGCS stated that they did so in order to enhance their self-esteem.

to cosmetic surgery in general: for example in a study of US high school students.⁴⁴⁸ Data on the long-term impact of cosmetic procedures on users' self-esteem, and hence the extent to which these aims are realised, are currently lacking (see paragraph 6.3).

- 5.11 While the hope of enhancing one's self-esteem is clearly a motivation for some users or potential users of cosmetic procedures, the extent to which the presence of *low* self-esteem increases the likelihood of having a procedure is unclear.⁴⁴⁹ While one US study found low self-esteem "led to higher levels of sociocultural attitudes toward appearance, which resulted in positive attitudes toward cosmetic surgery",⁴⁵⁰ this correlation has been questioned in other studies.⁴⁵¹ It has also been argued that, for those with high self-esteem, cosmetic surgery can be a proactive means of *enhancing* self-image.⁴⁵²

'For yourself'

- 5.12 The literature and our own consultative activities include a number of examples from people who emphasised that their motivation for deciding to have a cosmetic procedure was to enable them to feel attractive 'for themselves' rather than for other people or to increase their chances of forging new relationships.⁴⁵³ This highlights a tension frequently brought to our attention throughout this project between the way in which cosmetic procedures are marketed, and the ways in which they are used (particularly by women). This tension can be seen in different interpretations of what women mean when they say that they have a cosmetic procedure 'for themselves', rather than 'for' anybody else. From one perspective, the notion that women 'do it for themselves' points to their agency and dignity and pride in their appearance that is found in other beauty practices.⁴⁵⁴ From another perspective, this idea exemplifies the way in which marketing messages are internalised and perceived links between appearance and life satisfaction reinforced.⁴⁵⁵

⁴⁴⁸ Pearl A, and Weston J (2003) Attitudes of adolescents about cosmetic surgery *Annals of Plastic Surgery* **50(6)**: 628-30, at page 629: among a group of 40 high school students who stated they would choose to have cosmetic surgery in the future, 90% indicated that their motivation was "to feel better about themselves".

⁴⁴⁹ See, for example, Crerand CE, Magee L, and Sarwer DB (2012) Cosmetic procedures, in *The Oxford handbook of the psychology of appearance*, Rumsey N, and Harcourt D (Editors) (Oxford: Oxford University Press), at chapter 25, page 335, who note that research on pre-procedural psychological status of potential patients is lacking, and that while some studies report low self-esteem in women seeking breast augmentation, more recent studies "have found significantly less preoperative psychopathology".

⁴⁵⁰ Park JS, and Cho C-H (2011) Factors explaining college students' intention to receive cosmetic surgery in the future: a structural equation modeling approach *Journal of Medical Marketing: Device, Diagnostic and Pharmaceutical Marketing* **11(2)**: 127-43, at page 139.

⁴⁵¹ See, for example, Swami V, Chamorro-Premuzic T, Bridges S, and Furnham A (2009) Acceptance of cosmetic surgery: personality and individual difference predictors *Body Image* **6(1)**: 7-13, which took its data from 332 UK male and female university students and found that low self-esteem was not correlated with a higher likelihood of having cosmetic surgery.

⁴⁵² Delinsky SS (2005) Cosmetic surgery: a common and accepted form of self-improvement? *Journal of Applied Social Psychology* **35(10)**: 2012-28.

⁴⁵³ See, for example, 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, at page 823, which concludes that "the women we talked with did not have mammoplasty because they wanted to date or become romantically or sexually involved with more men. Instead, they wanted their bodies to represent them as attractive women." Similarly, a further study includes the observation by a participant that "I am not doing it for some guy. I'm doing it for myself": Sanchez Taylor J (2012) Fake breasts and power: gender, class and cosmetic surgery *Women's Studies International Forum* **35(6)**: 458-66, at page 464. See also: Nuffield Council on Bioethics (2017) *Cosmetic procedures: online questionnaire - analysis*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Online-questionnaire-analysis.pdf>.

⁴⁵⁴ See, for example, Gimlin D (2002) *Body work: beauty and self-image in American culture* (London: University of California Press), pp8-9.

⁴⁵⁵ See, for example, Rodgers RF, and DuBois RH (2016) Cognitive biases to appearance-related stimuli in body dissatisfaction: a systematic review *Clinical Psychology Review* **46**: 1-11 which concludes that there is robust support for the presence of attention biases towards body image-related stimuli amongst people with high levels of body dissatisfaction.

Body image and satisfaction

“Body image was a lot of it; I couldn’t find any clothes, every bit of clothes that I found were way too big for my waist, but barely fitting my top. You know, I felt self-conscious when I was with men, guys. I felt self-conscious; everywhere I went people were staring.”⁴⁵⁶

“I lost 7 stone in weight and was left with a large amount of loose skin which was uncomfortable and limited my ability to be active as well as my body image.”⁴⁵⁷

“I’ve never had cosmetic surgery, but I have wanted to since I was a teenager, due to feeling grotesque. I’m now 23.”⁴⁵⁸

- 5.13 Closely related to self-esteem are issues of body consciousness and body satisfaction (see paragraphs 1.6–1.13). Some studies indicate that those who are dissatisfied with their body are more likely to consider cosmetic procedures than those who are not,⁴⁵⁹ although it has also been suggested that people who actually undergo cosmetic surgery are more likely to report dissatisfaction with particular features, rather than dissatisfaction with their body in general (see also paragraph 5.14).⁴⁶⁰ The desire to ‘fix’ a particular aspect of their appearance that they were unhappy with was cited by 27 per cent of respondents to the 2014 Mintel survey as an actual or potential influence in having a cosmetic procedure,⁴⁶¹ and this is borne out in studies of those who had undergone specific procedures, including breast augmentation,⁴⁶² otoplasty,⁴⁶³ and FGCS.⁴⁶⁴
- 5.14 While fear of becoming unattractive has been cited as a reason for considering a cosmetic procedure,⁴⁶⁵ there does not appear to be a straightforward correlation between body dissatisfaction and undertaking a cosmetic procedure: as a participant in a Norwegian study commented: “I’m not dissatisfied with these breasts; they are nice, I just think I could be even more satisfied if they were bigger”⁴⁶⁶ (see also paragraph 5.11).

⁴⁵⁶ Quote from a 25-year-old breast reduction user in Adams J (2010) Motivational narratives and assessments of the body after cosmetic surgery *Qualitative Health Research* **20(6)**: 755-67, at page 763.

⁴⁵⁷ Respondent to the Working Party’s online questionnaire.

⁴⁵⁸ Respondent to the Working Party’s online questionnaire.

⁴⁵⁹ See, for example, Slevac J, and Tiggemann M (2010) Attitudes towards cosmetic surgery in middle-aged women: body image, aging anxiety, and the media *Psychology of Women Quarterly* **34(1)**: 65-74; and Tranter B, and Hanson D (2015) The social bases of cosmetic surgery in Australia *Journal of Sociology* **51(2)**: 189-206.

⁴⁶⁰ Slevac J, and Tiggemann M (2010) Attitudes towards cosmetic surgery in middle-aged women: body image, aging anxiety, and the media *Psychology of Women Quarterly* **34(1)**: 65-74, at page 70.

⁴⁶¹ Mintel (2014) *Cosmetic surgery: UK - executive summary* (London: Mintel), at page 3.

⁴⁶² Sarwer DB, LaRossa D, Bartlett SP *et al.* (2003) Body image concerns of breast augmentation patients *Plastic and Reconstructive Surgery* **112(1)**: 83-90, at page 87: users reported significantly greater dissatisfaction with their breasts compared to women who were not seeking augmentation. Similar findings were reported by Didie ER, and Sarwer DB (2003) Factors that influence the decision to undergo cosmetic breast augmentation surgery *Journal of Women’s Health* **12(3)**: 241-5.

⁴⁶³ Horlock N, Vögelin E, Bradbury ET, Grobbelaar AO, and Gault DT (2005) Psychosocial outcome of patients after ear reconstruction: a retrospective study of 62 patients *Annals of Plastic Surgery* **54(5)**: 517-24.

⁴⁶⁴ Koning M, Zeijlmans IA, Bouman TK, and van der Lei B (2009) Female attitudes regarding labia minora appearance and reduction with consideration of media influence *Aesthetic Surgery Journal* **29(1)**: 65-71.

⁴⁶⁵ Henderson-King D, and Henderson-King E (2005) Acceptance of cosmetic surgery: scale development and validation *Body Image* **2(2)**: 137-49.

⁴⁶⁶ Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80, at page 676.

Employment: success and workplace pressures

“In my late 30s, I developed fatty bags under my eyes, which made me really self-conscious and cost me a job because they made me look tired even when I wasn’t. I permanently looked like I hadn’t slept in the past few days. Cosmetic surgery saved me.”⁴⁶⁷

“Botox – appearing younger might improve [my] chances [of a] professional job.”⁴⁶⁸

5.15 People may consider cosmetic procedures with the aim of achieving professional success, or in order to maintain their existing position in workplace contexts, particularly if they feel that they are ‘too old’ to maintain a successful presence at work (see paragraph 5.6 for further discussion on ageing as a motivating factor). Both men and women may feel threatened by younger colleagues, and feel a corresponding pressure to look younger than their age in the workplace.⁴⁶⁹ Individuals may also feel that they need to achieve a certain ‘look’ according to the type of job they do, and may use cosmetic procedures in order to achieve that look.⁴⁷⁰ However, while there is evidence to support concerns that appearance can be a significant factor in obtaining (although not necessarily retaining) work in some spheres, a review of the available economic analysis of the costs incurred in attempting to achieve particular appearance ideals, including through cosmetic procedures, suggests that such investment is not necessarily cost-effective.⁴⁷¹

Responding to social and cultural ideals

“The rhinoplasty was done in secret as I felt some embarrassment / shame as it seemed as if I was rejecting my racial heritage (mixed Japanese, black American).”⁴⁷²

⁴⁶⁷ Respondent to the Working Party’s online questionnaire.

⁴⁶⁸ Respondent to the Working Party’s online questionnaire.

⁴⁶⁹ See, for example, Atkinson M (2008) Exploring male femininity in the ‘crisis’: men and cosmetic surgery *Body & Society* **14(1)**: 67-87, at page 78. This study involved 44 men who had undergone a cosmetic procedure, and 74% of participants discussed feeling threatened at work by “younger, smarter and healthier women - especially in image-oriented business environments that equate outward appeal with intellectual competency and moral worth.” See also: Sobanko JF, Taglienti AJ, Wilson AJ *et al.* (2015) Motivations for seeking minimally invasive cosmetic procedures in an academic outpatient setting *Aesthetic Surgery Journal* **35(8)**: 1014-20, a study of 72 US users of botox or dermal fillers where 27% of participants indicated that the pressure of looking younger in work settings was “the biggest influence in opting to pursue treatment”. Similar findings were also reported by Hurd Clarke L, and Griffin M (2008) Visible and invisible ageing: beauty work as a response to ageism *Ageing & Society* **28(5)**: 653-74.

⁴⁷⁰ For example, Boulton TN, and Malacrida C (2012) Women and cosmetic breast surgery: weighing the medical, social, and lifestyle risks *Qualitative Health Research* **22(4)**: 511-23 which, at page 519, notes the views of a waitress who felt that enlarging her breasts directly affected her ability to earn more money: “I had more or less been a career waitress... If I had an office job maybe I wouldn’t have wanted it so badly.” Similarly, concerns were expressed by a male pilot in Kinnunen T (2010) ‘A second youth’: pursuing happiness and respectability through cosmetic surgery in Finland *Sociology of Health & Illness* **32(2)**: 258-71, at page 268, who worried that having ‘tired’ eyes could lead to a negative impression from clients, who might suspect that he was hungover, drunk, or tired.

⁴⁷¹ Lee S (2015) Beauty pays but does investment in beauty? *IZA World of Labor* **198**.

⁴⁷² Respondent to the Working Party’s online questionnaire.

- 5.16 Appearance ideals vary between countries,⁴⁷³ regions,⁴⁷⁴ and communities,⁴⁷⁵ influencing the choices people make about the type of cosmetic procedure they consider. Where there are ‘competing’ standards and ideals (see Box 1.1 and paragraph 1.5), the connection between race and class may influence people’s choices: for example a Venezuelan study shows how individuals seek the perceived “gold standard” of a nose associated with being white;⁴⁷⁶ while a study of rhinoplasty in Iran shows how both men and women undertaking the procedure are not aiming to look more Western but more beautiful, sophisticated and cosmopolitan – values seen as “consistent with being Iranian”.⁴⁷⁷ People may wish to distance themselves from their heritage: for example through minimising characteristics such as heavy foreheads, sagging eyelids, and ‘potato’ noses (associated in one study with being Finnish);⁴⁷⁸ or by rejecting ideals of female beauty associated with traditional female roles.⁴⁷⁹
- 5.17 The use of skin-lightening methods is a particularly powerful example of how both men and women may equate lighter skin with beauty: widespread use of skin-lightening products is reported by the World Health Organization (WHO),⁴⁸⁰ and one 2014 estimate suggests that 15 per cent of the world’s population buys skin lighteners, despite the major health risks posed by some of their ingredients (see paragraphs 6.14–6.15).⁴⁸¹ In addition to the perceived correlation between lighter skin and beauty, skin lightening is regarded in some parts of the world as a means to achieve a range of tangible social and economic benefits, such as access to better job opportunities (see paragraph 5.15), higher social status, better marriage prospects, and better life circumstances in general.⁴⁸² As noted earlier, there are, however, significant counter movements, for example in India, Africa and Latin America, challenging this association between lighter skin, beauty, and success (see Box 2.1).

⁴⁷³ See, for example, Swami V, Frederick DA, Aavik T *et al.* (2010) The attractive female body weight and female body dissatisfaction in 26 countries across 10 world regions: results of the International Body Project I *Personality and Social Psychology Bulletin* **36**(3): 309-25; and Karupiah P (2012) Modification of the body: a comparative analysis of views of youths in Penang, Malaysia and Seoul, South Korea *Journal of Youth studies* **16**(1): 1-16.

⁴⁷⁴ See, for example, Borelli F, and Casotti LM (2012) The before and after: a study of plastic surgery consumption with young women in Brazil *Advances in Consumer Research* **40**: 379-85, at page 381, where one participant notes “the difference of “aesthetic standards” between Porto Alegre, where it was “fare more cool to be slim” and “uncool to have a big butt” and Rio de Janeiro, where the ideal is [for] the woman to be “all babe.”” See also: Rongmuang D, McElmurry BJ, McCreary LL *et al.* (2010) Regional differences in physical appearance identity among young adult women in Thailand *Western Journal of Nursing Research* **33**(1): 106-20.

⁴⁷⁵ For example, Holliday R, and Cairnie A (2007) Man made plastic: investigating men’s consumption of aesthetic surgery *Journal of Consumer Culture* **7**(1): 57-78, a small scale study of five gay men who had all received various cosmetic procedures.

⁴⁷⁶ Gulbas LE (2013) Embodying racism: race, rhinoplasty, and self-esteem in Venezuela *Qualitative Health Research* **23**(3): 326-35.

⁴⁷⁷ Lenehan S (2011) Nose aesthetics: rhinoplasty and identity in Tehran *Anthropology of the Middle East* **6**(1): 47-62. See also: Hua W (2013) *Buying beauty: cosmetic surgery in China* (Hong Kong: Hong Kong University Press). Similar arguments are made in China about blepharoplasty: Brownell S (2011) China reconstructs: cosmetic surgery and nationalism in the reform era, in *Asian medicine and globalization*, Alter JS (Editor) (Philadelphia: University of Pennsylvania Press), pp132-50.

⁴⁷⁸ See, for example, Kinnunen T (2010) ‘A second youth’: pursuing happiness and respectability through cosmetic surgery in Finland *Sociology of Health & Illness* **32**(2): 258-71, a Finnish study which observed participants’ desire to change a particular feature associated with ‘being Finnish’, and a concurrent desire to be more ‘American’ and ‘white’.

⁴⁷⁹ See, for example, Holliday R, and Elfving-Hwang J (2012) Gender, globalization and aesthetic surgery in South Korea *Body & Society* **18**(2): 58-81, at page 69.

⁴⁸⁰ World Health Organization (2011) *Mercury in skin lightening products*, available at: http://www.who.int/ipcs/assessment/public_health/mercury_flyer.pdf.

⁴⁸¹ IOL (19 June 2014) *Why are women still dying to be white?*, available at: <http://www.iol.co.za/lifestyle/style/fashion/why-are-women-still-dying-to-be-white-1705800#.vsutqfnF-so>.

⁴⁸² Darj E, Infanti JJ, Ahlberg BM, and Okumu J (2015) “The fairer the better?” Use of potentially toxic skin bleaching products *African Health Sciences* **15**(4): 1074-80. See also: Tate SA (2015) *Skin bleaching in black Atlantic zones: shade shifters* (Basingstoke: Palgrave Pilot).

Having a cosmetic procedure: role models and influences

- 5.18 As described above, the diverse range of aims shaping the decision to have a cosmetic procedure include the desire not to look old, to look more ‘normal’, to improve self-esteem and feel better about oneself, or to achieve success in various forms. However, not everyone who would like to look younger, or believes that they might be more successful if an aspect of their body were different, goes on to have a cosmetic procedure designed to achieve this change: indeed, it is still a minority who choose to have a procedure of any kind (see paragraph 3.7).⁴⁸³ Others may experience similar degrees of pressure with respect to appearance ideals but respond by managing their appearance in other ways, while others again may not experience these pressures in a significant way at all.⁴⁸⁴
- 5.19 In this section, we explore the role models and influences that emerged in the literature and in our own evidence-gathering as encouraging people to consider cosmetic procedures as a potential means to achieve their aims. While these influences seem disparate, a common feature of many of them is that they act in such a way as to make procedures seem more ‘available’: for example by making them familiar, appropriate, or affordable. While some of the sources of influence identified in the literature are very general (such as the influence of the media and broader ‘celebrity culture’), the way in which they will act on individuals will vary considerably, depending on how they intersect with a person’s values, priorities, financial status, and social relationships.⁴⁸⁵ Other influences that may lead people to consider whether a cosmetic procedure is appropriate for them relate to particular events or circumstances, and to personal histories, such as being bullied or experiencing significant bodily change, for example after pregnancy or weight loss.

The influence of family, friends, and peers

“... one of my friends had just had it done... And we were the same age, and she looked so great, and I thought, ‘oh well, for my sixty-fifth’.”⁴⁸⁶

“Surgery became a reality through my sister. After she had this surgery and it went well, I was encouraged to do it as well. I wouldn’t have done it unless I knew someone who already had.”⁴⁸⁷

- 5.20 The literature suggests that those who consider undergoing a cosmetic procedure give “significant weight to the information and experiences of other people who had undergone plastic surgery, typically friends and colleagues”⁴⁸⁸ and that knowing

⁴⁸³ An Australian study further indicates that, as of 2009, between 4.2% and 6.1% of Australian adults had undergone a cosmetic surgical procedure: Tranter B, and Hanson D (2015) The social bases of cosmetic surgery in Australia *Journal of Sociology* **51**(2): 189-206, at page 196.

⁴⁸⁴ See, for example, Grogan S (2017) *Body image: understanding body dissatisfaction in men, women and children*, Third Edition (Abingdon: Routledge), pp184-98.

⁴⁸⁵ See, for example, Dittmar H, and Howard S (2004) Thin-ideal internalization and social comparison tendency as moderators of media models’ impact on women’s body-focused anxiety *Journal of Social and Clinical Psychology* **23**(6): 768-91.

⁴⁸⁶ Brooks A (2017) *The ways women age: using and refusing cosmetic intervention* (New York: New York University Press), at page 149.

⁴⁸⁷ Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63**(4): 673-80, at page 678.

⁴⁸⁸ Darisi T, Thorne S, and Iacobelli C (2005) Influences on decision-making for undergoing plastic surgery: a mental models and quantitative assessment *Plastic and Reconstructive Surgery* **116**(3): 907-16, at page 911, involving 644 Canadian women considering undergoing a cosmetic procedure.

someone who has undergone cosmetic surgery predicts a person's interest in cosmetic surgery.⁴⁸⁹ These general conclusions are also supported by studies that show the influence of others on decisions to have specific cosmetic procedures, such as breast augmentation.⁴⁹⁰

Parents

"I showed them [labia] to my mother as I thought they were weird and she agreed and made an appointment with the doctor immediately."⁴⁹¹

"Most of the young girls are taken by their mothers or family members to do the surgery. A girl friend of mine from high school, her mom told her, 'your eyes are not pretty' and persuaded her to have the double-eyelid surgery done, even though my friend was very scared about the procedure in the beginning."⁴⁹²

5.21 Parents' influence on individuals' motivations to undergo, or consider undergoing, cosmetic procedures has been noted in a number of small-scale qualitative studies, although mainly not from within the UK.⁴⁹³ Cosmetic procedures may also be bought as a gift from parents to their offspring.⁴⁹⁴ In the related area of surgery undergone for appearance-related reasons by children with cleft lip and palate, some parents are very anxious for their children to achieve as normal an appearance as possible, while others leave decisions to their child,⁴⁹⁵ as described in a response to the Working Party's online questionnaire: "Having a cleft, I personally was never pushed by my parents to change my appearance and was only guided by what my own feelings were."⁴⁹⁶ Other research highlights that encouragement to undergo a cosmetic procedure may originate from offspring to their parents.⁴⁹⁷

⁴⁸⁹ Javo IM, and Sørli T (2010) Psychosocial characteristics of young Norwegian women interested in liposuction, breast augmentation, rhinoplasty, and abdominoplasty: a population-based study *Plastic and Reconstructive Surgery* **125(5)**: 1536-43, involving 1,800 participants.

⁴⁹⁰ See, for example, Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80, which found that eight out of 14 participants who were preparing to have breast augmentation knew someone who had undergone a similar operation. See also: 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, at page 833. This US study of 15 women who had undergone various elective breast surgeries which found that every participant knew at least one other woman who had undergone some form of elective cosmetic surgery, most often breast augmentation.

⁴⁹¹ Veale D, Eshkevari E, Ellison N *et al.* (2014) A comparison of risk factors for women seeking labiaplasty compared to those not seeking labiaplasty *Body Image* **11(1)**: 57-62, at page 60.

⁴⁹² Zhang M (2012) A Chinese beauty story: how college women in China negotiate beauty, body image, and mass media *Chinese Journal of Communication* **5(4)**: 437-54, at page 449.

⁴⁹³ See, for example, Lindridge AM, and Wang C (2008) Saving "face" in China: modernization, parental pressure, and plastic surgery *Journal of Consumer Behaviour* **7(6)**: 496-508. The role of parents of younger children in influencing body image is also thought to be significant: see Cash TF, and Smolak L (Editors) (2011) *Body image: a handbook of science, practice, and prevention*, Second Edition (New York: The Guilford Press), at pages 71, and 111-2.

⁴⁹⁴ Karupiah P (2012) Modification of the body: a comparative analysis of views of youths in Penang, Malaysia and Seoul, South Korea *Journal of Youth studies* **16(1)**: 1-16, at page 6, which includes the observation from one blepharoplasty user that "my parents gave me a gift after going through a stressful period in high school. I felt better after the procedure."

⁴⁹⁵ Clinical experience within the Working Party.

⁴⁹⁶ Respondent to the Working Party's online survey.

⁴⁹⁷ See, for example, Kinnunen T (2010) 'A second youth': pursuing happiness and respectability through cosmetic surgery in Finland *Sociology of Health & Illness* **32(2)**: 258-71, at page 267, where one mother notes her daughter's encouragement to modify her 'crying wrinkles' prior to the daughter's wedding. The mother observes: "they were not bad but a woman is vain and when her child asks, the mother wants to look a little better."

Partners

“My breasts have been positively commented upon many times, but when an ex of mine didn’t answer when I asked him if I should have breast enlargement, I took it as a yes. For some reason this small lack of comment has stuck with me.”⁴⁹⁸

“It wasn’t intended to make fun of me, but my first serious boyfriend at the age of 21 made me aware of my labia being unusual – he said he had never seen one like that before. I think that’s where all of this came from.”⁴⁹⁹

5.22 Relatively few people who seek or undergo cosmetic procedures are encouraged to do so by their partners,⁵⁰⁰ and one study argues that where male partners in heterosexual relationships do actively encourage cosmetic procedures, that endorsement is “significantly and positively associated with greater hostility toward women, more blatantly sexist attitudes to women, greater hostile sexism, and greater benevolent sexism.”⁵⁰¹ A UK survey of 5,000 women found that 60 per cent felt that their partners would be against their undergoing cosmetic surgery.⁵⁰² However, as illustrated in the quotations above, some qualitative studies have highlighted how casual comments from partners, rather than explicit encouragement, may influence women to undergo cosmetic procedures.

5.23 In addition to the role of negative comments, other research highlights the motivating role of an individual’s *perception* of what their partner might think of a particular aspect of their appearance.⁵⁰³ (In addition, motivations to undergo a cosmetic procedure may

⁴⁹⁸ Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80, at page 677.

⁴⁹⁹ Veale D, Eshkevari E, Ellison N *et al.* (2014) A comparison of risk factors for women seeking labiaplasty compared to those not seeking labiaplasty *Body Image* **11(1)**: 57-62, at page 60.

⁵⁰⁰ See, for example, 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, at page 825, where, among 15 female users of cosmetic breast surgery, the authors conclude that in most cases “partners tried to convince them not to have surgery.” See also: Miklos JR, and Moore RD (2008) Labiaplasty of the labia minora: patients’ indications for pursuing surgery *The Journal of Sexual Medicine* **5(6)**: 1492-5, where 8% of women who had undergone labiaplasty for purely aesthetic reasons indicated that their decision was influenced by their male partners. A further study on the experiences of women who had undergone labiaplasty similarly found that women infrequently referred to receiving negative comments about their labial appearance from their current partner: Sharp G, Tiggemann M, and Mattiske J (2016) Factors that influence the decision to undergo labiaplasty: media, relationships, and psychological well-being *Aesthetic Surgery Journal* **36(4)**: 469-78. For other procedures, 2.7% of users of botox or dermal fillers cited pressure from spouses as an influencing factor in their decision to undergo the procedures: Sobanko JF, Taglienti AJ, Wilson AJ *et al.* (2015) Motivations for seeking minimally invasive cosmetic procedures in an academic outpatient setting *Aesthetic Surgery Journal* **35(8)**: 1014-20. See further: Gimlin D (2006) The absent body project: cosmetic surgery as a response to bodily dys-appearance *Sociology* **40(4)**: 699-716, at page 711, where female users of cosmetic surgery note their partners’ opposition to their decision to have a procedure.

⁵⁰¹ Swami V, Pietschnig J, Stewart N *et al.* (2012) Blame it on patriarchy: more sexist attitudes are associated with stronger consideration of cosmetic surgery for oneself and one’s partner *International Journal of Psychology* **48(6)**: 1221-9, pp1225-6.

⁵⁰² Molina A, Baker R, and Nduka C (2012) ‘What women want’—the UK’s largest cosmetic surgery survey *European Journal of Plastic Surgery* **35(8)**: 607-12, at page 609.

⁵⁰³ See, for example, Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: a cross-cultural analysis of women’s narratives *Body & Society* **13(1)**: 41-60, at page 54, where around a quarter of the study’s 40 participants indicated that their decision to have a cosmetic procedure had been made in order to make themselves more appealing to a male partner. See also: Bramwell R, Morland C, and Garden AS (2007) Expectations and experience of labial reduction: a qualitative study *BJOG: An International Journal of Obstetrics & Gynaecology* **114(12)**: 1493-9, at page 1495, where one participant notes that the procedure was “maybe like a last-ditched attempt really – if I was a bit more feminine, or if I was a bit more, I don’t know, a bit more attractive then maybe he would change.”

be affected by a desire to improve a relationship, or to forge one – see paragraphs 5.34–5.35.)

Friends

*“I don’t really know if we get it off the media, I think we probably get it more from friends ‘cos I compare myself to them”.*⁵⁰⁴

5.24 Decisions to use cosmetic procedures may also be influenced by an individual’s friends.⁵⁰⁵ “Conversations with their female friends about appearance” have been associated with positive attitudes towards cosmetic surgery among Australian women,⁵⁰⁶ and the influence of friends has been found to be a significant motivating factor on decisions by women in the US to have botox or dermal fillers.⁵⁰⁷ In contrast, a US study exploring attitudes to cosmetic surgery among female undergraduates found that these did not appear to be affected by their friends’ attitudes to appearance (notably, in this study it was the attitude of students’ fathers towards appearance that was significant).⁵⁰⁸

Responding to bullying and teasing

*“I started getting laser on my upper lip when I was 13 because I was made fun of so cruelly by the boys in my class. However, even after the laser, I was still teased but just for another reason.”*⁵⁰⁹

5.25 A common example of the role of bullying and teasing in prompting consideration of a cosmetic procedure is that of children with prominent ears, and studies involving both children and adults who have undergone otoplasty do indeed suggest that teasing contributed to their experience.⁵¹⁰ A history of teasing and bullying has also been identified as a relevant factor in the development of the body image concerns that underpin decisions about surgery for adults who undergo a range of other cosmetic procedures including rhinoplasty, cosmetic dental procedures, liposuction, and breast surgery.⁵¹¹ Associations have been suggested between a history of teasing and higher levels of *interest* in cosmetic surgery,⁵¹² and it has also been reported that women who

⁵⁰⁴ Ashikali E-M, Dittmar H, and Ayers S (2016) Adolescent girls’ views on cosmetic surgery: a focus group study *Journal of Health Psychology* **21**(1): 112-21, at page 116.

⁵⁰⁵ See, for example, 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, at page 895, which concludes that “the odds of having a cosmetic surgery for those who have friends with procedures are 126% higher than those who do not have friends with procedures.” For a general discussion on friends’ influence on individuals’ body image, see: Cash TF, and Smolak L (Editors) (2011) *Body image: a handbook of science, practice, and prevention*, Second Edition (New York: The Guilford Press), pp113-4.

⁵⁰⁶ Sharp G, Tiggemann M, and Mattiske J (2014) The role of media and peer influences in Australian women’s attitudes towards cosmetic surgery *Body Image* **11**(4): 482-7, at page 485.

⁵⁰⁷ Sobanko JF, Taglienti AJ, Wilson AJ *et al.* (2015) Motivations for seeking minimally invasive cosmetic procedures in an academic outpatient setting *Aesthetic Surgery Journal* **35**(8): 1014-20, which concludes that friends were the “biggest influence” on decisions to have botox or dermal fillers by 27% of participants.

⁵⁰⁸ Henderson-King D, and Brooks KD (2009) Materialism, sociocultural appearance messages, and paternal attitudes predict college women’s attitudes about cosmetic surgery *Psychology of Women Quarterly* **33**(1): 133-42.

⁵⁰⁹ Respondent to the Working Party’s online questionnaire.

⁵¹⁰ See, for example, Horlock N, Vögelin E, Bradbury ET, Grobbelaar AO, and Gault DT (2005) Psychosocial outcome of patients after ear reconstruction: a retrospective study of 62 patients *Annals of Plastic Surgery* **54**(5): 517-24; and Niemelä BJ, Hedlund A, Andersson G, and Wahlsten VS (2008) Prominent ears: the effect of reconstructive surgery on self-esteem and social interaction in children with a minor defect compared to children with a major orthopedic defect *Plastic and Reconstructive Surgery* **122**(5): 1390-8.

⁵¹¹ See: Jackson AC, Dowling NA, Honigman RJ, Francis KL, and Kalus AM (2012) The experience of teasing in elective cosmetic surgery patients *Behavioral Medicine* **38**(4): 129-37, an Australian study of 449 adults undergoing cosmetic surgeries or dentistry which found that just under half of the sample had been teased or bullied about their appearance.

⁵¹² Jávo IM, Pettersen G, Rosenvinge JH, and Sørli T (2012) Predicting interest in liposuction among women with eating problems: a population-based study *Body Image* **9**(1): 131-6. See also: Park LE, Calogero RM, Harwin MJ, and DiRaddo AM

do *not* want to undergo cosmetic surgery have less history of teasing than women who either wanted, or had already had, cosmetic surgery.⁵¹³ However, other studies, including a Taiwanese study of 85 pre-operation cosmetic procedure candidates, found no correlation between other people's opinions (including teasing) and the likelihood of undergoing cosmetic surgery.⁵¹⁴

Celebrity, media, social media, and pornography

The influence of celebrity

“... celebrity has an impact on people wanting cosmetic surgery – they see celebrities having it done [...] and want it for themselves.”⁵¹⁵

“... there is so much pressure on young girls and women today to look like celebrities.”⁵¹⁶

“... young girls, and possibly guys, are exposed to cosmetic procedures a lot and see it as the norm because celebrities have had it done.”⁵¹⁷

5.26 The role of celebrity influence as a motivating factor for considering, or undergoing, cosmetic procedures is identified in a number of published studies, and also came up frequently across the Working Party's evidence-gathering activities.⁵¹⁸ Young women in particular may be motivated to use cosmetic procedures in order to emulate a particular physical feature of a celebrity whom they admire,⁵¹⁹ and celebrity 'worship' has been found to impact on the uptake of cosmetic surgery, especially where the individual admires the body shape or a particular feature of the celebrity.⁵²⁰

The influence of the media

“On TV people seem very happy about it. If I hadn't seen 'Extreme Makeover' or 'Big Brother' I wouldn't have done it.”⁵²¹

(2009) Predicting interest in cosmetic surgery: interactive effects of appearance-based rejection sensitivity and negative appearance comments *Body Image* **6(3)**: 186-93; and Markey CN, and Markey PM (2009) Correlates of young women's interest in obtaining cosmetic surgery *Sex Roles* **61(3-4)**: 158-66, which found that women who recalled being teased about their bodies were more likely to express an interest in changing their bodies surgically.

⁵¹³ von Soest T, Kvale IL, Skolleborg KC, and Roald HE (2006) Psychosocial factors predicting the motivation to undergo cosmetic surgery *Plastic and Reconstructive Surgery* **117(1)**: 51-62, at page 56.

⁵¹⁴ Chen H-c, Karri V, Yu R-I *et al.* (2010) Psychological profile of Taiwanese female cosmetic surgery candidates: understanding their motivation for cosmetic surgery *Aesthetic Plastic Surgery* **34(3)**: 340-9, at page 347.

⁵¹⁵ Meryll Willis, responding to the Working Party's call for evidence.

⁵¹⁶ Respondent to the Working Party's online questionnaire.

⁵¹⁷ Discussion event with members of the Nottingham Young Persons' Advisory Group, 13 August 2016.

⁵¹⁸ Factfinding meeting on consumer perspectives, 5 February 2016; Discussion event with members of ScotCRN YPG, Aberdeen, 18 June 2016; Factfinding meeting on visual culture and cosmetic procedures, 22 June 2016.

⁵¹⁹ See, for example, Lindridge AM, and Wang C (2008) Saving "face" in China: modernization, parental pressure, and plastic surgery *Journal of Consumer Behaviour* **7(6)**: 496-508; and Chae J (2012) "Yes! I had cosmetic surgery": celebrities' cosmetic surgery confessions in the media and their impact on Korean female college students' perceptions *Proceedings of the New York State Communication Association* **2010(1)**: 4.

⁵²⁰ Maltby J, and Day L (2011) Celebrity worship and incidence of elective cosmetic surgery: evidence of a link among young adults *Journal of Adolescent Health* **49(5)**: 483-9.

⁵²¹ Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80, at page 678..

*“It’s in the news all the time and more and more people have it done. There are even TV shows (e.g., *Botched*), that not only show people having surgery but having it multiple times.”⁵²²*

“It is the magazines out there that are pushing the idea of what beauty is. Of which in the 1960s – we’d be looking at images that weren’t being stretched out, smoothed over, manipulated. What we have got now are not real images [...] Our idea of beauty comes from an artist’s palette.”⁵²³

5.27 Although the role of ‘traditional’ media may be waning as online media use grows,⁵²⁴ a number of studies have identified links between television viewing and reading habits, and an interest in cosmetic procedures. The depiction of positive outcomes of cosmetic procedures in the media was cited as ‘encouraging’ by survey respondents who had expressed an active interest in cosmetic surgery;⁵²⁵ and women’s exposure to magazines has been found to increase the significance of appearance to their sense of self-worth, which may make them more open to the possibility of undergoing cosmetic surgery.⁵²⁶ Most research around the influence of reality television (specifically programmes that focus on cosmetic surgery) focuses on *attitudes* towards cosmetic procedures, and does not investigate any causative effects on people’s decisions to undergo cosmetic procedures.⁵²⁷ However, there is some evidence to suggest that high-intensity viewing of cosmetic reality TV shows is associated with the choice to seek cosmetic surgery.⁵²⁸

The influence of social media

“Is it my own motivation that I want to look like Kim Kardashian, or am I feeling pressurised by social media?”⁵²⁹

“Selfies and posts on social media, it makes people more conscious of how they look. The fact that we can take photos on our phones and see them instantly, on older cameras people had to wait until photos were developed to see them and couldn’t view them instantly.”⁵³⁰

⁵²² User of injections to relax wrinkles; chemical peels; laser / other light treatments, responding to the Working Party’s online questionnaire.

⁵²³ Discussion event with members of *Stitch in Time*, Rossendale, 13 July 2016.

⁵²⁴ Factfinding meeting on consumer perspectives, 5 February 2016.

⁵²⁵ Darisi T, Thorne S, and Iacobelli C (2005) Influences on decision-making for undergoing plastic surgery: a mental models and quantitative assessment *Plastic and Reconstructive Surgery* **116**(3): 907-16, at page 911.

⁵²⁶ Slevic J, and Tiggemann M (2010) Attitudes towards cosmetic surgery in middle-aged women: body image, aging anxiety, and the media *Psychology of Women Quarterly* **34**(1): 65-74. See also: Lindridge AM, and Wang C (2008) Saving “face” in China: modernization, parental pressure, and plastic surgery *Journal of Consumer Behaviour* **7**(6): 496-508, at page 502, which highlights the effect of the consumption of magazines “that carried numerous advertisements extolling the transformative powers of plastic surgery” on an individual’s success in life and personality.

⁵²⁷ See, for example, Mazzeo SE, Trace SE, Mitchell KS, and Gow RW (2007) Effects of a reality TV cosmetic surgery makeover program on eating disordered attitudes and behaviors *Eating Behaviors* **8**(3): 390-7; and Sperry S, Thompson JK, Sarwer DB, and Cash TF (2009) Cosmetic surgery reality TV viewership: relations with cosmetic surgery attitudes, body image, and disordered eating *Annals of Plastic Surgery* **62**(1): 7-11.

⁵²⁸ Crockett RJ, Pruzinsky T, and Persing JA (2007) The influence of plastic surgery “reality TV” on cosmetic surgery patient expectations and decision making *Plastic and Reconstructive Surgery* **120**(1): 316-24, at page 321: 31% of participants reported that they were “very much or moderately influenced” by cosmetic surgery reality TV shows; of this group, 85% were high-intensity viewers.

⁵²⁹ Discussion events with MA Bioethics and Society Students, King’s College London, 9 February and 22 March 2016.

⁵³⁰ Recipient of breast reduction, responding to the Working Party’s online questionnaire.

“Social media gives a wider audience... so more people are being influenced by it.”⁵³¹

5.28 There is no published evidence as yet on how the use of social media may directly influence individuals’ decisions to undergo cosmetic procedures. However, research on body image suggests that more frequent use of social networking websites may predict an increase in a person’s investment in their appearance, and this may in turn influence their desire to undergo cosmetic surgery.⁵³² One study in Sweden also suggests that frequent reading of fashion blogs may also have a small influence on adolescents’ consideration of cosmetic surgery.⁵³³

The influence of pornography

“I think drawings in biology textbooks and porn were the only times I had seen labia, and mine did not look like the ones shown.”⁵³⁴

“... ads, celebrities, models, porn – all too unrealistic and plastic.”⁵³⁵

5.29 Responses to our online questionnaire and call for evidence indicate that there is a widespread belief in the idea that pornography influences people’s attitudes to cosmetic procedures.⁵³⁶ However, to date, very little academic research has been undertaken in this area. Of the research available, it has been suggested that pornographic media can increase the likelihood of women *considering* labiaplasty.⁵³⁷ A later study by the same authors, however, found that exposure to pornography for women who had undergone labiaplasty compared to a control group did not in fact differ, although the labiaplasty users were found to have internalised media representations of female genitalia.⁵³⁸ A large-scale study of GPs in Australia, exploring their experience of patients requesting FGCS, found that all GP respondents ascribed significance to the role of pornography in influencing their patients’ choices, for example through affecting perceptions of normal anatomy.⁵³⁹ It has also been argued that such influences may operate indirectly, for example through changing fashions in intimate waxing and shaving, which may in turn

⁵³¹ Discussion event with young people: International Association of Bioethics Congress, 17 June 2016.

⁵³² de Vries D, Peter J, Nikken P, and de Graaf H (2014) The effect of social network site use on appearance investment and desire for cosmetic surgery among adolescent boys and girls *Sex Roles* **71(9-10)**: 283-95. See also: Soueid A, Nassab R, and Kok K (2016) Impact of social media on aesthetic perception in patients *Poster presentation*: BAAPS 32nd annual scientific meeting, 6-7 October.

⁵³³ Lunde C (2013) Acceptance of cosmetic surgery, body appreciation, body ideal internalization, and fashion blog reading among late adolescents in Sweden *Body Image* **10(4)**: 632-5.

⁵³⁴ Respondent to the Working Party’s online questionnaire.

⁵³⁵ *ibid.*

⁵³⁶ Nuffield Council on Bioethics (2017) *Cosmetic procedures: ethical issues - expert call for evidence: analysis*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Expert-consultation-analysis.pdf>.

⁵³⁷ Sharp G, Tiggemann M, and Mattiske J (2015) Predictors of consideration of labiaplasty: an extension of the tripartite influence model of beauty ideals *Psychology of Women Quarterly* **39(2)**: 182-93.

⁵³⁸ Sharp G, Tiggemann M, and Mattiske J (2016) Factors that influence the decision to undergo labiaplasty: media, relationships, and psychological well-being *Aesthetic Surgery Journal* **36(4)**: 469-78, at page 475.

⁵³⁹ Simonis M, Manocha R, and Ong JJ (2016) Female genital cosmetic surgery: a cross-sectional survey exploring knowledge, attitude and practice of general practitioners *BMJ Open* **6**. See also: Howarth H, Sommer V, and Jordan FM (2010) Visual depictions of female genitalia differ depending on source *Medical Humanities* **36(2)**: 75-9.

influence more widespread attitudes to what constitutes ‘normal’ appearance for a woman’s labia.⁵⁴⁰

Physical discomfort

“My partner had extremely different sized breasts, they did not fit conventional bras as they were so different. She was ashamed, walked with a stoop and was unhappy. After plastic surgery she was able to buy comfortable bras, and walk more upright.”⁵⁴¹

“Back pain, bad posture and difficulty running – since the operation I’ve been able to run more and have done four half-marathons.”⁵⁴²

5.30 For particular cosmetic procedures, physical discomfort, along with concern about appearance, has been cited as a contributory factor in the decision to have the procedure. For example, reasons given by women undergoing FGCS include discomfort in wearing particular clothes,⁵⁴³ exercising, or having sex.⁵⁴⁴ Women who have had breast reductions also cite discomfort as a key motivating factor, remarking on difficulties in exercising⁵⁴⁵ or sleeping.⁵⁴⁶ (Many of these women report improvements to levels of discomfort and pain following the procedure – see paragraph 6.5.) A study of young people undergoing otoplasty found that the most common reason given for deciding to have the procedure was pain, including discomfort when wearing a cap, hat or helmet, or pain from sunburned ears.⁵⁴⁷

⁵⁴⁰ Minerva F (26 January 2016) *Blog: should we bring pubic hair back?*, available at: <http://beautydemands.blogspot.co.uk/2016/01/should-we-bring-pubic-hair-back-by.html>. See also: McDougall LJ (2013) Towards a clean slit: how medicine and notions of normality are shaping female genital aesthetics *Culture, Health & Sexuality* **15**(7): 774-87, at page 775, which notes that the growing popularity of Brazilian waxing “indicates a change in genital aesthetics”.

⁵⁴¹ Respondent to the Working Party’s online questionnaire.

⁵⁴² Respondent to the Working Party’s online questionnaire; recipient of breast reduction.

⁵⁴³ For example, a respondent to the Working Party’s online questionnaire who had undergone labiaplasty noted that, prior to the procedure, she had experienced pain when wearing jeans. See also: Sorice SC, Li AY, Canales FL, and Furnas HJ (2017) Why women request labiaplasty *Plastic and Reconstructive Surgery* **139**(4): 856-63, at page 858, where 36 out of 50 users of labiaplasty (72%) reported discomfort when wearing tight clothing; and Miklos JR, and Moore RD (2008) Labiaplasty of the labia minora: patients’ indications for pursuing surgery *The Journal of Sexual Medicine* **5**(6): 1492-5, which retrospectively reviewed medical records and found that 55% (42 out of 82) of women who had undergone labiaplasty for ‘functional reasons’ had indicated that they had experienced discomfort while wearing clothing.

⁵⁴⁴ See: Miklos JR, and Moore RD (2008) Labiaplasty of the labia minora: patients’ indications for pursuing surgery *The Journal of Sexual Medicine* **5**(6): 1492-5, which found that 46% (38 out of 82) of women who had labiaplasty for functional reasons had experienced discomfort while exercising; and 60% (49 out of 82) stated that sexual intercourse was painful or uncomfortable. See also: Rouzier R, Louis-Sylvestre C, Paniel B-J, and Haddad B (2000) Hypertrophy of labia minora: experience with 163 reductions *American Journal of Obstetrics and Gynecology* **182**(1): 35-40, which reported that 43% of participants underwent the procedure because of discomfort during sexual intercourse; and 26% due to discomfort when playing sport.

⁵⁴⁵ See, for example, Adams J (2010) Motivational narratives and assessments of the body after cosmetic surgery *Qualitative Health Research* **20**(6): 755-67, at page 763, where one participant notes: “they even get in the way when I want to exercise; when I want to run. That’s just not an option.” See also the accounts of participants in Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: a cross-cultural analysis of women’s narratives *Body & Society* **13**(1): 41-60.

⁵⁴⁶ Klassen A, Pusic A, Scott A, Klok J, and Cano S (2009) Satisfaction and quality of life in women who undergo breast surgery: a qualitative study *BMC Women’s Health* **9**(1): 11, at page 6. See also: Starley IF, Bryden DC, Tagari S, Mohammed P, and Jones RP (1998) An investigation into changes in lung function and the subjective medical benefits from breast reduction surgery *British Journal of Plastic Surgery* **51**(7): 531-4.

⁵⁴⁷ Niemelä BJ, Hedlund A, Andersson G, and Wahlsten VS (2008) Prominent ears: the effect of reconstructive surgery on self-esteem and social interaction in children with a minor defect compared to children with a major orthopedic defect *Plastic and Reconstructive Surgery* **122**(5): 1390-8, at page 1395: 26 of the 42 patients referred to the pain of wearing headgear, and five commented on sunburned ears; appearance was mentioned as a problem by 27 patients. In addition, 24 patients mentioned being teased about their prominent ears.

Changes to the body post-pregnancy

“After breastfeeding, your boobs are going to sag.”⁵⁴⁸

“After I had my third son... my body was destroyed. I had three C-sections, and I breast-fed all my children. So prior to any of my pregnancies, I was a full 34C. I really loved my body, had no problems with my body ever. After the children, I was very saggy.”⁵⁴⁹

- 5.31 Pregnancy and the associated changes in a woman’s body have been identified as another reason for undergoing cosmetic procedures. Such procedures may be motivated by a desire to ‘repair’ the body following pregnancy,⁵⁵⁰ or to return to the “‘normal’ body that they felt they had had before pregnancy”.⁵⁵¹ A respondent to the Working Party’s online questionnaire also highlights concerns around finding a new partner after having children: “I could not believe a future man would find my post-pregnancy / breastfeeding / weight-loss breasts attractive, because I didn’t” (see also paragraph 5.35).

Being able to afford cosmetic procedures

“I have been dissatisfied with my own body since I was 19. Now I have the money and want to change something.”⁵⁵²

My lids used to drop down so when my eyes were open they still looked like they were closed... cobra they used to call it. But I have never worn make-up in my life till I had it done. Even on my wedding day I didn’t wear make-up. So I always said, ‘come the right time when I have my own money’ – which was my money left to me by my mother – ‘nobody else wants this money, it’s mine. I am going to have it done’. Which I did and I have worn make-up ever since... And it is not about feeling insecure, or being vain.”⁵⁵³

- 5.32 Given that cosmetic procedures are provided almost entirely in the private sector, affordability is clearly a factor influencing people’s decisions about whether to have a procedure, and if so which one.⁵⁵⁴ A US study of over 900 users of gastric band surgery,

⁵⁴⁸ Discussion event with young people: International Association of Bioethics Congress, 17 June 2016.

⁵⁴⁹ 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, at page 821.

⁵⁵⁰ Solvi AS, Foss K, von Soest T *et al.* (2010) Motivational factors and psychological processes in cosmetic breast augmentation surgery *Journal of Plastic, Reconstructive & Aesthetic Surgery* **63(4)**: 673-80. To highlight the reparative aims of women in this study, the author quotes (at page 676) one participant: “They had stretch marks and looked like pockets turned inside out... It’s not about having huge breasts; I just wanted to feel whole as a woman.”

⁵⁵¹ de Andrade DD (2010) On norms and bodies: findings from field research on cosmetic surgery in Rio de Janeiro, Brazil *Reproductive Health Matters* **18(35)**: 74-83, at page 78. See also: Hensel JM, Lehman Jr JA, Tantri MP *et al.* (2001) An outcomes analysis and satisfaction survey of 199 consecutive abdominoplasties *Annals of Plastic Surgery* **46(4)**: 357-63, at page 361, where 68% of participants indicated that the reason they underwent abdominoplasty was to remove excess tissue after pregnancy.

⁵⁵² de Andrade DD (2010) On norms and bodies: findings from field research on cosmetic surgery in Rio de Janeiro, Brazil *Reproductive Health Matters* **18(35)**: 74-83, at page 79.

⁵⁵³ Discussion event with members of Stitch in Time, Rossendale, 13 July 2016. The group member summarised it in this way: “One, it can be a lifetime’s ambition; and two, you can suddenly find yourself with the money; and three, if it makes you feel better, then what’s wrong with it?”

⁵⁵⁴ See, for example, British Association of Aesthetic Plastic Surgeons (13 February 2017) *The bust boom busts*, available at: https://baaps.org.uk/media/press_releases/29/the_bust_boom_busts, which suggests that the public are “by and large opting for less costly non-surgical procedures”.

for example, found that there was a direct relation between income and whether or not patients subsequently accessed cosmetic surgery to have excess skin removed;⁵⁵⁵ and the pharmaceutical company Allergan notes in its annual accounts how promotional offers cause non-seasonal variations in sales of products such as Botox.⁵⁵⁶ Lack of money is cited as a reason that prevents people from having procedures: nearly half the women responding to a large-scale UK survey said that they would have cosmetic surgery “if funds allowed”.⁵⁵⁷ It has also been suggested that unexpectedly receiving a windfall or inheritance may facilitate a decision to undergo cosmetic procedures;⁵⁵⁸ and that women may sometimes use financial settlements after the breakdown of relationships for cosmetic procedures with the view that this might help in finding a new partner.⁵⁵⁹ Users may take on extra work to pay for their procedure;⁵⁶⁰ and many providers of cosmetic procedures offer credit arrangements to facilitate access by those who are not in a position to pay up-front (see also paragraph 5.37).

- 5.33 Affordability is also given as a reason for people travelling abroad for cosmetic procedures. One qualitative study in the UK indicates that those who travel abroad for treatment are often ‘savvy’ consumers; most people interviewed had considered surgery for 5-10 years before coming to a decision about treatment, and had researched their surgeon carefully; for example, by ‘lurking’ on Facebook and other peer-led websites, and following the experiences of others having the same procedure.⁵⁶¹

Sex and intimate relationships

“I find quite difficult meeting people in general or sex partners cause of my lack of confidence.”⁵⁶²

“Men would say things to me, really sexually very, um, overt things that I found... offensive. I think that... because large breasts are supposed to be sexual, they thought that I was more sexually open than I am.”⁵⁶³

- 5.34 Motivations around existing intimate relationships identified in the literature focus predominantly on improving sex life. Users of cosmetic procedures report, for example, that a particular aspect of their body has previously ‘distracted’ them,⁵⁶⁴ or made them

⁵⁵⁵ Gusenoff JA, Messing S, O’Malley W, and Langstein HN (2008) Patterns of plastic surgical use after gastric bypass: who can afford it and who will return for more *Plastic and Reconstructive Surgery* **122(3)**: 951-8. Affordability was also associated with use of second or multiple operations.

⁵⁵⁶ Allergan (2017) *Annual report 2016*, available at: <https://allergan-web-cdn-prod.azureedge.net/actavis/actavis/media/allerganinvestors/financial-information/proxy-materials/10-k.pdf>, at page 21.

⁵⁵⁷ Molina A, Baker R, and Nduka C (2012) ‘What women want’—the UK’s largest cosmetic surgery survey *European Journal of Plastic Surgery* **35(8)**: 607-12, at page 607. In contrast, just 6.5% of the 5,000 women responding had actually undergone cosmetic surgery.

⁵⁵⁸ See, for example, Holliday R, and Cairnie A (2007) Man made plastic: investigating men’s consumption of aesthetic surgery *Journal of Consumer Culture* **7(1)**: 57-78, at page 72, which observes of one participant that “an inheritance gave him the economic means to pursue surgery, while the bereavement motivated him to take control of his body.”; Discussion event with members of Stitch in Time, Rossendale, 13 July 2016.

⁵⁵⁹ Clinical experience within the Working Party.

⁵⁶⁰ . See, for example, Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: a cross-cultural analysis of women’s narratives *Body & Society* **13(1)**: 41-60, at page 49, which notes that one participant reported having to “work one day job, one night job, occasionally a third job” for a year in order to save money for a facelift.

⁵⁶¹ Holliday R, Bell D, Jones M, Probyn E, and Sanchez Taylor, J (2014) *Sun, sea, sand and silicone: mapping cosmetic surgery tourism - final report*, available at: <http://1n1xkd2j1u702vcxsr1pe3h6.wpengine.netdna-cdn.com/files/2012/11/Sun-Sea-Final-Report.pdf>, at pages 3 and 12.

⁵⁶² User of injections to relax wrinkles, dermal fillers, and rhinoplasty, responding to the Working Party’s online questionnaire.

⁵⁶³ Recipient of breast reduction, in: Gimlin D (2006) The absent body project: cosmetic surgery as a response to bodily dys-appearance *Sociology* **40(4)**: 699-716, at page 708.

⁵⁶⁴ For example, one user of abdominoplasty noted that “the loose skin around her waist and hips frequently distracted her during sexual activity”: *ibid.*, at page 710.

feel uncomfortable during sex.⁵⁶⁵ Other research has suggested that women's decisions to undertake certain procedures may be motivated by a desire to enhance their partner's sexual experience.⁵⁶⁶

- 5.35 Some users of cosmetic procedures indicate that their motivations rested in part on the expectation that, by changing an element of appearance, they might improve marriage or relationship prospects.⁵⁶⁷ Some of these motivations also related to respondents' concerns around looking 'too old' to be successful in forging new relationships: for example a 63-year-old woman commented that "if men at the bars saw me now, I don't think they would even talk to me because everything and everyone has to be young... That's why I started the chemical peels and photo facials because they promised you'll look younger."⁵⁶⁸ Such ideas also emerge in a study with gay men: "if you get it wrong then you usually end up not pulling... it's really important to look good... so I had surgery on my cheeks and jaw to give them more definition."⁵⁶⁹

Reasons for the growing use of cosmetic procedures

- 5.36 The literature reviewed earlier in this chapter is concerned with the motivations and influences that may underpin the use of cosmetic procedures. As yet, there is little published academic research seeking to explain *why* such use is increasing, although it has been suggested that some of the same social and technological factors identified as contributing to declining body satisfaction (see paragraph 1.12) may play an important role in stimulating demand, particularly among young people.⁵⁷⁰
- 5.37 However, because of the commercial nature of the field, useful insights on market drivers and perceptions of users' behaviours can be gained from the market research companies that provide a detailed commercial analysis of market trends and associated factors, and are in a position to draw on unpublished trade data as well as published research. In 2015, for example, the market research company Key Note identified the following 'key drivers' in the cosmetic procedures market as a whole:

⁵⁶⁵ See, for example, Gimlin D (2007) Accounting for cosmetic surgery in the USA and Great Britain: a cross-cultural analysis of women's narratives *Body & Society* **13**(1): 41-60, which includes the testimony (at page 51) of one interviewee who noted her discomfort with sexual intimacy as a result of long-term dissatisfaction with her small breasts.

⁵⁶⁶ For example, research undertaken by a group of cosmetic surgeons with 258 women who had undergone FGCS found that 54% who had vaginoplasty and perineoplasty, and 23.5% of women who had combined vaginoplasty, perineoplasty, labiaplasty, and clitoral hood reduction indicated a desire to enhance their male partners' sexual experience: 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, at page 1568.

⁵⁶⁷ See, for example, Patil SB, Kale SM, Khare N, Jaiswal S, and Ingole S (2011) Aesthetic surgery: expanding horizons: concepts, desires, and fears of rural women in Central India *Aesthetic Plastic Surgery* **35**(5): 717-23, which found that an improvement in marriage prospects would be the most common reason for seeking cosmetic surgery, according to 872 unmarried women living in rural India. The author of this study notes, at page 721, that "this is an observation that is unique to the population under study. It is reflective of the complex social structure of India with respect to marriages." See also: Hamed SH, Tayyem R, Nimer N, and Alkhatib HS (2010) Skin-lightening practice among women living in Jordan: prevalence, determinants, and user's awareness *International Journal of Dermatology* **49**(4): 414-20, at page 416, where 62% of participants (both users and non-users of skin-lightening products) felt that having a lighter skin tone "is perceived by men as being more attractive and increases a woman's chances of getting married".

⁵⁶⁸ Hurd Clarke L, and Griffin M (2008) Visible and invisible ageing: beauty work as a response to ageism *Ageing & Society* **28**(5): 653-74, at page 665.

⁵⁶⁹ Holliday R, and Cairnie A (2007) Man made plastic: investigating men's consumption of aesthetic surgery *Journal of Consumer Culture* **7**(1): 57-78, at page 69. This small study of men who had received cosmetic procedures included one participant who noted the importance of 'looking good' in gay clubs.

⁵⁷⁰ See, for example, 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 1.5-6, citing research commissioned from Creative Research Ltd. with the general public and practitioners, and teenagers.

- “The UK population is increasingly ageing and will continue to be so over coming years. As the population ages, a greater number of people are seeking ways to enhance their appearance and maintain younger looks for personal and professional reasons.
- The increasing use of smartphones and social media has revolutionised the way businesses communicate with customers, helping to promote cosmetic surgery and encourage more people to turn to these procedures to improve their appearance.
- The popularity of travelling overseas for cosmetic surgery continues to rise, with more people in the UK now consider[ing] travelling abroad for cosmetic surgery procedures to save money.”⁵⁷¹

5.38 Other factors cited by Key Note in 2015, some of which are general to the sector, and others likely to apply to specific subgroups of potential users, include:

- economic growth, helping boost consumer confidence and increase spending on non-essential items (while also noting the reverse: that the industry is also vulnerable in economic downturns);
- advances in medical technology and the availability of cheaper less invasive procedures;
- increasing social acceptability of cosmetic procedures among consumers, influenced by media and celebrities;
- the popularity of selfies and use of social networking, “highlighting the increasingly image-conscious nature of the population”;
- increasing obesity, likely to boost demand both for weight-loss surgery and for subsequent cosmetic surgery to remove excess skin.⁵⁷²

5.39 Finally, as we noted in Chapter 1 in our discussion of the factors potentially associated with increasing levels of concern with body image (see paragraph 1.12), these economic, technological and social factors identified by Key Note as drivers of the cosmetic procedures market are themselves all embedded within a culture influenced by neoliberal ideologies that ‘expect’ work on the self.⁵⁷³

⁵⁷¹ Key Note (2015) *Cosmetic surgery: market update*, available at: https://www.keynote.co.uk/market-update/healthcare-medical-pharmaceuticals/cosmetic-surgery?full_report=true, at page 12.

⁵⁷² *ibid.*, pp12-7, and 33.

⁵⁷³ Elias A, and Gill R (2016) Beauty surveillance: the digital self-monitoring cultures of neoliberalism *European Journal of Cultural Studies*: [In press].

Chapter 6

Users' satisfaction,
outcomes, and risks

Chapter 6 – Users' satisfaction, outcomes, and risks

Chapter 6: overview

Most users of cosmetic procedures who are asked, report being satisfied with the initial outcomes of the procedures they have undertaken. Positive outcomes reported include improvements to self-esteem and well-being, feeling more attractive or less self-conscious, and receiving positive comments from others. It is not possible at present to assess whether initial satisfaction is maintained over time, as there is a significant lack of data on long-term physical or psychological outcomes.

As in any other bodily intervention, cosmetic procedures entail a degree of physical risk. Physical harms may arise as a result of products used in the procedure, through poor practice, or from the inherent risks associated with the procedure, such as infection or (for surgical procedures) bleeding and adverse reactions to general anaesthesia. Some complications are minor and temporary while others are more substantial and longer-lasting.

Psychological complications, such as anxiety and depression following an operation, may be as common as physical complications after cosmetic surgery, though the research evidence is limited. Those with pre-existing mental disorders appear to be more likely to suffer negative psychosocial outcomes after procedures. This group includes not only those suffering from body dysmorphic disorder (BDD), but also people with high levels of stress, and people taking medication to aid sleep or for anxiety. There is also an association between use of breast implants and suicide: although the mechanics of this relationship are not clear, it is likely that the association reflects higher rates of pre-existing mental disorder.

The increasing availability of cosmetic procedures also potentially poses social and communal harms. These include:

- encouraging a focus on appearance and adding to levels of appearance anxiety;
- shifting perceptions of what is 'normal' and reinforcing discriminatory attitudes;
- constructing ideals that can only be met through invasive means; and
- adding to the pressures on those who might like to, but cannot, meet these ideals.

Introduction

- 6.1 Having reviewed in Chapter 5 the available evidence on what motivates people to consider cosmetic procedures, and what they aim to achieve when using them, we now turn to review what is known, first about how people report their satisfaction with the outcome of their procedures; and second about the risks of adverse or unwanted outcomes, or of harms that arise in other ways. As in Chapter 5, significant difficulties arise both for practitioners and for prospective users of cosmetic procedures because of significant gaps in the evidence that is currently available.

Satisfaction with outcomes of cosmetic procedures

“My procedure was a success: my teeth were rendered into a more pleasing shape and I gained increased confidence as a direct consequence of this. I am happier.”⁵⁷⁴

“I have come to realise that the problems in my life were psychological and not physical.”⁵⁷⁵

“My life has improved dramatically after my breast reduction – I feel more confident that my breasts are proportionate to the rest of my body, and I no longer have back pain.”⁵⁷⁶

- 6.2 Given the complexity of the links between appearance and happiness or well-being (see paragraphs 1.16–1.19), it is unsurprising that the evidence with respect to satisfaction with the outcome of cosmetic procedures is equally complex and variable. As the personal responses to our consultation cited above illustrate, individuals are likely to have very different experiences, depending both on the procedure in question, and on the hopes and aspirations associated with it. Most users of cosmetic procedures who are asked, report being satisfied with the initial outcomes of the procedures they have undertaken (see paragraphs 6.6–6.7).
- 6.3 The surveys and studies that address the outcomes of cosmetic procedures from users' perspectives are of variable quality: in addition to the methodological limitations of many studies discussed in the previous chapter (see paragraph 5.3), the current lack of long-term studies of outcomes means that we cannot assess whether initial satisfaction with the outcome of a procedure is maintained over time.⁵⁷⁷ Moreover, it is important to distinguish between the question of whether users are satisfied with the outcomes of their procedures, and the question of whether, at a population level, there is a correlation between cosmetic procedures and enduring outcomes, such as increased self-esteem and enhanced well-being. In order to demonstrate the latter, comparative longitudinal studies are required, and to date there are very few of these.⁵⁷⁸
- 6.4 Recognising the limitations of current research in the field, we set out below the broad conclusions emerging from the existing literature, first with respect to physical and then psychosocial outcomes, while recognising that these are overlapping categories.⁵⁷⁹

Physical satisfaction

- 6.5 Where procedures have been undertaken for a combination of functional and appearance-related reasons, levels of satisfaction are generally reported as high. Women who have had breast reduction procedures, for example, note improvements

⁵⁷⁴ User of cosmetic orthodontics, responding to the Working Party's online questionnaire.

⁵⁷⁵ User of dermabrasion, responding to the Working Party's online questionnaire.

⁵⁷⁶ User of breast reduction, responding to the Working Party's online questionnaire.

⁵⁷⁷ That is, longer than the first post-operative follow-up appointment in the case of surgical procedures.

⁵⁷⁸ One exception is the Norwegian study cited in paragraph 6.16: von Soest T, Kvalem IL, and Wichstrøm L (2012) Predictors of cosmetic surgery and its effects on psychological factors and mental health: a population-based follow-up study among Norwegian females *Psychological Medicine* **42**(3): 617-26.

⁵⁷⁹ For further details of individual studies, see: Nuffield Council on Bioethics (2016) *Literature review: post-procedure experiences*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Post-procedure-experiences-review.pdf>.

both to discomfort and pain,⁵⁸⁰ and to their quality of life more generally.⁵⁸¹ Significant levels of user satisfaction following orthognathic procedures to change both the appearance and function of jaw alignment have been reported.⁵⁸² In addition, some studies suggest that sexual functioning and sex lives may improve for users of a variety of procedures, including breast procedures,⁵⁸³ female genital cosmetic procedures (FGCS),⁵⁸⁴ and abdominoplasty.⁵⁸⁵

Psychosocial satisfaction

6.6 Users of cosmetic procedures report satisfaction for a range of psychosocial reasons. Improvements to self-esteem and well-being are noted relatively frequently in the literature, for example.⁵⁸⁶ Other studies conclude that a significant number of research participants, predominantly women, feel more attractive and have improved body image as a result of their procedure.⁵⁸⁷ Changes in others' perceptions of, or reactions to, the person who has had the procedure may also contribute to satisfaction, including receiving positive comments from other people,⁵⁸⁸ and feeling less self-conscious /

⁵⁸⁰ See, for example, Brown A, Hill C, and Khan K (2000) Outcome of reduction mammoplasty — a patients' perspective *British Journal of Plastic Surgery* **53**(7): 584-7; Tykkä SA-SHHE (2001) Patients' satisfaction with breast reconstruction and reduction mammoplasty *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery* **35**(4): 399-405; and Menderes A, Mola F, Vayvada H, and Barutcu A (2005) Evaluation of results from reduction mammoplasty: relief of symptoms and patient satisfaction *Official Journal of the International Society of Plastic Surgery* **29**(2): 83-7.

⁵⁸¹ See, for example, Eggert E, Schuss R, and Edsander-Nord A (2009) Clinical outcome, quality of life, patients' satisfaction, and aesthetic results, after reduction mammoplasty *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery* **43**(4): 201-6; Mello A, Domingos N, and Miyazaki M (2010) Improvement in quality of life and self-esteem after breast reduction surgery *Aesthetic Plastic Surgery* **34**(1): 59-64; and Saariniemi KMM, Kuokkanen HOM, and Tukiainen EJ (2011) The outcome of reduction mammoplasty remains stable at 2–5 years' follow-up: a prospective study *Journal of Plastic, Reconstructive & Aesthetic Surgery* **64**(5): 573-6.

⁵⁸² See, for example, Zhou Y, Hägg U, and Rabie A (2001) Patient satisfaction following orthognathic surgical correction of skeletal Class III malocclusion *The International Journal of Adult Orthodontics and Orthognathic Surgery* **16**(2): 99-107; Modig M, Andersson L, and Wårdh I (2006) Patients' perception of improvement after orthognathic surgery: pilot study *British Journal of Oral and Maxillofacial Surgery* **44**(1): 24-7; and Murphy C, Kearns G, Sleeman D, Cronin M, and Allen PF (2011) The clinical relevance of orthognathic surgery on quality of life *International Journal of Oral and Maxillofacial Surgery* **40**(9): 926-30.

⁵⁸³ See, for example, Cerovac S, Ali FS, Blizard R, Lloyd G, and Butler PEM (2005) Psychosexual function in women who have undergone reduction mammoplasty *Plastic and Reconstructive Surgery* **116**(5): 1306-13; and Papadopulos N, Totis A, Kiriakidis D *et al.* (2014) Quality of life, personality changes, self esteem, and emotional stability after breast augmentation *European Journal of Plastic Surgery* **37**(9): 479-88.

⁵⁸⁴ See, for example, 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.

⁵⁸⁵ See, for example, Stuerz K, Piza H, Niemann K, and Kinz J (2008) Psychosocial impact of abdominoplasty *Obesity Surgery* **18**(1): 34-8.

⁵⁸⁶ See, for example, Behmand RA, Tang D-H, and Smith DJJ (2000) Outcomes in breast reduction surgery *Annals of Plastic Surgery* **45**(6): 575-80; Blomqvist L, and Brandberg Y (2004) Three-year follow-up on clinical symptoms and health-related quality of life after reduction mammoplasty *Plastic and Reconstructive Surgery* **114**(1): 49; O'Blenes CAE, Delbridge CL, Miller BJ, Pantelis A, and Morris SF (2006) Prospective study of outcomes after reduction mammoplasty: long-term follow-up *Plastic and Reconstructive Surgery* **117**(2): 351; Modig M, Andersson L, and Wårdh I (2006) Patients' perception of improvement after orthognathic surgery: pilot study *British Journal of Oral and Maxillofacial Surgery* **44**(1): 24-7; Figueroa-Haas CL (2007) Effect of breast augmentation mammoplasty on self-esteem and sexuality: a quantitative analysis *Plastic Surgical Nursing* **27**(1): 16-36; Alter GJ (2008) Aesthetic labia minora and clitoral hood reduction using extended central wedge resection *Plastic and Reconstructive Surgery* **122**(6): 1780-9; de Brito MJA, Nahas FX, Barbosa MVJ *et al.* (2010) Abdominoplasty and its effect on body image, self-esteem, and mental health *Annals of Plastic Surgery* **65**(1): 5-10; Viana GAP, Osaki MH, and Nishi M (2010) Effect of lower blepharoplasty on self-esteem *Dermatologic Surgery* **36**(8): 1266-72; and Papadopulos NA, Staffler V, Mirceva V *et al.* (2012) Does abdominoplasty have a positive influence on quality of life, self-esteem, and emotional stability? *Plastic and Reconstructive Surgery* **129**(6): 957e-62e.

⁵⁸⁷ See, for example, Sarwer DB, Wadden TA, and Whitaker LA (2002) An investigation of changes in body image following cosmetic surgery *Plastic and Reconstructive Surgery* **109**(1): 363-9; and Sarwer DB, Infield AL, Baker JL *et al.* (2008) Two-year results of a prospective, multi-site investigation of patient satisfaction and psychosocial status following cosmetic surgery *Aesthetic Surgery Journal* **28**(3): 245-50. For studies which focus on changes to body image following specific cosmetic procedures, see: Nuffield Council on Bioethics (2016) *Literature review: post-procedure experiences*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Post-procedure-experiences-review.pdf>.

⁵⁸⁸ See, for example, Sarwer DB, Gibbons LM, Magee L *et al.* (2005) A prospective, multi-site investigation of patient satisfaction and psychosocial status following cosmetic surgery *Aesthetic Surgery Journal* **25**(3): 263-9.

embarrassed in front of others.⁵⁸⁹ Women have reported 'having fun' and enjoying the results of bigger breasts after breast augmentation,⁵⁹⁰ or larger lips after lip fillers;⁵⁹¹ and cosmetic procedures are sometimes described in terms of 'a treat'.⁵⁹² A number of respondents to the Working Party's online questionnaire also indicated their positive reactions to having a cosmetic procedure, as set out in Box 6.1 below.

Box 6.1: Positive reactions to cosmetic procedures – respondents to the Working Party's online questionnaire

"Why do I do this? I want to look good. I value my appearance. It is a nice thing to look good. I feel good when I look good." *User of liposuction, breast augmentation, and facial needling*

"I had fillers due to loss of weight. Now I have to have it regularly and I feel and look younger than my age." *User of injections to relax wrinkles, dermal fillers, and rhinoplasty*

"I both feel better and looked better." *User of abdominoplasty, liposuction, and breast reduction*

"It helped me, it was really successful, simple and uplifting – in every way." *User of eyelid surgery*

"My life is different. I no longer have skin infections and I am more comfortable, literally, in my own skin." *User of abdominoplasty*

"Life is better as self-esteem increased." *User of breast reduction*

"Now I can see the benefits, and how it makes feel more confident about myself." *User of injections to relax wrinkles, dermal fillers, and rhinoplasty*

"It made me feel better in myself." *User of breast lift*

"[I] feel much more relaxed and comfortable in my skin. Smile more. Feel okay going without make up now." *User of cosmetic dentistry and eyelid surgery*

"I felt more confident to wear my hair up and show my ears (I previously used to always wear my hair over my ears)." *User of otoplasty*

"My confidence grew." *User of breast enlargement*

"I'm certainly a lot more confident. I do feel much more womanly". *User of breast enlargement*

6.7 Improvements to quality of life measures have also been reported in studies that include users of a variety of procedures, including facial surgery, procedures on the abdomen,

⁵⁸⁹ This is particularly noted by studies which focus on post-procedure assessments of women who have undergone breast reduction. See, for example, Hermans BJE, Boeckx WD, De Lorenzi F, and van Der Hulst RRWJ (2005) Quality of life after breast reduction *Annals of Plastic Surgery* 55(3): 227-31.

⁵⁹⁰ See, for example, Holliday R (2016) *Cosmetic surgery discourse and cosmetic surgery value: presentation to Beauty Demands seminar: Manchester - 24 March* who notes comments from a user of breast augmentation: "I was really young when I had them, and now I'm older, you know, and more confident, I probably wouldn't have them now – but then again, I have enjoyed them (laughs)!"

⁵⁹¹ For example, one respondent to the Working Party's online questionnaire notes, on her use of fillers: "I've just always fancied larger lips and thought it would be something fun to do."

⁵⁹² See, for example, Millward Brown & The Herald (2014) *Female body image study*, available at: <http://www.millwardbrown.com/docs/default-source/ireland-downloads/opinion-polls/herald-female-body-image-study-28-10-14.pdf?sfvrsn=2> where 4% of participants indicated that their rationale for having cosmetic surgery was because "I wanted to treat myself". This Irish study gathered the opinions of 1,000 18-54-year-old women on body image. Twenty-one participants had used cosmetic surgery.

and FGCS.⁵⁹³ Similarly positive findings have been reported by studies that focus on the quality of life outcomes for young people who have undergone cosmetic procedures on the nose and ears.⁵⁹⁴ Researchers have also explored whether cosmetic procedures lead to improvements in mental health.⁵⁹⁵ However, as the measurements and methodologies used to assess mental health following a procedure are inconsistent (see paragraph 1.17), conclusions that suggest improvements in this area following cosmetic procedures need to be treated with a degree of caution.⁵⁹⁶

- 6.8 While the majority of the literature emphasises user satisfaction, not all users of cosmetic procedures report positive outcomes. A recent synthesis identified several factors that appear to be associated with a higher risk of negative psychological outcomes following cosmetic surgery, including unrealistic expectations of the likely aesthetic or psychological benefits, and where the motive to seek treatment is reported as relating to relationship issues (see paragraphs 6.16–6.19 below).⁵⁹⁷ However, the extent to which these negative effects are the result of the cosmetic intervention itself or linked to the previous psychological status of the user involved is unclear. Drawing on current psychological theories of happiness, long-term gains in happiness resulting from cosmetic enhancement seem likely to be small (see paragraphs 1.16–1.19). Further evidence and improved research is needed in order to ascertain the circumstances in which cosmetic procedures are likely to contribute to a person's happiness and well-being in a sustained manner.

Evidence on risks of harm

“Totally unnecessary risk to health and image if it went wrong.”⁵⁹⁸

“I think it's damaging... psychologically, physically, emotionally, socially. We live in a world where there are enough pressures on people to conform already.”⁵⁹⁹

“... bullying can do more damage on occasion than a low risk procedure.”⁶⁰⁰

⁵⁹³ See, for example, Motegi E, Hatch JP, Rugh JD, and Yamaguchi H (2003) Health-related quality of life and psychosocial function 5 years after orthognathic surgery *American Journal of Orthodontics and Dentofacial Orthopedics* **124**(2): 138-43; Litner JA, Rotenberg BW, Dennis M, and Adamson PA (2008) Impact of cosmetic facial surgery on satisfaction with appearance and quality of life *Archives of Facial Plastic Surgery* **10**(2): 79-83; Trichot C, Thubert T, Faivre E, Fernandez H, and Deffieux X (2011) Surgical reduction of hypertrophy of the labia minora *International Journal of Gynecology and Obstetrics* **115**(1): 40-3; Swanson E (2012) Prospective outcome study of 360 patients treated with liposuction, lipoabdominoplasty, and abdominoplasty *Plastic and Reconstructive Surgery* **129**(4): 965-78; and Cingi C, Toros SZ, Cakli H, and Gürbüz MK (2013) Patient-reported outcomes after endonasal rhinoplasty for the long nose *Journal of Craniofacial Surgery* **24**(3): 1002-6.

⁵⁹⁴ See, for example, Chauhan N, Warner J, and Adamson P (2010) Adolescent rhinoplasty: challenges and psychosocial and clinical outcomes *Aesthetic Plastic Surgery* **34**(4): 510-6; and Hao W, Chorney JM, Bezuhly M, Wilson K, and Hong P (2013) Analysis of health-related quality-of-life outcomes and their predictive factors in pediatric patients who undergo otoplasty *Plastic and Reconstructive Surgery* **132**(5): 811e-7e.

⁵⁹⁵ See, for example, Simis KJ, Hovius SER, de Beaufort ID *et al.* (2002) After plastic surgery: adolescent-reported appearance ratings and appearance-related burdens in patient and general population groups *Plastic and Reconstructive Surgery* **109**(1): 9-17; Moss TP, and Harris DL (2009) Psychological change after aesthetic plastic surgery: a prospective controlled outcome study *Psychology, Health & Medicine* **14**(5): 567-72; and Papadopoulos N, Totis A, Kiriakidis D *et al.* (2014) Quality of life, personality changes, self esteem, and emotional stability after breast augmentation *European Journal of Plastic Surgery* **37**(9): 479-88.

⁵⁹⁶ Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38**(5): 1030-40.

⁵⁹⁷ *ibid.*

⁵⁹⁸ Respondent to the Working Party's online questionnaire.

⁵⁹⁹ *ibid.*

⁶⁰⁰ *ibid.*

“When my breasts first started heading south, I was pretty bummed, and I briefly wondered if a nip and tuck would be the answer. But the thought of a risky medical procedure just to pretend to be younger than I was seems crazy.”⁶⁰¹

- 6.9 The cosmetic procedures with which this report is concerned (see paragraphs 1.20–1.23) all entail some degree of physical risk, from minor to substantial. These vary widely depending on the procedure itself, the quality of materials used, the skills of the practitioner, and the standards of the clinic or environment in which the procedure takes place. While the risk of physical harm is the most obvious form of risk, it is important also to take into account both the risk of psychological harms, and concerns about wider social harms.

Physical harms to the individual

- 6.10 It is generally accepted that any intervention in the body in a healthcare context entails an element of physical risk to the patient, and this is also the case for users of cosmetic procedures, in particular cosmetic surgery.⁶⁰² As in any other form of bodily intervention, physical harm may occur as a result of products used during the course of cosmetic procedures (see paragraphs 6.11–6.15), poor practice, or from the inherent risks associated with the procedure. These include infection⁶⁰³ (for any type of invasive procedure), and bleeding and adverse reactions to general anaesthesia⁶⁰⁴ (for surgical procedures). Some complications are minor and temporary; others such as scarring, loss of movement, or the need for repeat surgery may have more substantial and longer-term effects.⁶⁰⁵ There are also reports of more serious complications, and even death, following cosmetic surgery.⁶⁰⁶ The fact that until very recently there has been no hub for recording complications in the UK makes firm conclusions on their frequency difficult to

⁶⁰¹ Mass Observation Archive (2012) *Autumn 2012 directive: part 2 - cosmetic surgery* (Brighton: The Keep).

⁶⁰² See further: Mercer MN (2009) Clinical risk in aesthetic surgery *Clinical Risk* **15(6)**: 215-7, who observes, at page 216: “All cosmetic treatments are medical interventions, and every medical intervention has a complication and failure rate.”

⁶⁰³ In breast augmentation surgery, for example, where research is more extensive than for many other cosmetic procedures, infection rates have been estimated at 2-2.5%: Pittet B, Montandon D, and Pittet D (2005) Infection in breast implants *The Lancet Infectious Diseases* **5(2)**: 94-106. For more detail on this and other studies, see: Nuffield Council on Bioethics (2015) *Literature review: evidence of harms caused by the use of non-therapeutic cosmetic procedures*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Review-of-harms-caused-by-cosmetic-procedures.pdf>.

⁶⁰⁴ Approximately one in every 10,000 cases which involve administration of general anaesthetic will result in serious complications. See: NHS Choices (2015) *General anaesthesia*, available at: <http://www.nhs.uk/conditions/Anaesthetic-general/Pages/Definition.aspx>.

⁶⁰⁵ A study of more than 5,000 women, whose data were contained within the Danish breast implant registry found that 16.7% of the women had registered an adverse event and 4.8% had required re-operation for a complication: Hvilsmo GB, Hölmich LR, Henriksen TF *et al.* (2009) Local complications after cosmetic breast augmentation: results from the Danish Registry for Plastic Surgery of the breast *Plastic and Reconstructive Surgery* **124(3)**: 919-25. A study which analysed the case notes of 278 patients who underwent abdominoplasty carried out by four surgeons in a London plastic surgery unit found that 18% suffered from early complications, 25% experienced late complications (including ‘dog ears’ (12%) and unsatisfactory scars (8%)), and 24% required revision surgery: Stewart K, Stewart D, Coghlan B *et al.* (2006) Complications of 278 consecutive abdominoplasties *Journal of Plastic, Reconstructive & Aesthetic Surgery* **59(11)**: 1152-5.

⁶⁰⁶ A retrospective analysis of severe or lethal complications related to cosmetic liposuction in Germany found that there were 72 cases of severe complications, including 23 deaths during a five-year period: Lehnhardt M, Homann HH, Daigeler A *et al.* (2008) Major and lethal complications of liposuction: a review of 72 cases in Germany between 1998 and 2002 *Plastic and Reconstructive Surgery* **121(6)**: 396e-403e. See also: Grazer FM, and de Jong RH (2000) Fatal outcomes from liposuction: census survey of cosmetic surgeons *Plastic and Reconstructive Surgery* **105(1)**: 436-46, who estimated a mortality rate of 1 in 5,000 procedures.

draw (see paragraph 4.38 regarding the recent relaunch of a breast implant registry in England).⁶⁰⁷

Breast implants

6.11 Some products which are, or have been, used for cosmetic procedures have raised a number of concerns about potential physical harm to users / patients. For example, high levels of concern were generated by the Poly Implant Prothèse (PIP) implant scandal in the early 2010s, where industrial grade silicone was used to fill breast implants which were subsequently distributed for use worldwide (see also paragraph 3.20).⁶⁰⁸ However, the PIP scandal is not the only controversy to befall breast implants: ‘silicone bag’-style implants developed by Dow Corning in the 1960s raised concerns about patient safety and, in 1992, the FDA declared a moratorium on their use.⁶⁰⁹ Serious safety concerns also arose in the past with respect to the Trilucent breast implant: particularly that the degradation of the soya bean oil filler could give rise to genotoxic breakdown products; and the risk of rupture.⁶¹⁰ Emerging concerns are also being raised with respect to the incidence of anaplastic large cell lymphoma (ALCL) in connection with breast implants.⁶¹¹ When ALCL occurs, treatment can involve excision of the breast implant and surrounding tissue, and chemotherapy.⁶¹² More commonly, the two main issues arising in the use of breast implants drawn to the attention of the Working Party⁶¹³ are capsular contracture (where tissue around the implant tightens or hardens),⁶¹⁴ and rupture (where the outer shell of the implant tears).⁶¹⁵

Dermal fillers

6.12 The emergence of non-autologous dermal filler products – predominantly used on the face to add volume and to reduce the appearance of skin creases or wrinkles – has also become a source of concerns in relation to their physical risk to users.⁶¹⁶ While ‘serious adverse events’ for fillers are reported as low, a 2013 review emphasised that “all dermal fillers have the potential to cause complications”. While many of these are associated with the volume of filler injected or the technique of the practitioner, others are associated

⁶⁰⁷ As the Keogh report put it bluntly: “We do not know how many cosmetic procedures are carried out each year, by whom, or with what outcomes.” See: 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 3.7.

⁶⁰⁸ For further background on the PIP fraud, see, for example, Reuters (2 February 2012) *Special report: the French breast implant scandal*, available at: <http://www.reuters.com/article/us-breast-implants-mas-idUSTRE8110WY20120202>.

⁶⁰⁹ US Food and Drug Administration (2013) *Regulatory history of breast implants in the US*, available at: www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/ucm064461.htm.

⁶¹⁰ Medicines and Healthcare products Regulatory Agency (2004) *Trilucent (soya bean oil filled) breast implants - update on actions from previous risks*, available at: www.gov.uk/drug-device-alerts/medical-device-alert-trilucent-soya-bean-oil-filled-breast-implants-update-on-actions-from-previous-risks.

⁶¹¹ See, for example, US Food and Drug Administration (2017) *Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL)*, available at: www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/ucm239995.htm.

⁶¹² Clemens MW, Medeiros LJ, Butler CE *et al.* (2016) Complete surgical excision is essential for the management of patients with breast implant-associated anaplastic large-cell lymphoma *Journal of Clinical Oncology* **34**(2): 160-8.

⁶¹³ As identified during a factfinding meeting with Peter Cranstone (Managing Director, EuroSurgical), 6 December 2016.

⁶¹⁴ One literature review suggests, for example, an overall incidence of 10.6%: Headon H, Kasem A, and Mokbel K (2015) Capsular contracture after breast augmentation: an update for clinical practice *Archives of Plastic Surgery* **42**(5): 532-43.

⁶¹⁵ The FDA suggests that for Allergan and Mentor implants, post-implantation rupture rates for primary breast augmentation are 10.1% (at ten years’ post-implantation) and 13.6% (eight years’ post-implantation), respectively. See: US Food and Drug Administration (2011) *FDA update on the safety of silicone gel-filled breast implants*, available at: <http://www.fda.gov/downloads/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/UCM260090.pdf>, at page 10.

⁶¹⁶ They were described by Sir Bruce Keogh as “a crisis waiting to happen”: 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 1.16. See also the views expressed in a letter to *The Guardian* by a consultant plastic surgeon: *The Guardian* (31 March 2017) *There is no quick fix in cosmetic surgery*, available at: www.theguardian.com/lifeandstyle/2017/mar/31/there-is-no-quick-fix-in-cosmetic-surgery.

with the material itself, including the formation of lumps (granulomas or nodules) under the skin that may then require surgical removal.⁶¹⁷ The Working Party was also told that using different kinds of filler on top of each other may, over time, change the nature of each filler, for example, from temporary to permanent; such a risk is exacerbated where users do not have clear information regarding the type and make of filler used on each occasion, especially as they may not always seek treatment from the same practitioner.⁶¹⁸

- 6.13 A 2012 study of the use of filler for patients with HIV identified infectious complications in 19 per cent of patients, with no association found between level of complication and levels of immune suppression.⁶¹⁹ The most serious complications of fillers block the blood vessels causing the death of tissue, and can exceptionally lead to blindness.⁶²⁰ A 2012 poll of UK plastic surgeons who were members of the British Association of Aesthetic Plastic Surgeons (BAAPS) found that 69 per cent of respondents had seen patients with complications following temporary fillers, and that 41 per cent of respondents reported seeing patients who either needed corrective surgery after using fillers, or who were assessed as being untreatable due to the damage that had been caused.⁶²¹

Skin-lightening products

- 6.14 The use of injectable skin-lightening substances, including glutathione, vitamin C and collagen, has been highlighted as “a potentially significant safety risk” to consumers, and has been the subject of a recent US Food and Drug Administration (FDA) advisory warning.⁶²² In particular, the intravenous use of glutathione (an antioxidant) has elicited concern due to a lack of data on its efficacy and safety; and reports of adverse effects ranging from temporary headaches to severe skin disorders and toxic effects on the kidneys and liver.⁶²³
- 6.15 Topical skin-lightening products interfere with the normal production of melanin (a brown pigment that gives the skin its colour and helps to protect it from UV damage) through

⁶¹⁷ Funt D, and Pavicic T (2013) Dermal fillers in aesthetics: an overview of adverse events and treatment approaches *Clinical, Cosmetic and Investigational Dermatology* **6**: 295-316.

⁶¹⁸ Factfinding meeting with Mr Niall Kirkpatrick, 6 May 2016.

⁶¹⁹ Nadarajah JT, Collins M, Raboud J *et al.* (2012) Infectious complications of Bio-Alcamid filler used for HIV-related facial lipoatrophy *Clinical Infectious Diseases* **55(11)**: 1568-74.

⁶²⁰ See: Beleznyay K, Carruthers JDA, Humphrey S, and Jones D (2015) Avoiding and treating blindness from fillers: a review of the world literature *Dermatologic Surgery* **41(10)**: 1097-117, who reviewed 98 cases of filler-induced vision changes, and commented that blindness was a “devastating complication” although the risk was “still exceedingly low”. For further discussion of the range of potential adverse effects of dermal fillers, see also: Alijotas-Reig J, and Garcia-Gimenez V (2008) Delayed immune-mediated adverse effects related to hyaluronic acid and acrylic hydrogel dermal fillers: clinical findings, long-term follow-up and review of the literature *Journal of the European Academy of Dermatology and Venereology* **22(2)**: 150-61; Carlos-Fabuel L, Marzal-Gamarra C, Martí-Álamo S, and Mancheño-Franch A (2012) Foreign body granulomatous reactions to cosmetic fillers *Journal of Clinical and Experimental Dentistry* **4(4)**: e244; Lazzeri D, Agostini T, Figus M *et al.* (2012) Blindness following cosmetic injections of the face *Plastic and Reconstructive Surgery* **129(4)**: 995-1012; Christensen L, Breiting V, Bjamsholt T *et al.* (2013) Bacterial infection as a likely cause of adverse reactions to polyacrylamide hydrogel fillers in cosmetic surgery *Clinical Infectious Diseases* **56(10)**: 1438-44; and Carruthers JD, Fagien S, Rohrich RJ, Weinkle S, and Carruthers A (2014) Blindness caused by cosmetic filler injection: a review of cause and therapy *Plastic and Reconstructive Surgery* **134(6)**: 1197-201.

⁶²¹ See: British Association of Aesthetic Plastic Surgeons (24 November 2012) *Two out of three surgeons seeing botched filler ops* (London: British Association of Aesthetic Plastic Surgeons).

⁶²² See: US Food and Drug Administration (2 September 2015) *Injectable skin lightening products: what you should know*, available at: <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm460788.htm>, where an FDA pharmacist notes: “These products pose a potentially significant safety risk to consumers. You’re essentially injecting an unknown substance into your body – you don’t know what it contains or how it was made”.

⁶²³ Dadzie OE (2016) Unethical skin bleaching with glutathione *BMJ* **354**.

acting on the cells which produce it.⁶²⁴ These products may contain substances such as hydroquinone, mercury, and corticosteroids, even though all three are prohibited for such use in EU member states by the 2009 EU Regulation on cosmetic products,⁶²⁵ and products containing them may be seized from vendors by local authority Trading Standards teams.⁶²⁶ The caution exercised by public authorities in this context reflects concerns about the adverse effects of using skin-lightening products which contain these substances. These include contact dermatitis and hyper-pigmentation (hydroquinone and mercury), corneal degeneration (hydroquinone), anxiety, depression, and psychosis (mercury),⁶²⁷ and skin thinning, eczema, and hormonal complications (corticosteroids).⁶²⁸

Psychological harms to the individual

- 6.16 While most users of cosmetic procedures who take part in surveys or studies report that they are satisfied with the initial outcome of their procedure (see paragraphs 6.2–6.7 above), users of cosmetic procedures may experience psychological complications as well as physical complications. One study drawing on the experience of plastic surgery nurses, for example, suggested that cosmetic surgery patients were more likely to experience psychological complications (in particular anxiety and depression following an operation) than physical complications.⁶²⁹ Another (longitudinal) study found that the women in the study cohort who had cosmetic surgery thereafter experienced greater increases in mental health symptoms and eating problems, compared with those in the cohort who did not have surgery.⁶³⁰
- 6.17 A major review of psychosocial predictors and outcomes of cosmetic procedures similarly identified worsening of depressive symptoms and psychological disturbances in some patients undergoing facelifts and rhinoplasties, while emphasising the methodological limitations of many of the studies reviewed.⁶³¹ The same review highlighted how patients may become highly distressed if the psychosocial effects that they were hoping for from their cosmetic procedure were not achieved.⁶³² A number of

⁶²⁴ Parliamentary Office of Science & Technology (2013) *Skin lightening treatments*, available at: https://www.parliament.uk/documents/post/postpb011_skin_lightening_treatments.pdf. These products, although applied topically, directly affect the epidermis and are therefore, like chemical peels, included within the definition of invasive procedures for the purposes of this project.

⁶²⁵ The Regulation specifies that hydroquinone must only be used as an oxidising colouring agent for hair dyeing, or for artificial nail systems, and it wholly prohibits the use of mercury and corticosteroids in cosmetic products: Europa.eu (2009) *Regulation (EC) No 1223/2009 of the European Parliament and of the Council of 30 November 2009 on cosmetic products (recast)*, available at: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:342:0059:0209:en:PDF>, at Annex III, reference number 14.

⁶²⁶ For example, Southwark Council have published a list of products seized by its Trading Standards service: Southwark Council (2014) *Alphabetical list of illegal cosmetics and illegally supplied medicinal products previously found in Southwark* (London: Southwark Council).

⁶²⁷ See, for example, Nordlund JJ, Grimes PE, and Ortonne JP (2006) The safety of hydroquinone *Journal of the European Academy of Dermatology and Venereology* **20**(7): 781-7; Olumide YM, Akinkugbe AO, Altraide D *et al.* (2008) Complications of chronic use of skin lightening cosmetics *International Journal of Dermatology* **47**(4): 344-53; Chan TYK (2011) Inorganic mercury poisoning associated with skin-lightening cosmetic products *Clinical Toxicology* **49**(10): 886-91; Ladizinski B, Mistry N, and Kundu RV (2011) Widespread use of toxic skin lightening compounds: medical and psychosocial aspects *Dermatologic Clinics* **29**(1): 111-23; World Health Organization (2011) *Mercury in skin lightening products*, available at: http://www.who.int/ipcs/assessment/public_health/mercury_flyer.pdf; and Al-Saleh I (2016) Potential health consequences of applying mercury-containing skin-lightening creams during pregnancy and lactation periods *International Journal of Hygiene and Environmental Health* **219**(4-5): 468-74.

⁶²⁸ See, for example, Nnoruka E, and Okoye O (2006) Topical steroid abuse: its use as a depigmenting agent *Journal of the National Medical Association* **98**(6): 934-9; and Olumide YM (2010) Use of skin lightening creams *BMJ* **341**: c6102.

⁶²⁹ Rankin M, and Borah G (2006) National plastic surgical nursing survey *Plastic Surgical Nursing* **26**(4): 178-83.

⁶³⁰ In addition to having higher levels of mental health symptoms than their peers before surgery: von Soest T, Kvalem IL, and Wichstrøm L (2012) Predictors of cosmetic surgery and its effects on psychological factors and mental health: a population-based follow-up study among Norwegian females *Psychological Medicine* **42**(3): 617-26.

⁶³¹ Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38**(5): 1030-40.

⁶³² *ibid.*, at page 1037.

anecdotal accounts from users who express regret or distress after having a cosmetic procedure can also be found, for example on patient and user web forums.⁶³³

- 6.18 There appear to be certain groups of users who are more likely to suffer negative psychosocial outcomes following cosmetic procedures, especially those with pre-existing mental health disorders, such as body dysmorphic disorder (BDD – see Box 6.2 below). However, it has been argued that it is important for practitioners to be aware not only of the needs of those with BDD (which itself refers to a spectrum of symptoms), but also of wider psychosocial risk factors for poor outcomes.⁶³⁴ For example, people taking medication to aid sleep or anxiety, higher levels of stress, and other forms of poor mental health have been found to be more likely to undergo cosmetic surgery.⁶³⁵ A number of epidemiological studies have also shown an association between breast implants and an increased rate of suicide (approximately two-to-three times the rate of the general population).⁶³⁶ Although the exact mechanics of this relationship are not clear, it has been suggested that this association may reflect a higher rate of pre-existing mental disorder among women seeking breast augmentation compared with the general population.

Box 6.2: Body dysmorphic disorder

Definition

Body dysmorphic disorder (BDD) is a psychiatric condition defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) used in the US.⁶³⁷

Defining features

- High levels of preoccupation and rumination about an imagined or very minor anomaly in appearance;
- Repetitive behaviours such as compulsive mirror checking, or seeking reassurance from others; and

⁶³³ See, for example, RealSelf (2012) *Full of regret*, available at: <https://www.realself.com/forum/full-regret>; and SteadyHealth.com (2015) *Forum discussion: labiaplasty nightmare*, available at: http://www.steadyhealth.com/Labiaplasty_Nightmare_t112049.html.

⁶³⁴ Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38**(5): 1030-40, at page 1036.

⁶³⁵ Schofield M, Hussain R, Loxton D, and Miller Z (2002) Psychosocial and health behavioural covariates of cosmetic surgery: Women's Health Australia study *Journal of Health Psychology* **7**(4): 445-57.

⁶³⁶ Brinton LA, Lubin JH, Burich MC, Colton T, and Hoover RN (2001) Mortality among augmentation mammoplasty patients *Epidemiology* **12**(3): 321-6; Koot V, Peeters P, Granath F, Grobbee D, and Nyrén O (2003) Total and cause specific mortality among Swedish women with cosmetic breast implants: prospective study *BMJ* **326**(7388): 527-8; Pukkala E, Kulmala I, Hovi S-L *et al.* (2003) Causes of death among Finnish women with cosmetic breast implants, 1971–2001 *Annals of Plastic Surgery* **51**(4): 339-42; Jacobsen P, Hölmich LR, McLaughlin JK, and *et al.* (2004) Mortality and suicide among Danish women with cosmetic breast implants *Archives of Internal Medicine* **164**(22): 2450-5; Brinton LA, Lubin JH, Murray MC, Colton T, and Hoover RN (2006) Mortality rates among augmentation mammoplasty patients: an update *Epidemiology* **17**(2): 162-9; Villeneuve PJ, Holowaty EJ, Brisson J *et al.* (2006) Mortality among Canadian women with cosmetic breast implants *American Journal of Epidemiology* **164**(4): 334-41; and Lipworth L, Nyren O, Ye W *et al.* (2007) Excess mortality from suicide and other external causes of death among women with cosmetic breast implants *Annals of Plastic Surgery* **59**(2): 119-23. For a review of the literature in this area, see: Zuckerman DM, Kennedy CE, and Terplan M (2016) Breast implants, self-esteem, quality of life, and the risk of suicide *Women's Health Issues* **26**(4): 361-5. A Danish study, however, found that women who have received breast implants are *not* more likely than women in the general population to report a history of depression prior to the surgery: Kjølner K, Hölmich LR, Fryzek JP *et al.* (2003) Characteristics of women with cosmetic breast implants compared with women with other types of cosmetic surgery and population-based controls in Denmark *Annals of Plastic Surgery* **50**(1): 6-12.

⁶³⁷ American Psychiatric Association (2013) *Diagnosics and statistical manual of mental disorders*, Fifth Edition (Arlington, Virginia: American Psychiatric Association Publishing). See also: The National Institute for Health and Care Excellence (2005) *Obsessive-compulsive disorder and body dysmorphic disorder: clinical guideline*, available at: <https://www.nice.org.uk/guidance/cg31>.

- Preoccupation marked enough to interfere significantly with social functioning and everyday life, and the condition not better accounted for by another mental health disorder such as anorexia nervosa.

There are significant levels of co-morbidity, for example with obsessive compulsive disorder (OCD), depression, social anxiety, and social phobia.

Incidence

- The incidence of people with BDD presenting to aesthetic clinics has been estimated to be between five and 15 per cent (compared with a population level of 1-3%).⁶³⁸

Recommended treatment for BDD

- Surgery in BDD is associated with poor outcomes: hence the current advice is that aesthetic procedures should not be offered to people with a diagnosis of BDD.
- Recommended treatment is psychological with a focus on treating and overcoming the underlying preoccupation (the core symptom of the condition), rather than attempting to change objective appearance through surgery. There is evidence for the benefits of cognitive behaviour therapy (CBT) and / or medication in achieving a reduction in symptoms.⁶³⁹

Screening for BDD

- NICE guidance recommends screening for BDD in aesthetic clinics, particularly where there appears to be excessive concern about a minor defect.⁶⁴⁰ However, the recommended screening questions generate a lot of false positives. This may be because of the changing focus on appearance in the general population, which makes it harder to define what constitutes 'excessive concern' with appearance.
- A simple validated screening tool for prospective patients / users is important, as is ongoing alertness on the part of the practitioner to the possible need to involve colleagues with psychological expertise. A number of screening tools are currently available, although concerns were expressed to the Working Party that it is easy for those seeking procedures to circumvent them.⁶⁴¹ In 2013, it was reported that only a minority of cosmetic surgery practices routinely provide pre-operative assessment by a clinical psychologist.⁶⁴²

- 6.19 In addition to factors associated with mental health, systematic reviews of the various factors associated with poor psychological outcomes identify: having a procedure to address relationship issues; unrealistic expectations (see Box 6.3 below); and dissatisfaction with previous cosmetic surgery.⁶⁴³

⁶³⁸ Sarwer DB, and Spitzer JC (2012) Body image dysmorphic disorder in persons who undergo aesthetic medical treatments *Aesthetic Surgery Journal* **32(8)**: 999-1009, at page 1001.

⁶³⁹ See, for example, The National Institute for Health and Care Excellence (2005) *Obsessive-compulsive disorder and body dysmorphic disorder: clinical guideline*, available at: <https://www.nice.org.uk/guidance/cg31>; and Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38(5)**: 1030-40.

⁶⁴⁰ The National Institute for Health and Care Excellence (2005) *Obsessive-compulsive disorder and body dysmorphic disorder: clinical guideline*, available at: <https://www.nice.org.uk/guidance/cg31>, at paragraph 1.4.2.

⁶⁴¹ Factfinding meeting on consumer perspectives, 5 February 2016.

⁶⁴² See: 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 5.13, which highlights the report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) on cosmetic procedures and its conclusion that only a third of sites who respondent stated that they routinely carry out psychological evaluation of patients prior to cosmetic surgery and, of those sites, only 4% of assessments were performed by a clinical psychologist.

⁶⁴³ Honigman RJ, Phillips KA, and Castle DJ (2004) A review of psychosocial outcomes for patients seeking cosmetic surgery *Plastic and Reconstructive Surgery* **113(4)**: 1229-37; and Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial

Box 6.3: Common scenarios where unrealistic expectations may lead to adverse outcomes⁶⁴⁴**Assumptions about the integrity of practitioners in private settings**

- Patients may assume that because practitioners are health professionals, they can expect a standard of care that may not always be forthcoming.

Ignorance about anatomy

- Common misunderstandings about the limits of cosmetic surgery include that scars can be removed or that surgery can be done without leaving any scars.

Expectation that cosmetic surgery is an 'exact science'

- There can be a lack of understanding that a surgeon is working with living tissue and that healing depends on factors such as preserving a good blood supply, stopping smoking and avoiding infection. Predicted surgical outcomes inevitably fall into a range, and no surgeon can tell a patient exactly what their feature will look like after surgery.

Non-specific requests or over-specific requests

- Patients may defer to surgeons as the expert who will know what will suit them and ask simply to look 'more attractive'. Others are very specific in their requests, for example choosing a size of breast implant that may be clinically inappropriate for their body size.

The uncertain link between physical change and psychosocial change

- There is no evidence to underpin the widely-held assumption that altering a physical feature will necessarily result in the hoped-for psychosocial change such as feelings of improved self-confidence, or in changes related to other people, such as being perceived as more attractive or employable. Whilst surgeons can be reasonably accurate about what they can achieve in terms of physical change within an acceptable range of outcomes, they can have no idea what impact this will have for any given individual particularly in the long term.

Patients with current emotional or psychiatric problems

- These may include, for example, patients with depression or who have had a recent life event (such as divorce) where surgery is perceived as a means of addressing basic unhappiness (see also Box 6.2 on BDD above).

Patients influenced by other people

- These may include, for example, those copying friends or having a procedure because a partner wants them to.

Unrealistic expectations on the part of health professionals

- Many health professionals share the assumption that changing a physical feature will necessarily result in psychological benefits, and wrongly assume that a larger disfigurement is a bigger problem than a smaller one (while there is no correlation between severity of disfigurement and distress – see paragraph 1.18).

Health professionals suggesting additional procedures

- Some practitioners may offer to carry out a procedure that has not been asked for (for example suggesting a rhinoplasty), or carry out a more complex procedure than that

predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38(5)**: 1030-40.

⁶⁴⁴ Drawn from clinical experience of Working Party members.

agreed to (for example reducing the tip of a nose when the patient has asked for a hump reduction) in the belief that this would be in a patient's interests.

Belief that nothing else can be done

- There is a widespread lack of awareness that evidence-based psychological interventions are effective (and in the case of BDD have better supportive evidence than surgery) in the management of body image concerns.

Harms to society

- 6.20 In addition to the risks of harms to individuals described above, the increasing availability and use of cosmetic procedures also have the potential for social or communal harms, affecting a much wider group of people than those who at present choose to have a cosmetic procedure. There is no clear line between these social harms and individual harms – communal harms matter because they change what actual individuals can be and do, for example by shaping (or indeed limiting) their options, and by affecting how others perceive or behave towards them.⁶⁴⁵
- 6.21 As we noted in Chapter 1, what is regarded as 'normal' or acceptable in terms of body shape or appearance is culturally influenced, and changes over time (see paragraph 1.3). This cultural influence is collective and reinforced by multiple factors and processes: there is no single 'agent' responsible. Although many of the factors identified earlier in this report, such as media, celebrity culture, commercial pressures, advertising, and social media, may play a primary part in shaping appearance ideals and encouraging anxiety about body image, such influences are also transmitted and reinforced, as well as resisted and challenged, by family, friends, peer groups, and individuals themselves. Thus, as the numbers of people considering, and undertaking, cosmetic procedures continue to rise (see paragraphs 3.7–3.12), the potential for these individual decisions to exercise wider social influence on others' perceived choices increases. Moreover, the use of surgical and other invasive procedures in changing appearance itself helps construct and shape appearance ideals that can only be met by surgery, thus feeding the cycle.⁶⁴⁶
- 6.22 Greater numbers of people undergoing cosmetic procedures thus lead not only to greater exposure to the risks of physical or psychological harms summarised above, but also contribute to the detrimental levels of anxiety about body image highlighted in Chapter 1. We set out below a number of harms that may potentially result from this cycle of influence.
- Pressures to focus constantly on one's appearance, and to achieve consistency with beauty ideals, can lead to personal appearance becoming a source of worry, anxiety, and distress. The potential for this to impact negatively on the physical and psychological health of a large proportion of the population (particularly, but not exclusively, girls and women) is considerable.⁶⁴⁷

⁶⁴⁵ See, for example, McHale JV (2015) Children, cosmetic surgery and perfectionism: a case for legal regulation?, in *Inspiring a medico-legal revolution: essays in honour of Sheila McLean*, Ferguson PR, and Laurie GT (Editors) (Abingdon: Routledge), at chapter 12.

⁶⁴⁶ Widdows H (forthcoming) *Perfect me!* (Princeton: Princeton University Press).

⁶⁴⁷ Rudiger JA, and Winstead BA (2013) Body talk and body-related co-rumination: associations with body image, eating attitudes, and psychological adjustment *Body Image* **10(4)**: 462-71.

- The increasing focus on appearance, both as a marker of self-worth and as a measure of social acceptance, is a matter of concern. Excessive attention and energy spent on the self and appearance detracts from other activities that have been shown to contribute more to happiness / well-being.⁶⁴⁸
- The threshold for appearance dissatisfaction has dropped, and children are taking active steps to control and alter their appearance at younger ages.⁶⁴⁹
- The impacts of appearance dissatisfaction appear to be greater for the less psychologically robust, who may also be at greater risk of experiencing negative outcomes after cosmetic procedures.⁶⁵⁰
- There are costs to the NHS, or other public health sectors, in dealing with complications of cosmetic procedures undertaken in the private sector, whether within the UK or abroad.⁶⁵¹
- The reduction in the variation in appearance ideals within and between cultures intensifies the pressure on those who might like to, but cannot, meet these ideals. This has implications for those who are already at risk of marginalisation – for example, those with visible differences, people who are overweight, and those with visible signs of ageing. At a societal level, this has the potential of increasing intolerance of those who do not meet the ideals.

6.23 We now turn to consider the implications of the harms and possible harms we have identified, alongside the evidence of user satisfaction, in our ethical analysis in Chapter 7.

⁶⁴⁸ Haidt J (2006) *The happiness hypothesis: putting ancient wisdom and philosophy to the test of modern science* (London: Arrow Books).

⁶⁴⁹ See, for example, the literature reviewed in Slater A, Halliwell E, Jarman H, and Gaskin E (2017) More than just child's play? An experimental investigation of the impact of an appearance-focused internet game on body image and career aspirations of young girls *Journal of Youth and Adolescence*: 1-13.

⁶⁵⁰ Brunton G, Paraskeva N, Caird J *et al.* (2014) Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment *Aesthetic Plastic Surgery* **38(5)**: 1030-40.

⁶⁵¹ See, for example, Griffiths D, and Mullock A (2017) Cosmetic surgery: regulatory challenges in a global beauty market *Health Care Analysis*: 1-15, who review the limited data available. The average cost to the NHS per patient has been estimated as being £5,000. See: The British Association of Aesthetic and Plastic Surgeons (7 October 2016) *Breastxit: a clean cut for the aesthetic sector*, available at: https://baaps.org.uk/about/news/34/breastxit_a_clean_cut_for_the_aesthetic_sector.

Chapter 7

Ethical analysis

Chapter 7 – Ethical analysis

Chapter 7: overview

- A key ethical concern with respect to the provision and use of cosmetic procedures is the role played by a commercially-driven industry within a social context of significant dissatisfaction and distress about personal appearance. By developing invasive cosmetic procedures that are marketed in line with prevailing appearance ideals, the industry plays an important role in reinforcing those ideals, and thereby contributing to the public health harms associated with poor body image.
- Such appearance ideals are a further source of concern where they feed existing negative and discriminatory attitudes with respect to factors such as age, gender, race, class, and disability.
- These concerns are compounded by the fact that procedures are offered within an apparently trust-based context where users might assume high standards of professional conduct and integrity – but where in practice commercial imperatives may dominate.
- It is not possible to draw absolute and robust distinctions between cosmetic and therapeutic treatments, or between some cosmetic procedures and routine beauty treatments. Nevertheless, there are clearly degrees to which different procedures, in different circumstances, can contribute to public health and discriminatory harms, or may compromise the professional responsibilities of practitioners with respect to the well-being of users.
- Recognising the social pressures that have the potential to limit, rather than extend, the choices that individuals experience as open to them, we put forward an ethical approach that focuses on the wider social context in which cosmetic procedures are promoted, rather than on the decisions made by individuals within that context. We acknowledge that similar concerns may also arise in connection with procedures that would generally be perceived as therapeutic / reconstructive interventions, or ‘simply’ as routine beauty treatments.
- We suggest an ethical approach to policy that includes two distinct elements, relating to ‘demand’ and ‘supply’ respectively. On the demand side, we challenge the promotion of potentially damaging appearance ideals, and the pressure exerted on people to meet them. On the supply side, we explore how a more ethical encounter between users and providers / practitioners could be fostered, particularly with respect to the use of these procedures by children and young people.
- Ethical questions arising on the demand side include the nature and extent of public health responsibilities of governments, and the corporate social responsibilities of industry. We argue that public health responsibilities include providing the conditions in which people can live healthy lives: this would encompass tackling the way in which unhealthy or discriminatory appearance ideals are promoted.
- Ethical questions arising on the supply side include consideration of the roles and responsibilities of cosmetic practitioners: in particular exploring what ‘informed consent’ can mean in the context of cosmetic procedures sought and provided in the private sector. High standards of governance for the industry as a whole, covering practitioners, products and premises, are a pre-requisite for any such encounter between potential user and practitioner to be conducted on an ethical basis.

Ethical distinctions and judgments

Drawing ethical distinctions

- 7.1 We outlined in Chapter 2 the emerging ethical concerns associated with the growing use of cosmetic procedures in the UK and beyond, especially when considered in the context of increasing levels of appearance anxiety, cultivated and sustained by broader social, economic and technological factors. The empirical evidence explored in succeeding chapters provides significant support for the concerns raised: with respect to the potential harms to public health of adding to appearance anxieties; of contributing to discriminatory attitudes with respect to appearance; and with respect to the dangerous disjunction between assumptions of trust-based care centred around patient welfare, and the reality of an industry driven by commercial imperatives that packages and sells procedures as consumer goods. These concerns are particularly pressing when considering children's and young people's exposure to idealised body images and access to cosmetic procedures. At the same time, while evidence about long-term outcomes is limited, we know that many people are satisfied at least initially with the outcome achieved by the procedure that they have had, and are pleased with their decision to make use of the procedures available to change their body. Attention to one's own appearance, and the enjoyment that can be found in managing it, can contribute to the way in which individuals flourish, even though the excess attention implicated in appearance anxiety and distress does not.⁶⁵² Any action taken in response to the evidence of wider harms thus also needs to take into account the potential impact on individuals' preferences and choices.
- 7.2 In order to analyse what action might be taken, and by whom, in response to the harms identified in this report, we first need to return to the question touched upon in Chapter 1 of whether, and if so how, we can make robust and meaningful distinctions between the procedures described as 'cosmetic', procedures considered therapeutic that nevertheless target appearance, and routine beauty procedures and treatments (see paragraphs 1.20–1.23). Alternatively, if such distinctions cannot be made, we need to take into account how our analysis and our recommendations might also apply to procedures or products that would not ordinarily be conceptualised as 'cosmetic procedures' but which cannot be precisely separated out from those that are.
- 7.3 The Working Party's terms of reference refer to 'non-reconstructive' cosmetic procedures, in recognition of a widely-shared intuition that procedures undertaken to restore a person's appearance after illness or injury do not raise the same kinds of ethical questions as procedures undertaken on an elective basis with the aim of changing one's appearance to comply with prevailing appearance ideals.⁶⁵³ However, the Working Party found that it is simply not possible to draw a consistent and coherent distinction between what is reconstructive and cosmetic, or even between what is cosmetic and therapeutic / clinical. Reconstructive procedures, just as much as cosmetic procedures, are influenced by cultural ideas about what is normal or desirable appearance: reconstructive surgery for a person born with a significant facial disfigurement, for example, will be guided by what is perceived as normal for a particular family or wider reference group,

⁶⁵² In this sense, attention to appearance might be considered to be part of a person's conception of a 'good life' as derived from Aristotle, as long as it does not become a focus of excessive concern: Aristotle (1980) *The Nicomachean ethics: book VII (4)* (translated and introduced by Ross D) (Oxford: Oxford University Press), pp169-70.

⁶⁵³ See, for example, the distinctions drawn on the NHS Choices website: NHS Choices (2015) *Plastic surgery*, available at: <http://www.nhs.uk/conditions/Plastic-surgery/Pages/Introduction.aspx>.

within that community at a particular time. What is defined as therapeutic is also dependent on the cultural context: in the US, for example, male circumcision has been regarded as medically beneficial, with health benefits outweighing the risks of the intervention,⁶⁵⁴ while in Europe, the procedure has predominantly been regarded as a cultural or religious choice, with no associated health benefits.⁶⁵⁵ What is perceived as a 'defect' in need of medical attention or remedy may be influenced by social norms in a particular society, just as much as what is seen as ideal or admirable in terms of appearance.⁶⁵⁶

- 7.4 It may be possible to distinguish procedures that aim to repair a person's appearance after accident or illness from other forms of reconstructive or cosmetic procedure, on the grounds that the hoped-for outcome is not usually a new 'imagined self',⁶⁵⁷ influenced by the ideals discussed earlier in this report, but rather an approximation to one's own prior appearance.⁶⁵⁸ However, reconstructive procedures, as performed by plastic surgeons in the public health sector, are not limited to such circumstances of loss or sudden change: they also include the removal of what are regarded as blemishes or disfigurements that have been present from birth, as well as procedures to change appearance related to congenital conditions, such as facial surgery for people with Down's syndrome, removal of 'extra' fingers or toes where a baby is born with more than five on each hand or foot, or limb-lengthening procedures for children born with achondroplasia. Such procedures, just like many 'cosmetic' procedures, aim to change a person's appearance away from what is 'normal for them' to what is (or is closer to) normal for the society in which they live.⁶⁵⁹
- 7.5 Nor do definitions of what procedures are made available on the NHS provide a reliable distinction between what is therapeutic (by implication clinically necessary) and what is cosmetic (by implication optional and a matter of personal choice).⁶⁶⁰ NHS practice is itself inconsistent: breast reconstruction after surgery for cancer is regarded as an intrinsic part of the therapeutic treatment (although some women choose not to accept it), while removal of large amounts of excess skin after bariatric surgery is not, even though the 'apron' of excess skin is not only perceived as unsightly but may also interfere significantly with daily life and cause considerable discomfort. Cost pressures on the NHS are also leading to procedures such as the removal of minor blemishes, warts or skin tags being categorised as low priority, or even unavailable altogether, demonstrating

⁶⁵⁴ Frisch M, Aigrain Y, Barauskas V *et al.* (2013) Cultural bias in the AAP's 2012 technical report and policy statement on male circumcision *Pediatrics* **131**(4): 796-800; Bossio JA, Pukall CF, and Steele S (2014) A review of the current state of the male circumcision literature *The Journal of Sexual Medicine* **11**(12): 2847-64; and Frisch M, and Earp BD (2016) Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence *Global Public Health* **19**: 1-16.

⁶⁵⁵ See, for example, Brusa M, and Barilan YM (2009) Cultural circumcision in EU public hospitals - an ethical discussion *Bioethics* **23**(8): 470-82.

⁶⁵⁶ Chambers C (2017) *Normal bodies: cultural, cosmetic, and clinical surgery* (working paper). See also: Ouellette A (2009) Eyes wide open: surgery to westernize the eyes of an Asian child *The Hastings Center Report* **39**(1): 15-8.

⁶⁵⁷ For a detailed discussion of the idea of the 'imagined self' in the context of the use of cosmetic procedures, see: Widdows H (forthcoming) *Perfect me!* (Princeton: Princeton University Press).

⁶⁵⁸ There can of course be elements of both: for example, deciding to have a larger breast size as part of reconstructive surgery after mastectomy. But in that case, it is still possible to separate out the two elements. We recognise that there may still be ethical questions about such 'restoration' or 'repair' but argue that these can be distinguished from those concerned with changing in response to social ideals which are the focus of this report.

⁶⁵⁹ See, for example, the discussion in McHale JV (2015) Children, cosmetic surgery and perfectionism: a case for legal regulation?, in *Inspiring a medico-legal revolution: essays in honour of Sheila McLean*, Ferguson PR, and Laurie GT (Editors) (Abingdon: Routledge), at chapter 12.

⁶⁶⁰ Chambers C (2017) *Normal bodies: cultural, cosmetic, and clinical surgery* (working paper).

again the fluidity of these definitional boundaries, and the social pressures that shape them.⁶⁶¹

- 7.6 In our public consultation, many respondents made clear distinctions based on the nature of people's *motivations*: in particular, between procedures undertaken with the desire to be 'more beautiful', which were felt to be potentially ethically problematic, and those designed to be more 'normal' which were generally felt to be justifiable (see Box 7.1 below). Yet, as discussed above, this distinction between wanting to be (perceived as) more beautiful and wanting to be (perceived as) more normal is far less clear than it first appears: both desires are shaped by social influence and pressure, and both may be implicitly discriminatory, for example with respect to age, race, or disability. In both cases, people's choices and desires will be affected by the attitudes of others around them to their appearance and by the way in which the option of particular procedures is framed and made available to them. As we saw in Chapter 5, for example, the desire, and perceived need, to look younger than one's chronological age is far from simple 'vanity' but may confront individuals every way they turn: professionally, socially, and in shops, media, and advertising.

Box 7.1: 'More beautiful' vs 'more normal': thoughts from the Working Party's open consultation

- "It seems to me like 'big' defects in one's children's appearance should be fixed - but only if it isn't risky for the kid's health and only if it is meant as a way to fix, rather than enhance, certain features." – *respondent to WP's online survey*
- "I could never consider cosmetic surgery. I just want to be normal, not enhanced." – *respondent to WP's online survey*
- "This was not a "vanity" project for me and I wasn't ashamed to tell people. It was a serious procedure to improve my health as well as my quality of life when I had worked hard to do that already by losing weight which I had been carrying since a child. (I was in my early 20s)." – *abdominoplasty user, responding to the Working Party's online survey*
- "If someone was having a cosmetic procedure when they looked fine and it was more about vanity, it probably would change my feelings about them." – *respondent to WP's online survey*
- "Morally speaking, I don't see the cosmetic procedure itself is a bad thing. It's just the reasons behind it." – *IAB discussion workshop*
- "I think that cosmetic surgery for if you've got a big burn... to help that is definitely 'good'. But it's when people are getting their boobs done for the fun of it, and you're, like, so young to be getting your boobs done – I don't think that's... It's each to their own..." – *IAB discussion workshop*
- "There is a difference between doing something to make you fit within the parameters of what is considered normal and having people, often young people, who are well within that normal range and deciding to have extreme things done". – *Stitch in Time, Rossendale*

⁶⁶¹ See, for example, Discover Laser (2017) *Skin tags, moles and warts are easily removed by our resident skin expert*, available at: <http://www.discoverlaser.co.uk/body-treatments/blemish-removal-body-skin-tags-moles-warts/>; and Mail Online (19 January 2017) *Breast cancer sufferer, 53, who had a life-saving mastectomy has differently shaped breasts after the NHS refused to lift her other one - despite promising to*, available at: <http://www.dailymail.co.uk/health/article-4135488/Cancer-sufferer-53-differently-shaped-breasts.html>.

- “It has a purpose for quite serious cases – like plastic surgery and things like that are extremely useful. But it’s where you draw the line – like who can get it? People who need it? Or people who want it?” – *Aberdeen YPG*

- 7.7 While not spelt out explicitly, one of the factors underpinning these suggested distinctions between ‘vanity’ and ‘wanting to be normal’ appears to be concern about levels of distress: it is assumed that an appearance out of the usual may cause emotional distress that needs or deserves to be alleviated, in a way that a desire to enhance may not. However, as we set out in Chapter 1, these distinctions are not supported by the psychological evidence: there appears to be no correlation between the severity of any disfigurement and degree of distress, and indeed people living with significant visual difference may be much happier with their appearance than others who might be regarded as beautiful (see paragraphs 1.16–1.19).⁶⁶² There are important differences between first-party and third-party perceptions of appearance, and what others might describe as a ‘want’, the individual concerned might perceive very powerfully as a ‘need’.
- 7.8 Moreover, even if it were the case that one motivation could be demonstrated to be more ‘deserving’ than another, such a distinction would not necessarily justify the *practice* of those ‘more deserving’ procedures. Where a person is being bullied or discriminated against in other areas of life, it would not automatically be assumed that it is that person who needs to be ‘fixed’. Rather, for characteristics covered by equality legislation such as disability, race, or age, equality law would demand that the behaviour of others, and the context of the bullying or discrimination, should be challenged (see paragraph 4.62). Why, therefore, in the context of discrimination or unkind treatment in connection with appearance, should it be widely assumed that it is the person’s appearance that should be the primary target for intervention?
- 7.9 Finally, in exploring aims and motivations underlying decisions to undertake particular procedures (see paragraphs 5.5–5.17), there is another important question to be raised, as to *who* is entitled to make such judgments (with respect to individuals’ actions) at all. Is it for practitioners or policy-makers or any others to specify that one person’s motivation for a cosmetic procedure is any better or worse than another’s, especially in light of the recognition of the social influences brought to bear on all of us to conform to appearance expectations and ideals?

Locating the source of harm: multiple continuums

- 7.10 The fact that it is impossible to delineate clear boundaries between cosmetic and therapeutic procedures, or between cosmetic procedures and routine beauty treatments, does not in any way undermine the sources of ethical concern and potential for societal harm summarised in paragraph 7.1. While it may not be possible to sketch out a simple continuum of procedures, moving from those that are ethically unproblematic to those that are ethically suspect or indubitably harmful in themselves, nevertheless there are clearly degrees to which different procedures, in different circumstances, contribute to the public health and discriminatory harms elucidated earlier in this report.
- 7.11 Thus, one way of conceptualising the various ways in which different cosmetic procedures may contribute to these harms, is by considering the way in which different cosmetic procedures can be positioned along *multiple* continuums, reflecting different

⁶⁶² Deliberative event with Changing Faces, 14 December 2016.

ethical concerns arising in connection with the many and various ways in which people seek to change the way they look and present themselves to others.

- 7.12 One of the most obvious ways of presenting or visualising that continuum would be by reference to physical risk: from activities such as haircuts and routine make-up at one end to major surgery (whether described as cosmetic or reconstructive) at the other. Invasive non-surgical procedures such as botox and dermal fillers, laser treatments and skin rejuvenation procedures would slot in at various points in between these two extremes, as would other appearance-related procedures such as hair dyeing, acrylic nail treatment, the use of sunbeds, tattooing, body-piercing, and scarification. Ethical concerns associated with this form of the continuum might focus on minimising risks of harm (particularly with reference to children and young people: see paragraph 7.36–7.41), promoting free and informed choices, and the professional responsibilities of the practitioners involved.
- 7.13 However, this risk-based continuum is far from the only way of positioning different procedures in relation to each other. The continuum could also be presented by reference to:
- degree of reversibility / irreversibility which is linked with, but distinct from, questions of physical risk;
 - the likelihood of the procedure achieving the desired physical aim: some procedures are much more predictable in their outcomes than others, and may hence pose lower levels of risk that the user will be disappointed with the outcome;⁶⁶³
 - the likelihood of the procedure achieving the desired psychological aim in the long-term, including alleviating social anxiety or enhancing self-confidence: this will depend on individual factors such as willingness to place oneself in social situations previously avoided, and development of good social skills, rather than automatically resulting from altered appearance achieved through cosmetic procedures;
 - the extent to which third party involvement is required in the procedure: this draws in questions of the roles and responsibilities of that third party, and in particular how these may correlate with patient expectations, for example with respect to the practitioner's skills and qualifications; and
 - the extent to which use of procedures may contribute to discriminatory practices or other forms of harm to others, however unintended: for example by implicitly endorsing the idea that particular forms of appearance are unacceptable and 'need' to be changed.
- 7.14 Moreover, the context in which the procedure takes place (even if the content of the procedure is exactly the same) may affect its position in the various continuums. The risks of lip filler, for example, may vary depending on the user, on the skills of the practitioner, and on the clinical suitability of the premises where the procedure takes place; and the aims of a young woman seeking a 'perfect pout' are very different from those of an older person wanting to repair damage from prolonged exposure to the sun.
- 7.15 **In other words, instead of trying to 'label' particular procedures, or particular motivations, as ethically acceptable or non-acceptable, we need to consider the context in which those procedures are perceived and promoted as desirable – and**

⁶⁶³ See, for example, Veale D, Naismith I, Eshkevari E *et al.* (2014) Psychosexual outcome after labiaplasty: a prospective case-comparison study *International Urogynecology Journal* **25**(6): 831-9, at page 838.

then to explore the distinct ethical questions that arise within that context. These ethical questions can be broadly categorised as relating to:

- responsibility for preventing or minimising the various kinds of public health and discriminatory harms identified in earlier chapters;
- the preservation and maintenance of trust as part of the practitioner / user relationship in a clinical context; and
- the extent to which particular responsibilities are owed to children.

It is important to recognise that these ethical questions may *also* arise in connection with procedures that would generally be perceived as therapeutic interventions, or ‘simply’ as routine beauty treatments.

7.16 We suggest that an ethical framework for responding to these challenges needs to include two distinct elements, that can be broadly categorised as being concerned with the ‘demand’ and ‘supply’ aspects of the industry respectively:⁶⁶⁴

- On the ‘demand’ side, with reference to the social context in which appearance ideals are embedded, we explore the roles and responsibilities of those who potentially have the power to influence how these ideals emerge and are promulgated, and the extent to which they act to promote or to challenge harmful and discriminatory ideals.
- On the ‘supply’ side, we consider the responsibilities of the cosmetic procedures industry and practitioners when they offer, or respond to requests for, procedures.

Challenging harmful or discriminatory ideals: responsibilities and power

“... if ‘normalising’ physical features became routine, it is unlikely that this will result in uniform acceptance for all people within their social groups. It is as likely that the range of ‘normality’ will simply grow narrower, creating new ‘in’ and ‘out’ groups.”⁶⁶⁵

“I would not feel in any place to judge [another person’s] decision. Though I think adherence to conventional beauty norms harms us all, I do not think that this person should bear a huge burden on their own for going against them. After all, most of the rest of us are hardly going out of our way to change them either.”⁶⁶⁶

7.17 We have seen how certain appearance expectations and ideals may ‘feed’ negative and discriminatory attitudes in many domains, for example with respect to age, gender, race and disability; and also more broadly in connection with the way in which both women and men are valued and encouraged to value themselves. The way in which cosmetic

⁶⁶⁴ For a similar approach in a different context, see: Wilkinson S, and Williams NJ (2016) Public funding, social change and uterus transplants: a response to commentaries *Journal of Medical Ethics* **42(9)**: 572-3 in which the authors recognise the social nature of the widespread emphasis on genetic parenthood over other kinds of parenthood – but argue that in looking at public policy responses, it is necessary to deal with society as it currently exists, not at how we would like it to be.

⁶⁶⁵ Mission and Public Affairs Council, Church of England, responding to the Working Party’s call for evidence.

⁶⁶⁶ Respondent to the Working Party’s online questionnaire.

procedures are promoted, and the significant growth in their use in recent years, contributes to these discriminatory attitudes in a number of ways:

- Cosmetic procedures tend to reinforce existing inequalities with respect to appearance standards and ideals. To use gender as an example, women are still judged on appearance to a greater degree than men traditionally have been, and therefore feel under pressure to do more to make themselves fit with appearance ideals.⁶⁶⁷ Ideals associated with being 'beautiful' as a woman are themselves problematic from the point of view of equality: beauty for women is still predominantly associated with looking young and decorative, rather than being authoritative or responsible.⁶⁶⁸ With respect to ethnicity, some procedures, such as eyelid surgery, skin-lightening and rhinoplasty, can be promoted on the premise that specific bodily features are markers of race or ethnicity, and are valued or disvalued accordingly.⁶⁶⁹
- The more common it becomes to 'fix' the appearance of those who do not conform to prevailing social standards and expectations (whether this is 'fixing' the distinctive facial features of those with Down's syndrome, pinning back prominent ears, or straightening crooked teeth), then the more those with these features, who do not wish to resort to invasive procedures to change their appearance, are likely to stand out. This potentially makes it less possible, both for individuals, and even more so for parents making decisions on behalf of their children, to decide *not* to have 'work done' to fix what others around them might perceive as flaws. It also makes things even more difficult for those with flaws that cannot be 'fixed': there are significant limitations on what reconstructive and cosmetic surgery can achieve.⁶⁷⁰
- If ideas of what is normal or acceptable appearance narrow, more people will fall outside this categorisation, meaning that more people may feel under pressure to take action to deal with 'flaws' that were once regarded as a non-remarkable aspect of appearance. Signs of visible ageing, such as wrinkles and jowls for example, are increasingly regarded as flaws that should be addressed through the use of invasive procedures; similarly, teeth that are uneven or not perfectly white are regarded as a defect in need of a remedy.
- As appearance matters more (to more of the population, and also as a more important dimension for evaluation both of the self and of others), then there is a significant risk that those who do not conform, at least to a minimum extent, to these ideals will experience increasing levels of discrimination.

7.18 As we argued earlier, there is no single agent responsible for the way in which appearance expectations and ideals are collectively promoted, reinforced, and policed: they emerge from a constellation of practices and players, and are the effect of whole industries that sell a particular account of what it is to be human.⁶⁷¹ However, it is possible to identify a number of key players who bear distinct responsibilities in this arena, and who, significantly, also have the power to make things change. These include: the state;

⁶⁶⁷ See, for example, House of Commons Petitions Committee and Women and Equalities Committee (2017) *High heels and workplace dress codes*, available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmcompetitions/291/291.pdf>.

⁶⁶⁸ See, for example, comments in a foreword by Susie Orbach in Elias A, Gill R, and Scharff C (2017) *Aesthetic labour: rethinking beauty politics and neoliberalism* (London: Palgrave Macmillan), ppix-x.

⁶⁶⁹ See, for example, Kaw E (1993) Steven Polgar Prize Essay (1991): medicalization of racial features: Asian American women and cosmetic surgery *Medical Anthropology Quarterly* **7**(1): 74-89; and Holliday R, and Elfving-Hwang J (2012) Gender, globalization and aesthetic surgery in South Korea *Body & Society* **18**(2): 58-81.

⁶⁷⁰ This emerged as a significant theme in the deliberative event with Changing Faces (14 December 2016).

⁶⁷¹ Adorno T, and Horkheimer M (1993) *Dialectic of enlightenment* (New York: Continuum).

the beauty, fashion, film, and music industries; media and advertising; and the cosmetic procedures industry itself. While individuals, friends, and families play their part in reinforcing and transmitting particular ideals (see, for example, paragraphs 5.20–5.24 and 6.21), that role is dwarfed by the marketing power and influence of the industries concerned, and the government’s capacity, if it chooses, to intervene.

- 7.19 This raises important questions with respect to the role of the state, and whether a government should intervene in the activities of the commercial sector in this way, other than to require necessary standards of safety. In the Nuffield Council’s 2007 report *Public health: ethical issues*, we suggested that the role of the state should indeed go beyond such a *laissez-faire* approach, and made an argument for what we called the ‘stewardship’ model of the state to justify and delineate the responsibilities of the state in the area of public health.⁶⁷² Starting with John Stuart Mill’s ‘harm principle’, which justifies state intervention only to prevent harm to others, we identified both the exceptions that Mill himself recognised to this principle (for example with respect to the state’s duties to protect children, and to promote education), and the limitations of the harm principle in areas like public health where communal interests are at stake, inequalities lead to unequal burdens or ill-health, and the role of individual consent is inevitably limited.
- 7.20 In our approach to a stewardship role for the state, we suggested that states have a duty to look after the important needs of those within their jurisdiction, both on an individual basis (thus recognising the importance of respecting individual freedoms) and collectively (recognising that at times communal benefits may come into conflict with individual choices and preferences). In particular, we argued that a stewardship state had a responsibility to provide conditions that allow people to be healthy, and to seek to reduce health inequalities. In other words, the state has an ‘enabling’ role in public health, recognising that many aspects of contemporary life, ranging from the built environment and provision of public services to social pressures mediated through technological developments (such as those identified in Chapter 1 of this report), have a major impact on people’s health, and yet lie outside the sphere of control of individuals. The further role of the stewardship state with respect to responding to inequalities provides clear justification for state action in combating discrimination and for actively promoting a fair society.⁶⁷³
- 7.21 **We suggest that this understanding of the stewardship role of the state provides strong justification for action on the part of the state with respect to the ‘demand side’ factors that influence why people consider having a cosmetic procedure in the first place, and which can be associated with discriminatory practices and harm to public health. Such action needs to be proportionate, taking into account the need to justify potential intrusion into the rights of individuals, including freedom of speech and the free sharing of information, attitudes and beliefs. It also needs to be evidence-based, with respect to both the harms at stake, and the likelihood of the proposed policy interventions to succeed in mitigating them. However, as we argue in our earlier report, ‘doing nothing’ is also an active policy choice, and hence cannot be justified as the simple default option, in the absence of overwhelming evidence of the need to act.**⁶⁷⁴

⁶⁷² Nuffield Council on Bioethics (2007) *Public health: ethical issues*, available at: <http://nuffieldbioethics.org/project/public-health>, at paragraphs 2.41-5.

⁶⁷³ As recognised in Great Britain through the Equality Act 2010, and the creation of the Equality and Human Rights Commission, who describe their role as “to help make Britain fairer”. See: Equality and Human Rights Commission (2017) *Who we are*, available at: <https://www.equalityhumanrights.com/en/about-us/who-we-are>.

⁶⁷⁴ Nuffield Council on Bioethics (2007) *Public health: ethical issues*, available at: <http://nuffieldbioethics.org/project/public-health>, at paragraph 3.38.

- 7.22 The precise nature of the role of the state with respect to regulating the demand side factors influencing the growing use of cosmetic procedures is dependent to a degree on the behaviour of those, in particular the beauty and fashion industries, media and advertising, who have the most direct impact on the way appearance ideals emerge and are promulgated. The business sector is legally bound to meet the minimum regulatory requirements imposed on it by national law, but its social responsibilities are not necessarily limited to the regulatory approach of the government in power. The well-established concept of ‘corporate social responsibility’ or CSR (a feature of corporate life since the 1950s) attempts to capture this tripartite relationship between government, industry and society, and has been characterised as a: “built-in, self-regulating mechanism whereby businesses monitor and ensure their adherence to law, ethical standards and international norms. Social responsibility encompasses the obligation of managers to choose and act in ways that benefit both the interests of the organisation and those of society as a whole.”⁶⁷⁵ Whilst some question the legitimacy and reality of CSR,⁶⁷⁶ the argument that CSR can in fact enhance profitability – ‘doing well by doing good’ – is widely accepted.⁶⁷⁷
- 7.23 Where business (whether collectively or on a company-by-company basis) takes such social responsibilities seriously, then the need for state action may be diminished: a self-regulatory system that operates well, for example, may be as effective in protecting individuals from public health harms or discrimination as a statutory system. Where such self-regulation, or other action relating to CSR, is *not* effective, on the other hand, it then becomes the role of the stewardship state to step in and act.⁶⁷⁸
- 7.24 The cosmetic procedures industry itself bears particular responsibilities in relation to demand side pressures, beyond those of others in the commercial sector concerned with appearance ideals. A key feature of the cosmetic procedures industry is precisely that it *is* an industry, and unlike other healthcare industries in the UK such as the pharmaceutical sector, it promotes its services directly to the public. Cosmetic surgery is dominated by large corporate chains, and while non-surgical procedures may be provided on a much more dispersed model, including by solo practitioners in high street beauty salons, the supply of the equipment and products used for those procedures is similarly a matter of competitive big business (see paragraphs 3.18–3.22). Procedures are packaged and marketed like consumer goods, with little reference to the fact that what is being sold is an invasive physical procedure with inherent risks and uncertain benefits, and often with implicit promises of happiness and success awaiting the ‘new you’ (see Box 2.3). Yet the very fact that it is so hard to disentangle cosmetic procedures from interventions categorised as reconstructive or therapeutic (see paragraphs 7.2–7.9) demonstrates how embedded these procedures are in concepts of healthcare – and hence in all the associated assumptions of trust-based relationships and a primary focus on patient welfare expected in a healthcare context.

⁶⁷⁵ Zhao J (2017) Promoting more socially responsible corporations through a corporate law regulatory framework *Legal Studies* **37(1)**: 103-36, at page 104.

⁶⁷⁶ The economist Milton Friedman, for example, argued that social issues were not a legitimate concern of business people. See: Friedman M (13 September 1970) *The social responsibility of business is to increase its profits*, available at: <http://www.colorado.edu/studentgroups/libertarians/issues/friedman-soc-resp-business.html>.

⁶⁷⁷ Carroll AB, and Shabana KM (2010) The business case for corporate social responsibility: a review of concepts, research and practice *International Journal of Management Reviews* **12(1)**: 85-105.

⁶⁷⁸ A recent example in the environmental field is that of the failure of the voluntary code to reduce the use of plastic bags that subsequently led to legislation introducing a tax. See: Wrap (2014) *UK voluntary carrier bag agreement: 2014 data - governments, retailers and the BRC*, available at: http://www.wrap.org.uk/sites/files/wrap/UK-Voluntary-Carrier-Bag-Agreement-Presentation_v4_0.pdf.

- 7.25 This in turn affects the responsibilities of both the corporate providers of cosmetic procedures, and of individual practitioners themselves operating in this highly commercialised field, not only with respect to questions of standards of practice (discussed below), but also with respect to the manner in which prospective users are encouraged to consider having a procedure. Essential to the inherently trust-based relationship between practitioners and their patients in the context of healthcare is concern for patient welfare: exercised by the practitioner, and assumed by the patient, regardless of whether the intervention in question is being provided in the public or private healthcare sector. This trust can only be maintained in the cosmetic sector if users / patients can genuinely be confident in the advice being provided by the practitioner, including with respect to the advertising or marketing materials that drew them to the clinic in the first place. A further significant responsibility lies with the more hidden sectors of the cosmetic procedures industry, concerned with the development of new cosmetic procedures, including through the repurposing of techniques and products developed initially for therapeutic uses (see paragraphs 3.13–3.15). These represent a very concrete example of the way in which the cosmetic procedures industry exercises influence on the demand side.
- 7.26 **The cosmetic procedures industry is not solely responsible for creating the appearance ideals that have been critiqued in this report. However, it is complicit in encouraging them through the procedures it develops and promotes, and plays a further role in associating the potential for appearance change with the trust-based ‘brand’ of the health professional.**

Justifying supply-side regulation

Regulating for safety: an ethical approach

- 7.27 We argued above that the stewardship role of the state provides justification for action on the part of the state to intervene with respect to the demand side factors implicated in the growing use of cosmetic procedures. This role also clearly justifies action to ensure that individuals are not put at the risk of unnecessary and avoidable harm; indeed such action could be justified by reference to a much more restrictive understanding of the role of the state.⁶⁷⁹ It is thus relatively uncontentious to argue for the setting and policing of standards across the sector that ensure that patients / users are treated in safe surroundings, with products or procedures that meet at least minimum safety requirements, and by practitioners who have the necessary skills and experience.⁶⁸⁰ The question of the means by which those standards are enforced (self- or professional regulation versus statutory approaches, for example) is a secondary issue: the primary role of the stewardship state is to be satisfied that an effective regime is in place. However, what those standards should be – what constitutes ‘safe’ practice in a field where some degree of risk is inherent – and who should be involved in setting them are more difficult but necessary questions.
- 7.28 The current regulation of ‘embodied practices’⁶⁸¹ that seek to shape the body – including cosmetic procedures – has been charged with both inconsistency and incoherence.⁶⁸² As we saw in Chapter 4 the statutory controls currently in place are far from adequate to protect patient and consumer safety, while elements of the cosmetic procedures industry appear to be far from recognising their own corporate social responsibilities in these

⁶⁷⁹ As in Mill’s harm principle, as discussed in paragraph 7.19.

⁶⁸⁰ National Bioethics Commission of Mexico, responding to the Working Party’s call for evidence.

⁶⁸¹ Pedwell C (2010) *Feminism, culture and embodied practice: the rhetorics of comparison* (Abingdon, Oxfordshire: Routledge).

⁶⁸² Bennett T (2015) *Cuts and criminality: body alteration in legal discourse* (Abingdon, Oxfordshire: Routledge).

respects. While the practice of individual health professionals is regulated through statutory regulatory bodies, supported by codes of professional ethics, the corporate elements of the industry (those who are most responsible for the way in which procedures are marketed, and for whom the financial rewards are the greatest) are at times free to delegate responsibility when things go wrong directly to the individual practitioner concerned (see paragraph 4.43). The regulation of premises by the CQC, which would appear to offer some degree of quality control with respect to the environment in which surgical procedures are provided, is limited, focusing primarily on administrative matters, and excluding the provision of non-surgical procedures entirely, whether they are provided in healthcare premises, beauty salons or as a mobile service. Professional regulatory bodies are not resourced to take proactive action with respect to the actions of the health professionals within their remit; non-healthcare practitioners who provide non-surgical procedures, such as beauty therapists, are subject to no compulsory controls on their practice at all; and controls on product safety are still inadequate.

- 7.29 What, then, would constitute an ethical approach that could underpin regulation in the future and provide a common thread in this labyrinth of partial regulatory measures? A helpful starting point is to look again at the similarities and differences between cosmetic procedures and those that offer an undisputed therapeutic (functional) benefit. In the context of a therapeutic procedure, benefit and the possibility of adverse outcome are weighed against each other. Risk is in some respects accepted in the context of potential health benefits, in particular where the nature of the health threat has a major impact on the life of the individual concerned. Nevertheless, the development of new treatments or procedures is closely regulated, particularly for new medicines, with strict requirements with respect to evidence on both risks and benefits before marketing authorisation can be obtained (see paragraph 4.34).
- 7.30 In the context of cosmetic procedures, on the other hand, the desired benefit is primarily psychological rather than physical, and it is widely assumed that the appropriate level of physical risk to which patients / users should be exposed should be considerably lower.⁶⁸³ Moreover, in the case of cosmetic procedures, the *likelihood* of the desired benefit is much harder to quantify: a procedure that is technically successful from the practitioner's point of view may for many reasons completely fail to satisfy the patient's hopes and desires. Yet many cosmetic procedures are promoted with quite inadequate evidence with respect to risk (see paragraphs 6.9–6.15).
- 7.31 **We therefore suggest that, in the absence of physical health benefits, the regulation of invasive cosmetic procedures should start from the requirement proactively to demonstrate both user safety and effectiveness with respect to their claimed outcomes. That is to say, procedures and products should be demonstrated to be safe and effective *before* being allowed on to the market, rather than marketed until risks are discovered.** The exponential growth in the materials used as dermal fillers (see paragraph 3.19) provides an appropriate example. Whilst the use of botulinum toxins is rarely associated with long-term complications when administered by a skilled practitioner, the use of dermal fillers has been associated with cases of serious complications (see paragraphs 6.12–6.13). Nevertheless, the number of 'injectable' products has risen steeply but without a requirement as yet in the UK or Europe of proven safety or effectiveness. Similarly, claims or promises of physical or

⁶⁸³ See, for example, Griffiths D, and Mullock A (2017) Cosmetic surgery: regulatory challenges in a global beauty market *Health Care Analysis*: 1-15.

psychological benefit made by those promoting procedures are not subject to rigorous review. A shift in emphasis on to the need to justify claims for products or procedures, through clinical trials and peer-reviewed evidence on effectiveness and safety, could help promote significantly higher standards of practice across the sector.

- 7.32 The contrasting approaches to the role of evidence on risk and effectiveness taken to developments in female genital cosmetic surgeries (FGCS) by professional bodies in the UK, the US, Australia, and New Zealand provide a helpful example (see Box 7.2 below). In the UK, professional advice to doctors undertaking such surgery is permissive, at least with respect to surgery for adults, on the grounds that there is insufficient evidence of harm to justify a ban. In the US, Australia and New Zealand, on the other hand, doctors are strongly discouraged from performing such surgery outside the context of clinical research, on the grounds of absence of proof of efficacy and safety.⁶⁸⁴

Box 7.2: Approaches to female genital cosmetic surgery (FGCS) in the UK, US, and Australia and New Zealand

In a position paper published in 2013, the Royal College of Obstetricians and Gynaecologists (RCOG) defined FGCS as “non-medically indicated cosmetic procedures” and stressed that clinicians who performed FGCS were operating without a clear evidence base regarding benefits, efficacy or indeed risks and complications.⁶⁸⁵ However, the RCOG goes on to state that the case for an outright ban is weak, arguing that a ban could only be justified if “evidence showed that the practice brings a high risk of significant harm... with little benefit”. It concludes that current evidence did not support a ban, although it nevertheless advised that “FGCS should not normally be carried out on women and girls under 18 years of age”.⁶⁸⁶ As such, the paper supported clinical discretion, at least with respect to adults.

In contrast, the American Congress of Obstetricians and Gynecologists’ (ACOG) Committee on Gynecologic Practice issued a Committee Opinion in 2007 that stated that offering or recommending ‘designer vagina’ procedures against claims of enhanced sexual experience was untenable in the absence of “data supporting the efficacy of these procedures and their potential complications”.⁶⁸⁷ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in their position paper on cosmetic vaginal procedures similarly “strongly discourages the performance of any surgical or laser procedure that lacks current peer reviewed scientific evidence other than in the context of an appropriately constructed clinical trial”.⁶⁸⁸ Thus, the ACOG and RANZCOG take a much more precautionary approach, in the absence of

⁶⁸⁴ The effectiveness of such guidance on professional practice is, of course, affected by the weight given to that guidance, and the extent to which it can be enforced within a particular jurisdiction.

⁶⁸⁵ 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>, pp1-4.

⁶⁸⁶ *ibid.*, at pages 6 and 8. The British Society for Paediatric and Adolescent Gynaecology made the same recommendation with respect to girls under 18. See: British Society for Paediatric & Adolescent Gynaecology (2013) *Position statement: labial reduction surgery (labiaplasty) on adolescents*, available at: <http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf>.

⁶⁸⁷ The American Congress of Obstetricians and Gynecologists (2007) *ACOG Committee opinion: vaginal ‘rejuvenation’ and cosmetic vaginal procedures*, available at: <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co378.pdf?dmc=1&ts=20161111T0722592573>.

⁶⁸⁸ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2015) *Vaginal ‘rejuvenation’, laser ablation for benign conditions and cosmetic vaginal procedures*, available at: [https://www.ranzcog.edu.au/RANZCOG_SITE/media/DOCMAN-ARCHIVE/Vaginal%20rejuvenation%20and%20cosmetic%20vaginal%20procedures%20\(C-Gyn%2024\)%20Amended%20July%202016.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/DOCMAN-ARCHIVE/Vaginal%20rejuvenation%20and%20cosmetic%20vaginal%20procedures%20(C-Gyn%2024)%20Amended%20July%202016.pdf).

evidence of efficacy and safety, than the RCOG position which was based on the absence of proof of risk of significant harm.

- 7.33 This situation not only highlights how the attitude taken to evidence can lead to opposing regulatory approaches, but also demonstrates how, in the absence of statutory provisions, medical practice has been left to define norms in this area without the involvement of a wider constituency in the debate. This raises much wider questions about the appropriate management and regulation of emerging technologies and interventions, but is particularly important with respect to areas like cosmetic procedures: that are contentious, that raise questions of equity between different populations, and that take place primarily within private practice where commercial incentives can override concern for patient or user benefit.⁶⁸⁹ In the latter regard, the private sector FGCS industry has been framed as like “the old Wild Wild West: wide open and unregulated.”⁶⁹⁰ These questions take on a global perspective when we see the patenting and exporting of products and procedures, and their movement through international flows of practice and consumption. Such concerns reinforce the need for wider societal engagement on the acceptability and desirability of some medical innovations;⁶⁹¹ and for both national governments and international agencies to intervene, where appropriate, to protect individuals from the consequences of commercial imperatives. While the decision to regulate may reinforce the social acceptability and ‘normalisation’ of cosmetic procedures, a decision *not* to regulate what is made readily commercially available risks leaving potential users entirely unprotected.⁶⁹²
- 7.34 The current role of the medical establishment in guiding practice on the provision of FGCS returns us to the question of the extent to which cosmetic procedures should be considered to be ‘medical’ procedures. Despite the difficulty in creating clear and robust dividing lines between what constitutes ‘cosmetic’ and ‘therapeutic’ procedures (see paragraphs 7.3–7.5), nonetheless three of the features characterising the procedures with which this report is concerned are that they are non-reconstructive, non-essential with respect to physical function, and not generally made available within the public health system (see paragraph 1.23). In other words, they are not perceived as being made available in response to medical need. Indeed, they are often marketed as consumer goods: presented, for example, either as a casual consumer choice (such as ‘lunch hour’ procedures) or on a par with more expensive consumer purchases such as luxury handbags⁶⁹³ (see paragraph 3.16).
- 7.35 However, they *are* invasive procedures that carry the risks (in some cases considerable) of adverse consequences, even when carried out by skilled practitioners in appropriate premises. Indeed, as we saw earlier (see paragraphs 3.14–3.15), the procedures themselves have often been ‘repurposed’ from therapeutic procedures, and clearly carry the same risks as when undertaken for therapeutic purposes, although in some cases

⁶⁸⁹ Similar concerns have been reported with respect to the private provision of fertility treatment, where women undergoing IVF are encouraged to have expensive ‘add-on’ treatments often have little if any evidence base for their claimed effectiveness: Heneghan C, Spencer EA, Bobrovitz N *et al.* (2016) Lack of evidence for interventions offered in UK fertility centres *BMJ* **355**.

⁶⁹⁰ Goodman MP (2009) Female cosmetic genital surgery *Obstetrics & Gynecology* **113**(1): 154-9, at page 156.

⁶⁹¹ See, for example, Nuffield Council on Bioethics (2012) *Emerging biotechnologies: technology, choice and the public good*, available at: http://nuffieldbioethics.org/wp-content/uploads/2014/07/Emerging_biotechnologies_full_report_web_0.pdf, at paragraph 10.4.

⁶⁹² See, for example, Griffiths D, and Mullock A (2017) Cosmetic surgery: regulatory challenges in a global beauty market *Health Care Analysis*: 1-15.

⁶⁹³ See, for example, the comparison with “the price of an Hermès Birkin bag” in The Telegraph (3 December 2016) *The teeth-tweakments that will make you look instantly younger*, available at: <http://www.telegraph.co.uk/beauty/face/teeth-tweakments-will-make-look-instantly-younger/>.

with much more limited evidence as to the effectiveness of the hoped-for (cosmetic) effect. Any decision to undertake such a procedure should thus be taken with the same degree of careful consideration as for any medical procedure – or possibly, indeed, more so in the absence of any clinical benefit. Any practices, on the part either of individual practitioners or of organisations offering access to cosmetic procedures, that minimise or underplay the risks and uncertainties associated with invasive cosmetic procedures, must be unacceptable. While practitioners (whether doctors, nurses, dentists, or beauty therapists) have legitimate interests in practising their professions undisturbed, the public health responsibilities of the state provide a strong justification for intrusion where poor practice puts users at risk of harm.

Responsibilities with respect to children and young people

“Encouraging children to change their appearance perpetuates a culture of perfectionism which is particularly damaging to children who are more susceptible to social pressures.”⁶⁹⁴

“Children can be insensitive to those who they perceive as different – and bullying can do more damage on occasion than a low risk cosmetic procedure.”⁶⁹⁵

7.36 If, as we argue above, the state has a responsibility to take action to enable adults to live healthy lives, and to protect them where possible from avoidable harms, then that responsibility is even stronger with respect to the protection of children and young people. Moreover, we know that adolescents are particularly susceptible to peer and social pressures; are heavy users of the forms of social media and the rating and monitoring apps that have been linked both with increasing appearance anxiety and greater interest in cosmetic procedures; and are at a stage in their lives when they are particularly tentative and malleable with respect to their sense of their own identity.⁶⁹⁶ In addition, there are good physiological reasons why surgical procedures carried out during the teenage years are unlikely to be satisfactory in the long-term, because children’s bodies are still growing and developing at this point. We suggest, therefore, that there are powerful reasons why the state should take a proactive role with respect to children’s and young people’s access to cosmetic procedures.

7.37 Such an approach might seem in conflict with current thinking in medical practice where the importance of children and young people participating in healthcare decision-making, and their developing capacity to give consent for themselves is increasingly recognised. However, while young people over the age of 16 are deemed in law to be competent to make healthcare decisions for themselves,⁶⁹⁷ and those under the age of 16 may demonstrate such competence in connection with a particular decision,⁶⁹⁸ the legal justification for recognising medical decision-making capacity in younger people is premised on the assumption that proposed treatment is recommended by a health professional and is in the child’s best interests.⁶⁹⁹ Moreover, parents in most parts of the UK retain a concurrent entitlement to consent on behalf of their children up to the age of

⁶⁹⁴ Respondent to the Working Party’s online questionnaire.

⁶⁹⁵ *ibid.*

⁶⁹⁶ See, for example, Ricciardelli LA, and Yager Z (2016) *Adolescence and body image: from development to preventing dissatisfaction* (Abingdon: Routledge), cited in Grogan S (2017) *Body image: understanding body dissatisfaction in men, women and children*, Third Edition (Abingdon: Routledge), at page 7. See also: paragraphs 1.7–1.13 and Box 1.4.

⁶⁹⁷ Section 2(5), Mental Capacity Act 2005.

⁶⁹⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112.

⁶⁹⁹ *ibid.*

18,⁷⁰⁰ recognising that parental concern for their child's welfare may still, exceptionally, justify their overriding their child's decision.⁷⁰¹ This welfare role is also shared by the state, which is empowered to intervene in children's concerns on welfare grounds, up to the age of majority.⁷⁰²

- 7.38 The role of a parent in consenting to (and indeed initiating consideration of) a cosmetic procedure on behalf of a child also requires further consideration. While there is generally understood to be a wide zone of parental discretion in terms of the decisions parents take for children, and the values that underpin those decisions, this zone is not boundless. In terms of access to medical procedures, health professionals are not required by law (and indeed would be acting against their ethical codes) to provide procedures that they do not believe are in a child's interests. The fact that a parent consents to a cosmetic procedure on behalf of their child, or even initiates consideration of that procedure, does not necessarily mean that it is ethically acceptable for a professional to provide it. There are strong arguments, encapsulated in the concept of a 'child's right to an open future'⁷⁰³ why there should be limitations on the freedom of parents to make decisions for their children that can reasonably be deferred. These arguments are particularly powerful with respect to decisions that, once taken, are irreversible; and in cases where a child might potentially take a very different view from a parent on what constitutes his / her interests, either at the time or later.⁷⁰⁴
- 7.39 In the wider healthcare context, good practice on caring for children increasingly takes a family-centred approach, involving children themselves (from a very young age), as well as parents in decision-making. As we argued in our 2015 report *Children and clinical research: ethical issues*, even very young children have a stake in decisions made about their own lives and want to 'have a say', even though their wishes cannot always be determinative.⁷⁰⁵ Where children have complex health needs, a multidisciplinary approach is taken, involving professionals with a range of expertise, as well as the treating doctor, the family, and the child himself or herself. One example of current good practice in this field that is of particular relevance to the question of how access to cosmetic procedures by children should be managed is found in the way decisions about procedures for cleft lip and /or palate are managed in the NHS (see Box 7.3 below).

Box 7.3: Decisions on surgery for cleft lip and / or palate

Cleft lips are usually diagnosed during an ultrasound carried out in the 18th-21st weeks of pregnancy.⁷⁰⁶ However, cleft palates, and also minimal cleft lips, are usually not identified until a baby has been born.⁷⁰⁷ When a diagnosis of cleft lip and / or palate

⁷⁰⁰ In Scotland, however, young people are formally treated as adults from the age of 16, and parental rights and responsibilities cease at this point. See: Section 1, Age of Legal Capacity (Scotland) Act 1991; Sections 1 and 2, Children (Scotland) Act 1995.

⁷⁰¹ Nuffield Council on Bioethics (2015) *Children and clinical research: ethical issues*, available at: <http://nuffieldbioethics.org/project/children-research/>, paragraphs 4.47-8.

⁷⁰² See, for example, *Re W (a minor) (medical treatment: court's jurisdiction)* [1993] 1 FLR 1; and *Re R (a minor) (wardship: medical treatment)* [1992] 1 FLR 190.

⁷⁰³ Feinberg J (1980) The child's right to an open future, in *Whose child?*, Aiken W, and LaFollette H (Editors) (Totowa, New Jersey: Rowman & Littlefield), pp124-53.

⁷⁰⁴ See: Ouellette A (2009) Eyes wide open: surgery to westernize the eyes of an Asian child *The Hastings Center Report* **39**(1): 15-8 for a troubling example of a parent who did not wait.

⁷⁰⁵ Nuffield Council on Bioethics (2015) *Children and clinical research: ethical issues*, available at: <http://nuffieldbioethics.org/project/children-research/>, paragraphs 1.21-2.

⁷⁰⁶ NHS Screening Programmes (2012) *Cleft lip: information for parents*, available at: http://www.nhs.uk/Conditions/Cleft-lip-and-palate/Documents/Cleft_lip_-_Parents_-_FASP76.pdf, at point 3.

⁷⁰⁷ Personal communication, Mark Henley, 1 February 2017; *ibid.*, at point 1.

(CLP) is confirmed, a programme of NHS care begins, which can last until the patient is in their early 20s.⁷⁰⁸

Healthcare professionals who contribute to this programme of care work in multidisciplinary teams. At each of the 17 NHS specialist CLP centres in the UK,⁷⁰⁹ a collaborative community of experts care for the patient at various points of their development from childhood to adulthood. Teams include nurses, paediatricians, geneticists, cleft surgeons (plastic and maxillofacial surgeons), speech and language therapists, ear, nose and throat (ENT) physicians, paedodontists, orthodontists, restorative dentists, and, in most centres, psychologists.⁷¹⁰

Children with CLP may undergo at least three surgical procedures, but some require many more (as many as 40 surgical procedures). However, at present it is estimated that a child with CLP is likely to require five or six procedures as they grow up.⁷¹¹

Procedures undertaken for functional and appearance-related aims are intertwined. For example rhinoplasties for breathing and appearance to remove the stigma of the cleft may be considered for patients with CLP in early adolescence, but also when they are in late adolescence after their face has grown further. Also in older adolescence, orthognathic surgery and orthodontic work will take place over a course of two years, after which restorative dentistry may be considered.

When the patient reaches their early 20s, soft tissue surgeries to modify the patient's lips and nose may be undertaken by a plastic surgeon. Alternatively, the patient may choose to avoid further surgery or to undergo autologous fat transplants to add volume to areas of their face as an alternative to surgery.⁷¹²

7.40 As we emphasise in our earlier report on children and clinical research,⁷¹³ a child's age is a very uncertain proxy for decision-making capacity and maturity. However, for pragmatic reasons, both law and policy frequently need to draw 'bright line' distinctions based on age, including determining the age at which in law, childhood and the associated parental responsibility comes to an end. In terms of procedures concerned with appearance, established law prohibits both access to sunbeds and tattooing for people under the age of 18, and the beauty industry has also, of its own initiative, developed age-based criteria for some procedures such as intimate waxing (see paragraph 4.48). We therefore suggest that there are strong justifications for similarly limiting access to cosmetic procedures to people over the age of 18, with exceptions only for cases involving a multidisciplinary approach as described above. We set out our specific recommendations in Chapter 8 (see paragraphs 8.41–8.45).

7.41 In identifying the specific age of 18, we recognise that the concerns relating to young people's access to cosmetic procedures summarised above do not simply disappear overnight at age 18, and may continue to apply into young adulthood. Nevertheless, the protective role of the state with respect to minors cannot simply be applied also to those

⁷⁰⁸ See, for example, the various stages of treatment for CLP in the NHS set out by Nottingham University Hospitals NHS Trust (2017) *Trent Regional Cleft Network: the journey of care*, available at: <https://www.nuh.nhs.uk/our-services/services/trent-regional-cleft-network/the-journey-of-care/>.

⁷⁰⁹ NHS Choices (2016) *Treatments for cleft lip and palate*, available at: <http://www.nhs.uk/Conditions/Cleft-lip-and-palate/Pages/Treatment.aspx>. There are 13 centres in England, one in Wales, two in Scotland, and one in Northern Ireland.

⁷¹⁰ Psychologists may also suggest that patient seeks further support from Changing Faces: personal communication, Mark Henley, 1 February 2017. See also: Changing Faces (2017) *Advice and support*, available at: <https://www.changingfaces.org.uk/adviceandsupport>.

⁷¹¹ Personal communication, Mark Henley, 1 June 2017.

⁷¹² *ibid.*

⁷¹³ Nuffield Council on Bioethics (2015) *Children and clinical research: ethical issues*, available at: <http://nuffieldbioethics.org/project/children-research/>, at paragraph 4.5.

considered adults within the relevant jurisdiction without unacceptable incursions into their autonomy. Rather, the awareness that adults, as well as children, may find themselves in situations of vulnerability highlights the importance of the responsibilities of practitioners in the way that they respond to requests for treatment. We now turn to consider the nature of those responsibilities.

Practitioner / user relationships

“Cosmetic surgery is a personal choice, and I would hesitate to judge someone for choosing it. Some people do benefit enormously.”⁷¹⁴

“I was very annoyed when a dentist, without first asking me, ground down one of my front teeth to make my teeth more symmetrical. Similarly a friend of mine who had a front tooth implant and even had the imprint of the original tooth was most annoyed when the dentist made the implant suit his, the dentist’s, idea of what a tooth should look like. It made my friend look like an American, which he wasn’t at all happy about.”⁷¹⁵

- 7.42 In earlier parts of this chapter, we have sought to locate the potential sources of harm that may be associated with the use of cosmetic procedures, and considered the roles of those who have both the power and responsibility to challenge the discriminatory appearance ideals that can underpin the decision to have a particular procedure. However, it is also necessary to recognise that, given the social nature of interest in and concern with appearance, people will continue to seek, and may indeed derive benefit from, the cosmetic procedures that are made available to them. It is hard to imagine demand for invasive cosmetic procedures ever disappearing altogether, although the nature of that demand is likely to evolve and change.
- 7.43 The question therefore arises: in the current environment, what responsibilities do individual practitioners (regardless of their professional background) have towards those requesting cosmetic procedures? How can the starting point of users be strengthened to promote a more equal relationship between user and practitioner? What would an ‘ethical encounter’ between practitioner and user of cosmetic procedures look like?
- 7.44 **Some of the ethical challenges that arise in connection with the provision and use of cosmetic procedures fall outside the sphere of influence of individual practitioners. They cannot be held primarily responsible for the many and various social factors that we have identified as contributing to growing anxiety about appearance, although their role in reinforcing these factors through the provision of cosmetic procedures should not be overlooked. Nor are they responsible for the inadequate and patchwork nature of regulation in this field or for the failures of some parts of the industry to demonstrate corporate social responsibility. However, they can, and must, hold themselves responsible for the ethical consequences of their own practice, ensuring that the way that they practise does not make them ‘part of the problem’.**

⁷¹⁴ Female respondent, age 35: Mass Observation Archive (2012) *Autumn 2012 directive: part 2 - cosmetic surgery* (Brighton: The Keep).

⁷¹⁵ Respondent to the Working Party’s online questionnaire.

7.45 We suggest that an ethical approach to practice that would ensure that individual practitioners are not ‘part of the problem’ would include:

- Acting first and foremost in the best interests of their users / patients, and not taking on the role of a salesperson: particularly in terms of how options and choices are presented to potential users.
- Using their influence to challenge inappropriate marketing or advertising on the part of employers or colleagues that risks undermining the consent process (see also below).
- Recognising the limits of their own competence: not only with respect to their skills in providing particular procedures, but also with reference to understanding the needs, experiences and motivations that bring individuals to request those procedures. The fact that cosmetic procedures constitute a physical intervention whose hoped-for benefits are primarily psychological (see paragraphs 5.5–5.17) highlights the importance of practitioners, at the very least, having access to psychological expertise, through multidisciplinary working or other forms of professional and peer support.
- Recognising how the susceptibility of those seeking cosmetic procedures to the risks of sub-optimum outcomes (in particular dissatisfaction with what is technically a successful procedure) cannot simply be a question of identifying and excluding ‘vulnerable groups’. Susceptibility exists along a spectrum, and a diagnosis of BDD for example (see Box 6.2), is inevitably an artificial line within the spectrum of those suffering from significant anxiety about their appearance. Practitioners should not hesitate to probe in some depth what users hope to achieve, and be frank about the evidence as to how likely these aims are to be realised.
- Being alert to the fact that decisions to seek cosmetic procedures are user-led, rather than practitioner-led, and being proactive in ensuring potential users have access to the information and support they need to make a decision that is right for them. This includes discussing alternative interventions where the evidence suggests that these are more likely to be effective.
- Ultimately being prepared to say ‘no’ to a request for a particular procedure, if, in their professional judgment, they are not confident that it is likely to achieve what the potential user hopes for.
- Taking the lead in ensuring appropriate ongoing care where users suffer suboptimal outcomes from the procedure.

Informed consent and shared decision-making

7.46 As a number of the points above imply, while ethical engagement between practitioner and user of cosmetic procedures cannot be reduced simply to the question of informed consent, nevertheless the approach taken to consent is a key element in that encounter. Throughout this report we have identified ways in which concerns about appearance may be prompted or exacerbated by multiple social factors, and how cosmetic procedures are promoted and marketed, by industry and others, as a solution to those concerns. It is important for practitioners to recognise that such influences may potentially have the effect of *limiting*, rather than enhancing, people’s choices. This places a heavy responsibility on the practitioner to take particular care in the way in which they share information with the potential user, including, where appropriate, challenging the users’ assumptions about their need for treatment.⁷¹⁶ As Box 7.4 below illustrates, the way in

⁷¹⁶ See, for example, how the Royal College of Obstetricians and Gynaecologists emphasises the importance of women requesting FGCS being made aware of the true range of appearance of female genitalia, and suggesting that where women are anxious about appearance, rather than experiencing functional discomfort, accurate information about physiology may be sufficient to alleviate their concerns: 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>.

which options are presented by practitioners can have a powerful effect on how potential users or patients make choices.

Box 7.4: Making decisions about reconstructive breast surgery

The percentage of women who choose to have reconstructive breast surgery after cancer in the UK varies from hospital to hospital. In 2009, for example, the percentage of women choosing immediate reconstruction (as opposed to delayed reconstruction or mastectomy only) varied between nine per cent and 43 per cent across the 30 English Cancer Networks.⁷¹⁷ Women's decisions are influenced by interactions with healthcare professionals, the way that alternatives to reconstructive surgery are presented, and by prevailing 'norms' regarding surgical practice within each hospital system.⁷¹⁸

In the US, the percentage of women choosing surgery reportedly varies between 63 per cent and 80 per cent around the country. According to an investigation by the New York Times, "while plastic surgeons and oncologists aggressively promote breast reconstruction as a way for women to "feel whole again," some doctors say they are beginning to see resistance to the surgery."⁷¹⁹ A systematic review of 28 studies found that women who chose not to have reconstructive surgery fared no worse, and sometimes better, in terms of body image and quality of life,⁷²⁰ and 'going flat' campaigns, such as 'Flat and Fabulous' have started to emerge.⁷²¹

- 7.47 We suggest that in this context **shared decision-making** – where users or patients play an active role in decisions about their treatment or care – may prove a better model than the traditional consent process, where patients are asked only to accept or refuse a treatment offered by their doctor.⁷²² In genuinely shared decision-making, consultations should be partnerships between practitioner and user, in contrast both with the traditional understandings of the doctor / patient relationship and with models of consumer choice and high-pressure sales. The practitioner brings their clinical perspective and technical knowledge, while the user discusses their expectations for outcome, lifestyle goals and preferences for treatment. Good information for users is clearly a crucial element of this.
- 7.48 In most therapeutic situations patients seek a cure or amelioration of physical or mental ill-health. Where users approach a practitioner for cosmetic procedures, the relationship is likely to be different, with the user having a clear idea from the outset what treatment and outcomes they want. Shared decision-making encourages those seeking treatment to explore with the practitioner what they hope to achieve from the treatment, including both psychological and physical benefits, and requires practitioners to engage with users not only on the technical aspects of treatment, but also about their hopes, beliefs, lifestyle and any other factors that might affect the decision. We return to examples of good practice in shared decision-making in our final chapter (see Box 8.2).

⁷¹⁷ The NHS Information Centre (2011) *National mastectomy and breast reconstruction audit*, available at: <http://content.digital.nhs.uk/catalogue/PUB02731/clin-audi-supp-prog-mast-brea-reco-2011-rep1.pdf>, at page 41.

⁷¹⁸ Harcourt D, and Rumsey N (2004) Mastectomy patients' decision-making for or against immediate breast reconstruction *Psycho-Oncology* **13**(2): 106-15.

⁷¹⁹ New York Times (31 October 2016) 'Going flat' after breast cancer, available at: <https://www.nytimes.com/2016/11/01/well/live/going-flat-after-breast-cancer.html>.

⁷²⁰ Lee C, Sunu C, and Pignone M (2009) Patient-reported outcomes of breast reconstruction after mastectomy: a systematic review *Journal of the American College of Surgeons* **209**(1): 123-33.

⁷²¹ Flat & Fabulous (2017) *Homepage*, available at: <http://www.flatandfabulous.org/>.

⁷²² See, for example, Joseph-Williams N, Lloyd A, Edwards A *et al.* (2017) Implementing shared decision making in the NHS: lessons from the MAGIC programme *BMJ* **357**: j1744.

7.49 A model of consent practice based around genuinely shared decision-making is a necessary feature of ethical practice of cosmetic procedures. However, as we emphasised above (see paragraph 7.46) good consent practice is a necessary, but not sufficient, response to the ethical concerns that arise in the context of the growing use of cosmetic procedures. In the final chapter of this report, we return to the broader questions, first of the demand side influences contributing to the growth of the sector, and second to the role of regulators, the professions and industry in promoting high standards of 'supply'; and make recommendations for action on the part of the multiple organisations and agencies that have the power to effect change.

Chapter 8

Policy implications and
recommendations

Chapter 8 – Policy implications and recommendations

Chapter 8: overview

Action to promote more ethical practice is required both with respect to ‘demand side’ influences on people to consider cosmetic procedures, and on the supply of those procedures. Further work to improve the information and research base, essential for better practice, is also urgently required.

Demand side recommendations

- The Advertising Standards Authority should follow the example of Transport for London in prohibiting advertising that is likely to create body confidence issues, or cause pressure to conform to unrealistic body shapes.
- The social media industry should collaborate to fund independent research on the contribution played by social media to appearance anxiety, and how this can be minimised; and should act on the findings.
- The Equality and Human Rights Commission should develop specific guidance on appearance-related discrimination, founded on the requirements of existing equality legislation.
- The Department for Education should ensure that all children and young people have access to evidence-based resources on body image, through compulsory elements of the curriculum.

Supply side recommendations

We endorse all of the recommendations in the Keogh report and believe that they should be implemented in full. We further urge the Royal College of Surgeons to consider how best to continue taking a leadership role in promoting high standards in cosmetic surgery.

- The Department of Health and the Medicines and Healthcare products Regulatory Agency should require robust evidence both of safety, and of effectiveness with respect to their claimed benefits, *before* devices used for cosmetic purposes such as dermal fillers and implants may be placed on the market.
- The Department of Health should bring forward legislation to make dermal fillers prescription-only.
- The Royal College of Surgeons and the General Medical Council should work together to ensure that all surgeons undertaking cosmetic surgery are certified to do so.
- Public Health England should initiate a public awareness campaign to alert prospective users of cosmetic procedures to the importance of seeking practitioners who are ‘quality-marked’ through membership of a register accredited by the Professional Standards Authority.
- The remit of the Care Quality Commission should be extended to all premises where invasive cosmetic procedures are provided.
- People under the age of 18 should not be able to access invasive cosmetic procedures, other than in the context of multidisciplinary healthcare.

The major providers of cosmetic procedures should collaborate to fund the independent development of high quality information for users; and to develop a code of best practice for the provision of cosmetic procedures.

Introduction

8.1 In the previous chapter, we argued that an ethical approach to policy with respect to the provision and use of cosmetic procedures should include two discrete but intersecting elements:

- Action on the ways in which individuals are encouraged to respond to the promotion of potentially damaging appearance ideals (the ‘demand-side’ influences and pressures). Such action is required both specifically in connection with the promotion and use of cosmetic procedures; and also with respect to the broader social context within which interest in cosmetic procedures is situated.
- Action to foster a more ethical encounter between users and practitioners of cosmetic procedures (the supply side). This includes a particular concern in respect of access to these procedures by children and young people.

In this chapter we explore how, in practice, changes to promote more ethical practice might be achieved in each of these domains.

8.2 We begin by drawing attention to two issues that have emerged repeatedly throughout this inquiry, and that are significant in considering practical ways forward with respect to questions of both demand and supply:

- **The absence of high quality data with respect to many of the issues touched upon by this report.** There is no publicly available information even on the total number of procedures carried out, whether within the UK or elsewhere. Information about the relative popularity of different procedures, or the characteristics of those seeking them, derives from the practice of a subset of surgeons belonging to particular professional associations, relates primarily to surgery, and is likely to be atypical. There is a particular lack of information on the use of non-surgical procedures. There is also a scarcity of long-term independent data with respect to the outcomes of those having cosmetic procedures, despite the positive claims made for them; and much more research needs to be done on the factors underlying appearance anxiety and their relationship with the uptake of invasive cosmetic procedures.
- **The delays and failures of successive governments in responding to the series of major reports over the past decade that have laid bare the inadequate state of regulation of the cosmetic procedures industry.** While action is gradually being taken with respect to some of the Keogh report’s recommendations, such as valuable work on practitioner standards by the Royal College of Surgeons, the General Medical Council, Health Education England, and the Joint Council for Cosmetic Practitioners, significant gaps remain. These include the Government’s decision *not* to regulate on the requirement for practitioners to be appropriately qualified for the procedures they offer, but instead to rely on voluntary measures to encourage practitioners to obtain the necessary skills for safe practice. In terms of product safety, the controls over dermal fillers, in particular, remain wholly inadequate. It is also a matter of concern that the Royal College of Surgeons’ Cosmetic Surgery Interspecialty Committee is no

longer operational, which sends the message that the College regards the need for action in this area to be time-limited, rather than an ongoing responsibility.

- 8.3 In what follows, alongside our own recommendations, we also highlight where further work to improve the information and research base, essential for better practice, is urgently required. In making our recommendations, we distinguish what, in our view, would be ideal and should be achieved in the long-term, and what may be more immediately achievable in the current regulatory environment. For pragmatic reasons, we focus on the scope for change within the UK, while reiterating the global nature of these issues, in particular on the demand side.

Demand-side approaches: tackling the wider social context

Challenging industry claims and discriminatory ideals

- 8.4 Despite the widespread limitations of data and research evidence cited above, one area where the research literature *is* strong is with respect to the purported links between appearance and levels of happiness or general well-being. While the ‘beauty myths’ – equating beauty with happiness and success – are widely promoted in advertising and the media, the psychological evidence does not support any predictive link between achieving societal ideas of ‘beauty’ and levels of happiness. In contrast, a person’s own attitudes and beliefs with respect to their appearance may indeed be a factor in their happiness, encompassing not only how they rate their own appearance with respect to relevant ideals, but also other important factors such as the relative value they place on their appearance, and their sensitivity to social messages about appearance ideals (see paragraph 1.18).
- 8.5 Thus, while a proportion of users of cosmetic procedures may experience enhanced self-esteem as a result of their changed appearance (see paragraph 6.6), this outcome cannot be predicted by providers or advertisers of specific procedures as a general rule. There is no evidence to suggest that greater happiness is *in general* associated with particular shapes of nose or size of breasts, for example, even though on an individual level achieving change with respect to a particular part of the body may improve body satisfaction. Indeed, earlier in this report, we highlighted the likely contribution of the mass dissemination of explicit messages that equate beauty with happiness, within an airbrushed celebrity culture, to the current worrying levels of appearance anxiety, particularly among young people (see paragraph 1.12).
- 8.6 We have also argued for a ‘stewardship’ role of the state: an understanding of state responsibilities with respect to public health that not only justifies the protection of those within its jurisdiction from private harms, but also requires positive public action to provide conditions that enable people to flourish with respect to both their physical and mental health (see paragraphs 7.19–7.21). Such public action is justified to counteract both the specific claims made about the positive effects of cosmetic procedures, and more generally to counter the effects of broader visual and media cultures in which choices about cosmetic procedures are embedded. Moreover, such responsibilities go wider than state actors. The demands of corporate social responsibility place a similar onus on industry (both collectively and as individual businesses) to respond to concerns about the conflation of particular appearance ideals and happiness (see paragraphs 7.22–7.25). Where industry does not meet these obligations voluntarily, then state action is justified in imposing necessary measures through regulation.

- 8.7 A second important theme in this report is the way in which the promotion of specific appearance ideals – for example the idealisation of women being young, thin (with curves), white, and able-bodied – may feed negative and discriminatory attitudes (see paragraphs 2.3–2.5 and 2.13–2.15). The development and marketing of cosmetic procedures has the scope to contribute to such discriminatory attitudes by endorsing particular ideals and offering technical ‘fixes’ to achieve them (see paragraph 7.17). Just as the stewardship role of the state, as discussed above, justifies action to enable people to live healthier lives, it also justifies action in response to inequality and discrimination. This role is explicitly recognised within the UK by equality legislation supported and enforced by the work of the Equality and Human Rights Commission ((EHRC) see paragraph 4.62).
- 8.8 In the sections that follow, we identify specific action that could be taken by industry: first in connection with the images and claims promulgated through advertising; and second in connection with the wider role played by social and traditional media. We then look at the additional part that other organisations, including governmental bodies such as the EHRC, could play. We note that, while the achievement of some of our recommendations would require significant shifts in public attitudes, there are powerful examples of how such public attitudes can and do change over time, not least in the way that attitudes have been transformed over the past 30 years to the acceptability of smoking in public places or of drink-driving. It is our aim to contribute to a similar shift in attitudes over time with respect to the impact of unrealistic and sometimes discriminatory appearance ideals.
- 8.9 Indeed, while we have identified some of the ways in which the value placed on particular appearance ideals may in practice be discriminatory in a number of domains, not least in that of employment (see paragraphs 2.13–2.15), we have also commented on how these attitudes to appearance coexist with an increasing trend towards inclusivity, particularly with reference to public awareness and acceptance of disability and difference (see paragraphs 2.3–2.4). These conflicting messages demonstrate both the complex way in which competing attitudes and trends coexist, and also point towards the scope for building on existing positive developments.

Advertising

- 8.10 The Advertising Standards Authority (ASA) is currently looking at concerns about body image in advertising, as part of a broader investigation into gender stereotyping established in the light of the strong public response to the “Are you beach body ready?” advertisement (see 4.55–4.56). **We welcome this initiative, and highlight, in particular, the need for the ASA to find ways of taking into account the cumulative effect of multiple advertisements over time in which particular appearance ideals are promoted.** In areas such as this, a reactive approach by the regulator of looking only at complaints about individual adverts on a case-by-case basis is clearly insufficient. The ASA’s current remit already emphasises the need for advertisements to be socially responsible, and as a self-regulatory body it has the flexibility to amend its remit where necessary. We urge the ASA to make full use both of its existing powers, and its scope for flexibility of approach.
- 8.11 In 2016, Transport for London (TfL) amended its advertising policy in order to refuse advertising that “could reasonably be seen as likely to cause pressure to conform to an unrealistic or unhealthy body shape, or as likely to create body confidence issues, particularly among young people” (see paragraph 4.57). **We warmly support this**

initiative by TfL, and encourage the ASA and the Committee of Advertising Practice (CAP) to follow TfL’s approach in their own guidance to the industry.

- 8.12 Turning specifically to the advertising of cosmetic procedures, we believe that there is a clear need for stricter advertising standards that prevent advertisers from claiming, or strongly implying, a likely link between cosmetic procedures and emotional benefit. No change in the ASA’s existing remit would be required in order to achieve such higher standards: they would be justified both by reference to social responsibility, as indicated above, and in line with existing requirements that “marketing communications must not materially mislead or be likely to do so” (see paragraph 4.53).
- 8.13 The digital manipulation by industry of images of models and celebrities is a particular cause of concern where these techniques are used to disguise or change features in a potentially discriminatory manner: for example by making models’ skin colour lighter, limbs longer, or eyes wider. We note that the ASA already forbids ‘post-production techniques’ that it regards as misleading, such as the digital manipulation of before and after photographs (see paragraph 4.53). However, we suggest that more is required. Guidance on post-production techniques should take into account the social irresponsibility of the use of such techniques in circumstances where they can potentially contribute to discriminatory attitudes, unrealistic appearance ideals, or appearance-related anxiety.

Recommendation 1: We recommend that the Advertising Standards Authority and the Committee of Advertising Practice follow the example of Transport for London in prohibiting advertising that is likely to create body confidence issues, or cause pressure to conform to an unrealistic or unhealthy body shape.

Recommendation 2: We recommend that the Advertising Standards Authority and the Committee of Advertising Practice revise their guidance to industry to make clear that the following practices are not acceptable in advertisements:

- **claiming, or strongly implying, that there is a likely link between cosmetic procedures and emotional benefit;**
- **using post-production techniques in circumstances where they can potentially contribute to discriminatory attitudes, unrealistic appearance ideals, or appearance-related anxiety.**

Recommendation 3: We further recommend that the Advertising Standards Authority works proactively to monitor compliance with such standards, in line with its recent commitments to devote more resources to proactive review of advertisements and its ongoing work on body image.

Social media and traditional media

- 8.14 We welcome the fact that social media companies such as Facebook / Instagram are beginning to include concerns about body image in the campaigning and educational work they undertake among adolescents (see paragraph 4.60). We note, however, that their attention to these issues appears to be of relatively recent origin, and much more needs to be done. In particular we note the scope for social media platforms to work collaboratively together for the public good (see paragraph 4.60), and commend a similarly collaborative approach with respect to the impact of social media use on appearance anxiety and self-esteem. **In the light of the increasing concerns emerging with respect to correlations between social media use and such body**

image issues (see paragraph 1.12), we suggest that collaborative work across the sector to tackle these issues falls squarely within the remit of their corporate social responsibilities. In particular, we highlight the need for more research in order to understand better how social media contributes to appearance anxiety, and how this can be minimised; together with a commitment to take action accordingly. Such a programme of work could include:

- funding research to improve understanding of the impacts of social media use, including the role played by the rating of images through 'likes', on appearance anxiety and self-esteem;
- implementing more effective controls on adverts distributed via social media;
- funding and disseminating educational programmes to combat cyber-bullying and teasing with respect to appearance, and to promote a social norm that this is unacceptable;
- funding the development, evaluation, and roll-out of evidence-based social media literacy interventions to promote the positive benefits and minimise the harms of social media, with particular reference to the sharing and rating of photos;
- developing similar guidance for parents and teachers in promoting safe social media use in children, working with key youth organisations including the Be Real Campaign, Girlguiding and Scouting movements, the NSPCC, and the UK Safer Internet Centre; and
- encouraging and supporting targeted campaigns that put under scrutiny the imperative to be 'beach-body ready', perfect, or flawless.

8.15 Similarly, we suggest that marketing apps designed for children as young as nine that encourage them to 'play' at having cosmetic surgery makeovers, is clearly inappropriate and irresponsible. **We endorse the campaign by the international organisation Endangered Bodies (see paragraph 4.60) which has established a petition to Apple, Google, and Amazon requesting them to exclude from their app stores any cosmetic surgery games targeted at children.**

8.16 Broadcast media have also played a part in influencing how cosmetic procedures are perceived, particularly through the growth and popularity of cosmetic surgery makeover shows (see paragraphs 1.12 and 2.11). While there is considerable diversity within the genre with respect to attitudes to body image and appearance ideals, a common feature conveyed by many is the idea that surgical 'fixes' to problems are always available to those who choose their surgeon wisely. We have argued earlier in this report that this belief can both be harmful, in contributing to unrealistic expectations and the likelihood of adverse outcomes (see Box 6.3); and can potentially contribute to the discrimination experienced by those who cannot conform to prevailing appearance ideals (see paragraph 7.17). We suggest that these concerns justify action on the part of the broadcasting regulator, Ofcom, to review the available evidence and consider the need for specific advice about cosmetic makeover shows to accompany its Broadcasting Code.⁷²³

Recommendation 4: We recommend that the social media industry (including Facebook / Instagram, Snapchat, Twitter, and YouTube) collaborate to establish and fund an independent programme of work, in order to understand better how

⁷²³ Ofcom (2017) *Programme-related guidance*, available at: <https://www.ofcom.org.uk/tv-radio-and-on-demand/information-for-industry/guidance/programme-guidance>.

social media contributes to appearance anxiety, and how this can be minimised; and to take action accordingly.

Recommendation 5: We recommend that Ofcom review the available evidence and consider whether specific guidance to accompany its Broadcasting Code is warranted with respect to the tacit messages about body image and appearance ideals that may be conveyed by makeover shows involving invasive cosmetic procedures.

Other action to challenge discriminatory ideals

8.17 As we noted above (see paragraphs 8.8–8.9), contemporary concerns about exclusion and discrimination in connection with appearance exist alongside significant momentum towards more inclusive attitudes to diversity. Examples of existing campaigns promoting greater diversity of appearance in role models include:

- Models of Diversity – a campaign for the “fashion, beauty and marketing industries to recognise the beauty in people of all races, ages, shapes, sizes and abilities”,⁷²⁴
- the Face Equality campaign launched by Changing Faces to promote the fair and equal treatment of people with disfigurements to their face or body, and the removal of prejudice and discrimination,⁷²⁵ and
- the Be Real campaign, whose strapline on diversity states “We want media, businesses and advertisers to positively reflect what we really look like – whatever our age, gender, ethnicity, size and shape, and regardless of whether we have a disability.”⁷²⁶

8.18 The Be Real Body Image Pledge calls on companies to sign up to reflect diversity, reflect reality, and promote health and well-being in their communications and in the images they promote.⁷²⁷ Similarly, the Face Equality campaign calls on employers to create a culture and practice of face equality for people with disfigurements as employees and customers. **We commend the work of these and similar campaigns, while recognising the need for companies to go beyond the ‘letter’ of signing up to such a pledge and ensure that their actions and wider commercial strategy are in tune with its spirit.**

8.19 As we have identified earlier in this report (see paragraphs 2.13–2.15), discrimination on the grounds of appearance often coincides with, or contributes to, discrimination on other grounds, such as age, race, and disability, that are already prohibited under the Equality Act 2010.⁷²⁸ It is also important to note that people with severe disfigurements are protected from discrimination under the Act “as if they had a disability” (see paragraph 4.62). Full use of existing powers, not only of enforcement, but also importantly for influence, for example through advice and guidance, should be made to challenge discrimination based on appearance.

⁷²⁴ Models of Diversity (2017) *Homepage*, available at: <http://www.modelsofdiversity.org/>.

⁷²⁵ Changing Faces (2017) *Campaigns: Face Equality Day*, available at: <https://www.changingfaces.org.uk/campaigns/face-equality>. See also: Changing Faces (2017) *Disfigurement in the UK*, available at: <https://www.changingfaces.org.uk/wp-content/uploads/2017/05/DITUK.pdf>.

⁷²⁶ Be Real (2017) *The campaign: real diversity*, available at: <http://www.berealcampaign.co.uk/the-campaign/real-diversity.html>.

⁷²⁷ Be Real (2016) *Be Real body image pledge*, available at: <http://www.berealcampaign.co.uk/assets/filemanager/images/general/Body%20Image/Be%20Real%20Body%20Image%20Pledge.pdf>.

⁷²⁸ Legislation.gov.uk (2010) *Equality Act 2010*, available at: <http://www.legislation.gov.uk/ukpga/2010/15/contents>.

Recommendation 6: We recommend that the Equality and Human Rights Commission:

- develop and publish specific guidance on disfigurement and appearance-related discrimination, founded on the requirements of existing equality legislation; and
- take discrimination related to appearance into account when monitoring discrimination relating to areas such as age, race, gender, and disability.

Responsibilities of the state towards children and young people

- 8.20 The stewardship role of the state is particularly strong in relation to its responsibilities to protect the welfare, including the mental health and well-being, of children. This responsibility was explicitly recognised by the UK Prime Minister in January 2017, when she highlighted the need to “employ the power of government as a force for good to transform the way we deal with mental health problems right across society, and at every stage of life.” She emphasised that such action is required “not in our hospitals, but in our classrooms, at work and in our communities.”⁷²⁹
- 8.21 Given the way that many of the appearance-related pressures described in this report are embedded in technologies that are an increasingly important part of people’s lives (see in particular paragraph 1.12 and Box 1.4), it is crucial to help children and young people to deal with them robustly from an early age, alongside action to challenge at source those pressures that are potentially discriminatory or harmful. A number of preventive initiatives and interventions have been shown to be effective in reducing appearance concerns and distress (see Box 1.3). **We endorse the work of the Be Real campaign in developing and promoting evidence-based teaching resources on body image, and emphasise the importance of all children having access to such resources.**

Recommendation 7: We recommend that the Department for Education act to ensure that all children and young people have access to evidence-based resources on body image, whether through PSHE (personal, social, health, and economic education) lessons or through other (compulsory) elements of the curriculum.

- 8.22 There are also excellent examples of practice in the voluntary sector: we learned, for example, of the work of organisations such as Fixers, who support young people to take action with respect to issues of concern to them, including body image,⁷³⁰ and the UK Safer Internet Centre, whose work includes training and supporting young people to become peer educators with respect to positive social media use.⁷³¹ Such approaches recognise young people’s own capacity to tackle issues of concern to them in a manner that will engage their peers, and is supported by positive evidence on the effectiveness

⁷²⁹ Gov.uk (9 January 2017) *Prime Minister unveils plans to transform mental health support*, available at: <https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support>.

⁷³⁰ Fixers (2017) *Homepage*, available at: <http://www.fixers.org.uk/home/about.php>. See also: Fixers (2017) *Fixers: body*, available at: <http://www.fixers.org.uk/home/issues/body.php> for their work relating to the body and body image.

⁷³¹ UK Safer Internet Centre (2015) *Best practices: using peer education to transform e-safety in schools*, available at: <https://www.saferinternet.org.uk/blog/best-practices-using-peer-education-transform-e-safety-schools>.

of interventions that focus on ‘training the trainers’.⁷³² There is considerable benefit in initiatives of this kind being developed and supported through voluntary sector organisations, with the skills and expertise to reach and support young people in appropriate ways. However, such voluntary sector initiatives should not be seen as shouldering the responsibilities properly borne by the state, and by the various sectors of industry that profit from the promotion of particular appearance ideals. We also reiterate the importance of schools taking responsibility for supporting children and young people in dealing robustly with these pressures.

Supply-side approaches: regulating for safety and empowering users / patients

Introduction

8.23 Throughout this report, we have identified practices in the cosmetic sector that are clearly unsafe. While progress has been made on some of the recommendations made in the Keogh report (see paragraph 8.2), the slow progress on controls over what is contained within dermal fillers (see paragraphs 4.33–4.39), and the rejection by government of Keogh’s recommendations for a compulsory register of practitioners qualified to provide invasive cosmetic procedures, provide clear examples of the areas where the safety and well-being of users continues to be put unacceptably at risk.

8.24 **We endorse all Keogh’s recommendations, and believe that they should be implemented in full.** We recognise, however, that there appears to be little political appetite at present for bringing in the new legislative framework that would be required to achieve some of Keogh’s core recommendations. As such, our own recommendations seek wherever possible to make use of existing regulatory mechanisms, while also highlighting where we believe legislative change to be essential. **We also urge the Royal College of Surgeons (RCS) to consider how best to continue taking a leadership role with respect to promoting and supporting high standards in cosmetic surgery, in the light of its decision to wind up its Cosmetic Surgery Interspecialty Committee. We suggest that, in order to maintain impetus with respect to high standards in this commercialised area of surgery, which falls outside quality control systems existing within the NHS, a dedicated and permanent resource within the Royal College will be required.**

Making products and procedures safer

8.25 We argued in Chapter 7 that, in the absence of physical health benefits, the regulation of invasive cosmetic products and procedures should start from the requirement proactively to demonstrate both safety and effectiveness with respect to their claimed outcomes (see paragraph 7.31). Indeed, it seems likely that most users or prospective users of procedures already base their decisions on the assumption that such checks have been made.⁷³³ Before invasive procedures can be made publicly available, manufacturers and providers should be required to demonstrate good quality safety and effectiveness data, just as would be required for any pharmaceutical product posing an

⁷³² See, for example, Halliwell E, Jarman H, McNamara A, Risdon H, and Jankowski G (2015) Dissemination of evidence-based body image interventions: a pilot study into the effectiveness of using undergraduate students as interventionists in secondary schools *Body Image* 14: 1-4.

⁷³³ The vast majority of the respondents to our online survey, for example, took the view that the primary responsibility for making sure that procedures are safe lay with professionals and the Government, not with individual consumers.

equivalent physical risk. Innovative surgical procedures should similarly follow the same good practice procedures that would be expected for functional surgery in the NHS.⁷³⁴ Such threshold requirements before innovations in the cosmetic sector can be offered should be accompanied by requirements to keep, and report, long-term data on procedures, complications and outcomes (see also paragraph 8.40). The creation by NHS Digital of a Breast and Cosmetic Implant registry is a welcome first step (see paragraph 4.38).

- 8.26 First and foremost, this approach should apply to the products used in invasive cosmetic procedures, where EU and UK regulation has historically been far too lax. While from May 2020 devices such as dermal fillers, cosmetic implants, and liposuction equipment will be regulated in EU member states on the same basis as medical devices (we refer to these below as ‘cosmetic devices’), it is currently unclear how clinical assessment of the risks and benefits of these cosmetic devices will be carried out. Much will depend on the content of the EU ‘common specifications’ to be developed for use by notified bodies in making these assessments; and on how consistently these specifications will then be applied (see paragraph 4.37). Moreover, in contrast with the FDA regulatory requirements for breast implants in the US (see paragraph 3.21), there do not appear to be any requirements within the new Regulation for long-term follow up of clinical outcomes as a condition of the marketing authorisation, unless these are to be included within the common specifications.
- 8.27 While the inclusion of cosmetic devices within the Medical Devices Regulation is welcome, it will still be a further three years before the new requirements will be applied within EU member states, and it is impossible to predict at this point what degree of patient / user protection they will offer. It is also unclear at this stage whether the UK will aim to harmonise its regulatory requirements with those of the EU, or whether it will take the opportunity to adopt a different approach.
- 8.28 We therefore suggest that additional measures, in line with those recommended in the Keogh report, are still warranted as a matter of urgency, particularly with reference to dermal fillers. We recognise the technical difficulties in making dermal fillers prescription-only within current legislation relating to medicines and medical devices as recommended by Keogh (see paragraph 4.39). However, we suggest that these difficulties would not be impossible to overcome, particularly given the current interest in both the House of Commons and House of Lords in the safety of cosmetic practice.⁷³⁵ Indeed, we argue that prescription-only status, which would ensure the involvement of a health professional qualified to prescribe in all procedures involving dermal fillers, is particularly important given that the qualifications and standards being developed for practitioners providing non-surgical procedures are to remain voluntary (see paragraph 8.23). We also note and welcome initiatives to ensure safer practice that have been undertaken in the absence of regulatory action, such as the approach of the Medical

⁷³⁴ See, for example, Royal College of Surgeons (2014) *Good surgical practice*, available at: <https://www.rcseng.ac.uk/standards-and-research/gsp/>, paragraphs 1.2.3-4.

⁷³⁵ We note that Kevan Jones MP in the House of Commons brought forward a Private Members’ Bill in the 2016/17 session of Parliament, and a significant number of MPs and peers have raised questions about the safety of cosmetic procedures. There is also a tradition of ‘hand-out’ bills, where departments support MPs who have been successful in the Private Members’ ballot in taking forward Bills that have broad support, but for which official Government time has not been made available.

Defence Union (MDU), which announced in 2013 that it would only provide indemnity for its members when administering fillers if they used products approved by the FDA.⁷³⁶

Recommendation 8: We recommend to the European Commission that the ‘common specifications’ for the clinical assessment of cosmetic devices, to be developed under the Medical Devices Regulation 2017, should be based on the need proactively to demonstrate both safety and effectiveness with respect to their claimed benefits through clinical trial data and robust outcome measures. CE marking should also be dependent on commitments to collect and publish long-term outcome data.

Recommendation 9: We recommend that the Department of Health and the Medicines and Healthcare products Regulatory Agency, in the lead up to Brexit, develop a UK approach to the regulation of cosmetic devices based on the need proactively to demonstrate both safety and effectiveness with respect to their claimed benefits through clinical trial data and robust outcome measures. Marketing authorisation should be dependent on commitments to collect and publish long-term outcome data.

Recommendation 10: We recommend that the Department of Health bring forward stand-alone legislation to make all dermal fillers prescription-only.

Recommendation 11: We recommend that, until new standards relating to safety and effectiveness of cosmetic devices are in place, insurers of cosmetic practitioners (including the medical and dental defence organisations who provide indemnity cover as a benefit of membership) should, as a matter of good practice, restrict indemnity to procedures using dermal fillers approved under the US regulatory system by the FDA.

8.29 On the specific question of female genital cosmetic surgery (FGCS), we note how the specialist medical colleges in the US and in Australia / New Zealand have cautioned their members against offering procedures that lack current peer-reviewed scientific evidence, other than in the context of an appropriately constructed clinical trial. In contrast, in the UK the Royal College of Obstetricians and Gynaecologists (RCOG) takes a permissive approach to FGCS on the basis that there is an absence of evidence as to harm (see paragraph 7.32 and Box 7.2). In the light of the arguments above with respect to the importance of demonstrating claimed safety and effectiveness *before* offering cosmetic treatments outside a research setting, we suggest that the RCOG should review its guidance. It is also very important that the circumstances in which procedures offered as ‘FGCS’ do, or do not, fall within the ambit of the Female Genital Mutilation Act, should be clarified, given ongoing concerns as to their legality (see paragraph 4.50).

Recommendation 12: We recommend that the Royal College of Obstetricians and Gynaecologists should review its guidance to its members on female genital cosmetic surgery and emphasise the need for evidence, demonstrating safety and effectiveness with respect to claimed outcomes, before procedures are offered outside a research setting.

Recommendation 13: We recommend that the Home Office should clarify the circumstances in which procedures offered as ‘FGCS’ do, or do not, fall within the ambit of the FGM Act, in the light of ongoing concerns as to their legality.

⁷³⁶ Medical Defence Union (2013) *Dermal fillers and MDU indemnity*, available at: <https://www.themdu.com/guidance-and-advice/journals/mdu-journal-april-2013/news>.

Regulating practitioners

- 8.30 It is uncontroversial to argue that the state has a responsibility to take proportionate action to protect individuals within its jurisdiction from predictable and avoidable sources of harm (see paragraph 7.27). The 2013 Keogh report (itself commissioned by the English Department of Health) identified numerous ways in which action by the Government, and also by others concerned with health standards and governance such as the General Medical Council (GMC) and the Royal College of Surgeons (RCS), would improve the protection available to users of cosmetic procedures within the UK. We recognise and endorse the progress that has been made since 2013 (see Boxes 4.1, 4.2, and 4.4, and paragraphs 4.19–4.21). Nevertheless, we remain concerned about both the speed of progress, and the significant gaps in protection that remain. These have left many potential users of cosmetic procedures exposed to the risks of poor quality, or even dangerous care, particularly (since compliance has financial costs) at the cheaper end of the market.
- 8.31 In the regrettable absence of statutory controls over the standards and qualifications required for cosmetic practitioners (see paragraph 8.23), we identify below the use of other, existing, levers to improve levels of safety for potential users / patients.
- 8.32 **We welcome the work by the RCS in developing a certification scheme, under which surgeons working in a variety of surgical specialties can demonstrate their competence in performing particular cosmetic procedures or groups of procedures** (see Box 4.2). However, we are concerned that this scheme, like so many other good practice initiatives, is voluntary, and that access to appropriate training for those wishing to specialise in cosmetic, rather than reconstructive, surgery, can be difficult (see Box 4.3).

Recommendation 14: We recommend that the Royal College of Surgeons require, and enable, all members of the College who practise cosmetic surgery to participate in its certification scheme.

Recommendation 15: We recommend that the Royal College of Surgeons work with the other surgical Royal Colleges, the major private providers of cosmetic surgery, and professional bodies representing surgeons working in the cosmetic sector, to ensure that those wishing to specialise in cosmetic surgery are able to access the training that they need to achieve the necessary standards.

Recommendation 16: We recommend that the General Medical Council and the medical defence associations work together to ensure that surgeons who are performing cosmetic surgery must meet these requirements in order to be indemnified when performing such surgery. One possible approach would be through the proposed ‘credentialing’ scheme currently being developed by the General Medical Council.

- 8.33 We welcome the publication by both the General Medical Council and the Royal College of Surgeons of detailed guidance to doctors with respect to the high ethical standards expected of those working in the cosmetic sector (see paragraph 4.6, and Boxes 4.1 and 4.2). We further welcome the work undertaken by the newly established Joint Council for Cosmetic Practitioners (JCCP) to develop a similar code of practice (see paragraph 4.21).

Recommendation 17: We recommend that other regulatory bodies whose registrants provide cosmetic procedures, in particular the General Dental Council and the Nursing and Midwifery Council, develop specific guidance on cosmetic practice for their own registrants, to complement the guidance issued by the General Medical Council and the Royal College of Surgeons.

- 8.34 We recognise that there are limitations on the scope for professional regulatory bodies proactively to ‘police’ their guidance. Nevertheless, it is clear from ongoing concerns about inappropriate access to prescription-only medicines such as botox that the current entirely reactive approach is inadequate to protect users. **We welcome the GMC’s commitment to monitoring the implementation of its latest guidance on cosmetic practice, and suggest that this offers an opportunity to explore ways in which regulators could work with other organisations, for example Trading Standards, Citizens Advice, and the Care Quality Commission (CQC), to alert them to examples of malpractice that might otherwise not reach them in the form of a complaint.**
- 8.35 **We endorse the work carried out by Health Education England (HEE) setting required standards for training and practice (regardless of professional background of the practitioner) across a range of non-surgical procedures. We also welcome the establishment of the new Joint Council for Cosmetic Practitioners (JCCP), and its commitment to seek registration with the Professional Standards Authority (PSA) (see paragraph 4.20). In the absence of any statutory requirements for practitioners to be registered with the JCCP, the effectiveness of its work is likely to be highly dependent on levels of public awareness of its existence and its role. It is therefore particularly important that those registered with the JCCP are able to demonstrate that they are accredited practitioners, for example through the use of the PSA’s ‘accredited registers quality mark’.⁷³⁷**

Recommendation 18: We recommend that, once the Joint Council for Cosmetic Practitioners has achieved accreditation with the Professional Standards Authority, Public Health England and its counterparts in the other countries of the UK should initiate a public awareness campaign to publicise the existence of the quality mark, alongside other sources of user advice, once available. Such a campaign should also draw attention to the lack of regulatory controls on practitioners not covered by the quality mark.

Regulation of premises and of provider organisations

- 8.36 The regulation of the premises from which cosmetic procedures are offered is a significant cause for concern, leaving users of non-surgical treatments, in particular, with unacceptably low levels of protection (see paragraph 4.27). While the premises on which surgical treatments are provided *are* subject to regulation by the CQC, the regulatory requirements focus primarily on physical and administrative aspects, and do not at present seek to monitor or measure quality of care directly. Indeed, in line with the business model common in the private hospital sector, surgeons themselves are rarely direct employees of the ‘providers’ (the individual, partnership or organisation running the hospital or clinic), but rather have ‘practising privileges’ to provide surgery within

⁷³⁷ Professional Standards Authority (2017) *Apply for the quality mark*, available at: <http://www.professionalstandards.org.uk/what-we-do/accredited-registers/apply-for-the-quality-mark>.

particular premises, bearing sole responsibility for their own professional practice (see paragraph 3.23). As a result, the regulatory system does not hold the provider directly accountable for instances of inadequate care, but rather for failings to have adequate policies and procedures in place.

- 8.37 **We conclude that the role of the CQC should be extended in a proportionate manner to all premises where invasive non-surgical procedures, covered by the accreditation system to be developed by the JCCP, are provided.** Local authorities already have the discretion to license premises providing cosmetic procedures involving intense pulsed light (IPL) and lasers: pending legislative change, and as a minimum, local authorities should be encouraged to follow the example of the London boroughs and others, and make use of this discretionary power to protect their residents. The cost of such registration and inspection should be borne by the private sector providers.
- 8.38 **The CQC's role for both surgical and non-surgical procedures should further be extended to ensure that 'providers' – the individuals, partnerships or organisations responsible for running hospitals or clinics – share responsibility for the quality of care provided with the doctors with whom they contract to provide the direct medical care.** As a minimum, providers should be required as a condition of registration to ensure that any surgeons providing cosmetic surgery in their premises are certified under the RCS cosmetic surgery certification scheme, once fully in force. Similarly, providers should be required to ensure that practitioners providing non-surgical treatments are appropriately qualified and registered with the JCCP or other health regulatory body. Providers should also demonstrate adequate systems for complaints and redress within the UK where things go wrong: including taking responsibility for ensuring complaints are properly handled; ensuring any litigation can take place in the UK (regardless of the domicile of the practitioner); and providing 'back-up' indemnity in cases where practitioners have inadequate levels of insurance or cannot be traced.

Recommendation 19: We recommend that the Department of Health act to extend the role of the Care Quality Commission (CQC) to all premises where invasive non-surgical procedures are provided.

Recommendation 20: We recommend that the CQC review its registration and inspection criteria for providers of cosmetic procedures so that, as a minimum providers are held responsible for:

- ensuring that surgeons providing services under contract to them are certified under the Royal College of Surgeons' scheme, once fully in force;
- ensuring that any practitioners providing non-surgical procedures under their name are registered with a body accredited by the Professional Standards Authority (when non-surgical procedures are brought within the CQC's remit); and
- taking the lead in responding to any complaints and litigation in connection with care provided under their name, regardless of the employment status of the practitioner concerned.

- 8.39 As we noted at the start of this chapter, a common thread of concern that has run through this report relates to the lack of even basic data with respect to cosmetic practice, and the difficulties this creates in supporting evidence-based practice. While we welcome the creation of the Private Healthcare Information Network (PHIN) to which private hospitals

are now required to submit data (see Box 4.2), we note the absence of any equivalent requirements with respect to the collection of data on non-surgical procedures. We are further concerned to note that, while the RCS has developed outcome measures, and published requirements for a future national audit of cosmetic surgical practice, it has not taken on responsibility for establishing and running that audit itself. It is currently unclear how, or whether, such an audit will be taken forward.

- 8.40 **We conclude that as an absolute minimum, information should be collected and made publicly available with respect to the number and type of cosmetic procedures (surgical and non-surgical) carried out, alongside basic demographic data regarding those seeking procedures. Anonymised pre-treatment and post-treatment outcome data (both short-term and long-term) are also crucial in order to improve the current poor evidence base with respect to the outcomes of procedures.**

Recommendation 21: We recommend that the UK departments of health should work with the Royal College of Surgeons, the Joint Council for Cosmetic Practitioners, the Private Healthcare Information Network, and the Care Quality Commission to find ways to close the significant gaps in data collection that currently remain.

Recommendation 22: We further recommend that the clinical codes used by the NHS to record and classify patient information should be adjusted to enable the NHS to record accurate information about any complications of cosmetic practice that require follow-up treatment in the NHS.

Access to procedures by children and young people

- 8.41 We argued in Chapter 7 that there are clear justifications for the state to take a proactive and protective role with respect to children and young people's access to invasive, non-reconstructive cosmetic procedures (see paragraphs 7.36–7.417.40). It is already accepted in the UK that some procedures designed to change physical appearance without any scope for functional benefit, such as tattoos and the use of sunbeds, should not be made available to anyone under the age of 18, regardless of their ability to consent to such treatments, and regardless of their parent's willingness to consent on their behalf (see paragraph 4.48).
- 8.42 **We argue that a similar approach should be taken to access to invasive, non-reconstructive cosmetic procedures, and that there should be a strong presumption against access to these procedures by children and young people under the age of 18.** Such access should be regarded as exceptional, and in need of robust justification, rather than routinely permissible at the request of parents, or children themselves.
- 8.43 The question therefore arises as to what would constitute 'robust justification' for exceptional access of this kind. Existing NHS good practice provides a helpful model. In cases where the NHS currently provides procedures to children designed to change their appearance (for example some of the procedures involved in cleft lip and palate surgery which are not required for functional reasons but are routinely offered in order to achieve what is regarded as a more normal appearance), it is currently best practice for decisions about their care to be made in consultation with both parents and child, with the support of a multidisciplinary team (see Box 7.3). Such an approach helps ensure that a wide range of views are heard; that the child's future interests, as well as their own and their

parents' understanding of their current interests, are considered; and that individual professional or commercial interests play no part in the decision.

- 8.44 We recognise that parents can be placed in a difficult situation where their children are distressed about some aspect of their appearance, and believe that a surgical or other invasive procedure will provide a solution. Parents need access to advice and support to enable them to understand the limitations of surgical solutions to the appearance anxieties common both in adolescence and in earlier childhood, so that they in turn can support their children in working out how best to deal with such anxieties.
- 8.45 **Drawing on best practice for reconstructive surgery within the NHS, we conclude that invasive non-reconstructive cosmetic procedures should only ever be offered to a child in the context of care by a multidisciplinary team.** This should be in an environment away from commercial pressures, where everyone's input (in particular that of the child) can be heard, and with a clear focus on the welfare of the child. In particular, careful consideration should be given to the question of whether there are good reasons why the procedure could not be delayed until adulthood. It should therefore be impossible for someone under 18 to access cosmetic surgery with the involvement of only a single practitioner, or to walk in off the street and have access to an invasive non-surgical procedure in a clinic or salon.

Recommendation 23: We recommend that the UK departments of health work with the relevant health regulators, Royal Colleges, professional associations, and major provider organisations to ensure that children and young people under the age of 18 are not able to access cosmetic procedures, other than in the context of multidisciplinary healthcare.

Practitioner / user relationships

Responsibilities to empower users

- 8.46 We have argued throughout this report that potential users' interest in cosmetic procedures cannot be set apart from the wider social context in which we all live: both in terms of general societal influences prevalent in the early twenty-first century (including, but not limited to, our increasingly visual culture and the role of mobile social media); and the particular fashions, values, and preferences that are influential at any one time in a person's own social circle. The active marketing of invasive cosmetic procedures by the commercial sector, often targeting particular social groups, is also an important part of this wider picture. We have seen how procedures can be marketed as a treat or as something users 'deserve' to give to themselves; sometimes they are compared with luxury items in a way that places them firmly in the context of desirable consumer goods. Such comparisons and associations contribute to the way in which a decision to have a cosmetic procedure may be perceived as trivial, and can help divert attention away from the fact that these are invasive procedures, sometimes irreversible, with scope for negative medical consequences.
- 8.47 This recognition has important consequences for the responsibilities of individual practitioners, who, in seeking consent from their prospective users / patients, need to be confident that they are indeed aware of the possible risks as well as having a realistic idea of the possible benefits (see below, paragraphs 8.52–8.55). It also has important consequences for the responsibilities of provider organisations, particularly with respect

to their sales and marketing information, and for regulators and others concerned with promoting high standards in the provision of cosmetic procedures. The information that potential users obtain *before* they first have a consultation with a practitioner is highly influential in determining attitudes to procedures. If a potential user has already been 'sold' a procedure by the information available on provider websites, by a salesperson or 'advisor' in a clinic, or through the implied promises of advertising or celebrity endorsement, then it will be much harder for a practitioner to ensure that they are in a position to weigh up risks and benefits fairly, and for the user to make a decision that is genuinely right for them.

- 8.48 The RCS has recently published information for prospective cosmetic surgery patients on its website: this includes suggested questions that prospective patients should ask before making decisions about surgery,⁷³⁸ and details drawn from the NHS Choices website about what is involved in specific procedures. Information about surgical procedures is also available on the websites of the British Association of Aesthetic Plastic Surgeons (BAAPS) and the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS). While we welcome these initiatives, we suggest that more needs to be done to coordinate the production and regular updating of independent high quality information, in order to ensure that prospective patients / users are readily able to access it, without needing prior knowledge of where to look.
- 8.49 Given the commercial nature of much of the cosmetic procedures market, we suggest that as part of their corporate social responsibilities, providers should take the lead in providing the funding for an independent programme of work to develop and maintain a hub of information to be made available free to users or prospective users of cosmetic procedures. Building on the existing information available through various sources, such a programme should be taken forward in collaboration with users themselves, alongside those with relevant professional expertise, such as the RCS, the JCCP, BAAPS, and BAPRAS. It should also include consideration of the most effective means of presenting and disseminating information, including through social media.

Recommendation 24: We recommend that the major providers of cosmetic procedures collaborate with both the relevant professional bodies, and users of cosmetic procedures, to fund the independent development, regular updating, and wide dissemination of detailed information for users about both surgical and non-surgical procedures.

- 8.50 In addition to providing information about individual procedures, including the evidence base for their claimed effects and their associated risks, such an initiative should also include prompts for the kinds of questions prospective users should feel able to ask provider companies and practitioners. In Box 8.1 below, we suggest some of the most important questions that users should feel able to ask.

Box 8.1: Prompts for questions to ask providers / practitioners

- What qualifications does the practitioner have to perform the procedure?
- What will the procedure involve?
- What pain or discomfort am I likely to feel during or after the procedure? How long is any pain or discomfort likely to last?
- How long will the effects of the procedure last? Will it need to be repeated?

⁷³⁸ Royal College of Surgeons (2016) *Cosmetic surgery: are you thinking about having cosmetic surgery?*, available at: <https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/>.

- What are the consequences of the procedure? (For example, will there be any scars or lack of sensation? What is the impact of breast implants on breastfeeding?)
- What is the range of possible aesthetic outcomes from this procedure, assuming it goes well? What is a realistic expectation?
- What are the worst- and best-case scenarios?
- What risks are associated with the treatment? How serious are they, and how often do they arise?
- How good is the evidence that this practice is a) safe; b) effective in achieving the desired appearance; c) effective in achieving any other desired aims such as providing psychological or social benefits?
- What will it all cost? Will there be repeated costs? (Is this a procedure I need to have every few months?)
- At what point can I change my mind, without having to pay anyway?
- How will you manage any complications? Who will pay?
- What will happen if I don't like the outcome?
- What records will you keep? Will I get a copy?
- If there's a problem, how will you deal with a complaint? Will the company handle it, or will you pass it on to the doctor / practitioner to deal with?

8.51 In addition to ensuring that people have easy access to unbiased and high quality information about procedures in advance of approaching a clinic or practitioner, provider organisations have further responsibilities with respect to the way that they communicate with potential users at the initial point of contact. **We conclude that:**

- **Providers should ensure that there is no scope for confusion between practitioners and sales staff. Where initial contact is made through a call centre, before referral to a clinic, for example, it should be clear to patients / users that they are not speaking to a practitioner.**
- **Face-to-face consultations (whether free or chargeable) should be with suitably trained staff who are qualified to explore with potential patients / users what they are seeking to achieve; discuss what procedures might potentially be suitable (including alternatives to cosmetic procedures); and able to make an appropriate referral. Sales staff should never be described as 'advisors', and should not offer advice; and appointments with sales staff should not be called 'consultations'.**
- **For surgical procedures, patients should not be able to book their surgery until they have had a consultation with the surgeon who will carry it out, even if this leads to delay in scheduling the procedure.**
- **No financial commitments should be asked of users before a firm decision has been made as part of a two-stage consent process (see below).**

Consent processes: shared decision-making and professional responsibilities

8.52 In Chapter 7, we recognised that individual practitioners cannot be held personally responsible for many of the ethical challenges arising out of the promotion and use of cosmetic procedures, but that they could, and should, be held responsible for the ethical consequences of their own practice. In particular, they should ensure that they are not 'part of the problem' (see paragraph 7.44). In addition to meeting the requirements outlined earlier in this chapter with respect to their qualifications, the products they use, and the premises from which they practise, a critical ethical responsibility for practitioners

is that of satisfying themselves that their prospective users are in a position to give informed consent to the procedure they are seeking.

8.53 We reiterate here our earlier endorsement of the professional guidance documents to doctors providing cosmetic procedures, issued by the GMC and by the RCS in 2016, which include detailed guidance on good consent practice. Equivalent guidance should be available for all practitioners providing invasive cosmetic procedures (see paragraph 8.33 and Recommendation 17). In particular, we highlight the following features of good consent practice which should be at the heart of such guidance for all practitioners working in this field:

- **The importance of shared decision-making**, drawing on the expertise of the practitioner, alongside exploration of the wishes of the user, in order to enable the user to come to a decision that is right for them (see Box 8.2 below). This process of shared decision-making should lead to a two-part consent process, including a ‘cooling-off period’, both for surgery, and for non-surgical procedures when undertaken for the first time. Users should not be asked to make financial commitments before the end of this process. It is meaningless to emphasise that users have the right to withdraw or change their mind at any point if, in practice, they have made substantial financial commitments at the first consultation.
- **Recognition of the limits of one’s expertise as a practitioner, and the importance of multidisciplinary practice.** Other forms of expertise may also be necessary in order to enable users to make informed decisions: practitioners should be proactive about referring users, or seeking additional sources of advice wherever necessary. Practitioners should be expected, as a minimum, to have access to psychological expertise, and sufficient awareness themselves (acquired through training) to know when to refer. Practitioners also need access to peer and professional support for themselves.
- **The importance of obtaining information where necessary from the user’s GP.** Given the potential for harm to health, the involvement of the user’s GP in order to ensure that relevant medical information that could affect the outcome of the procedure is available, should be the default position.⁷³⁹ If users refuse to allow their GP to be contacted, practitioners should only proceed if quite confident that they have the background medical information they need.

Box 8.2: Good practice in shared decision-making

A ‘shared-decision making’ consultation between clinician and patient should include an exploration of:

- the patient’s expectations of the procedure – both what it will involve, the outcome physically and in terms of changes to their lifestyle or psychological well-being;
- the risks involved, recognising that these may need to be emphasised by the practitioner given the ways they are generally minimised in media and marketing;
- any previous experience they have had of cosmetic procedures and their short- and long-term response to it; and

⁷³⁹ We recognise that confidential health information will usually only be shared between health professionals. However, the Working Party was told that it was good practice among non-health practitioners providing invasive cosmetic treatments to refer prospective users first to their GP when any concerns were highlighted, for confirmation that there would be no contraindications to the treatment requested. Factfinding meeting with Cheryl Cole, 21 February 2017.

- what has influenced them to seek a cosmetic procedure, and whether there are any alternative, less invasive, ways in which their aims can be achieved.

Discussing these factors will help both the practitioner and user to understand the patient's hopes or expectations. For example, for a patient seeking rhinoplasty, the consultation would explore both the hoped-for physical change (such as a slimmer, or less humped, nose) and psychosocial changes (such as feeling less preoccupied with their nose, more confident, or more attractive). While practitioners can usually make a fair assessment of whether the user's wishes can be achieved physically, they cannot assess or guarantee that the physical change will bring the psychological changes the user is hoping for. Distinguishing clearly between the physical and psychological is likely to help patients make a realistic assessment of the procedure and to make a decision that is right for them.

In addition to these factors, practitioners should ensure that they have covered all the information outlined in Box 8.1 above, taking responsibility for providing such information, regardless of whether users have explicitly requested it.

It is also important that information is provided in a clear way, and that users have time to reflect on their options and ask further questions before making a decision. It should be clear to users that they can change their minds at any time. For complex and invasive procedures, it is important to have a two-stage process to provide an opportunity for patients to ask questions and for clinicians to check that patients have understood and retained key information about the procedure. Clear follow-up plans should always be provided.

Recommendation 25: We recommend that the major providers of cosmetic procedures jointly develop a code of best practice to which they, and all practitioners working in their name, should adhere. Such a code should include:

- Recognition of the importance of clear distinctions between sales staff and practitioners, with 'consultations' and 'advice' only offered by appropriately qualified staff.
- Commitment to shared decision-making and a two-part consent process, with no financial commitments asked of users before the end of this process.
- Recognition of the limits of one's experience as a practitioner, and commitment to multidisciplinary practice.
- Commitment to obtaining information where necessary from the user's GP, as a default position.

- 8.54 Difficult situations arise for practitioners when they are doubtful about the likelihood of the procedure achieving the benefits for which the user hopes. This is a particular challenge for practitioners working within commercial and competitive healthcare settings. Where users wish to go ahead with a treatment that the practitioner believes will not bring the benefits the patient is seeking, the practitioner should encourage the user to access counselling from a regulated provider. As recommended above, practitioners should also have links to a psychosocial practitioner who can provide advice where a practitioner is concerned about a user's expectations of the outcome of treatment. Practitioners should *not* provide treatment which they judge will not be of overall benefit to the user: that is, where they believe that it will not achieve the user's expectations with respect to physical or psychological gain, set against the risks.

8.55 We identify the following as necessary to support practitioners in following such practice:

- high quality research to develop accessible and useable tools to help practitioners better identify and support prospective users at risk of poor outcomes;
- high quality research to improve understanding of the factors and processes underpinning positive and negative outcomes of cosmetic procedures;
- the development of clear referral routes to more specialist pre- or post-procedural assessment, support or intervention; and
- the provision of training for practitioners (promoted through appraisal and requirements for continuing professional development) to raise awareness of risk factors for suboptimal outcomes, and to promote the desirability of a routine, appropriate pre-procedural assessment.

Recommendation 26: We recommend that the UK Research Councils and other major research funders should actively encourage high quality interdisciplinary research proposals that aim to fill the significant gaps in the evidence base identified in this report with respect to the provision and use of cosmetic procedures. Such research is essential in order to promote more ethical practice in the sector. In addition to the recommendations already made with respect to much improved data collection, we highlight the need for research:

- to improve understanding of the factors associated with poor outcomes after cosmetic procedures, and the development of practical tools to help practitioners identify and support prospective users who are more likely to have such outcomes; and
- to improve the evidence base with respect to the long-term physical and psychological outcomes, both positive and negative, of different cosmetic procedures.

Redress

8.56 Finally, we turn to the question of redress. When things go wrong from the point of view of the patient / user, it is clearly important that providers have systems in place to respond appropriately, whether the complaint arises as a result of poor practice, of adverse consequences unconnected with poor practice, or because the outcome did not meet expectations. As in other areas of medical practice, seeking compensation for alleged negligence through the civil courts can be stressful and difficult (see paragraphs 4.40–4.44).

8.57 We have already emphasised the importance of providers' complaints systems, and the potential role of the CQC in ensuring that providers take the lead role in responding to complaints, even where the practitioner concerned is self-employed (see paragraph 8.38 and Recommendation 20). While most complaints may be resolved satisfactorily at local level, in some cases a further tier of independent review is important, both to provide third-party scrutiny of the complaint in question, and to provide reassurance as to the fairness of the complaints system as a whole. While there is a voluntary Independent Sector Complaints Adjudication Service (ISCAS), no action has been taken with respect to the recommendation in the Keogh report that the remit of the Parliamentary and Health Service Ombudsman should be extended to include private practice, including cosmetic procedures (see paragraph 4.44). **We agree with the Keogh report that patients / users of cosmetic procedures would best be protected by extending the role of the Parliamentary and Health Service Ombudsman.** In the absence of such legislative

action, we believe that as a minimum all providers of cosmetic procedures should be required to sign up to an independent arbitration service.

Recommendation 27: We recommend that the Care Quality Commission should require all providers within its remit to guarantee access to an independent arbitration service, in cases where complaints cannot be resolved to patients' / users' satisfaction at provider level.

Appendices

Appendix 1: Method of working

Background

The Nuffield Council on Bioethics established the Working Party on *Cosmetic procedures: ethical issues* on 24 June 2015. The Working Party subsequently met nine times between October 2015 and March 2017.

In order to inform its deliberations, the Working Party launched an initial expert call for evidence and a shorter online survey for interested members of the public in January 2016. In total, 35 individuals and organisations responded to our expert call for evidence; 448 interested members of the public responded to our online survey.

Between February 2016 and June 2017, the Working Party also held a series of factfinding meetings, which addressed distinct questions and issues that arose throughout the project (see further below). Three literature reviews were also carried out:

- Evidence of harms caused by the use of non-therapeutic cosmetic procedures;
- Cosmetic procedures: demand, motivations, and influencing factors; and
- Post-procedure experiences.

We are very grateful to all who contributed their time and expertise to this report.

Expert call for evidence

The call for evidence took two forms: the first was an 18-question document aimed at professional organisations, stakeholders, and researchers; the second was a broader 15-question survey hosted by the Survey Monkey website which sought the views of members of the public with a general interest in cosmetic procedures. For further details on the Working Party's call for evidence, see Appendix 2.

Factfinding meetings

Throughout the course of this project, the Working Party held factfinding meetings with a wide range of individuals and organisations. A total of 26 meetings were held, each of which lasted between one and three hours.

5 February 2016: consumer perspectives

- **Christiana Clogg**, founder and Managing Director of the Good Surgeon Guide
- **Marcos Eleftheriou**, solicitor specialising in cosmetic procedures at Irwin Mitchell
- **Leah Hardy**, freelance journalist with an interest in cosmetic procedures
- **Liam Preston**, Public Affairs Manager, YMCA England with responsibility for the Be Real campaign
- **Marie Robinson**, founder member, PIP Action Campaign
- **Deborah Sandler**, founder, CosmeticSupport.com website
- **Jan Spivey**, founder member, PIP Action Campaign
- **Sally Taber**, Director, Cosmetic Assurance Ltd. (responsible for the 'Treatments You Can Trust' website)

23 March 2016: skin-lightening

- **Steve Garner**, Head of Criminology & Sociology, Birmingham City University; Visiting Researcher, Department of Social Policy, Open University

15 April 2016: regulation and governance perspectives

- **Paula Case**, Senior Lecturer, Liverpool Law School, University of Liverpool
- **Marie Fox**, Professor of Socio-Legal Studies, University of Birmingham
- **Ruth Holliday**, Professor of Gender and Culture, University of Leeds
- **Marie-Andrée Jacob**, Professor, School of Law, Keele University
- **Meredith Jones**, Reader, Department of Social Sciences, Media and Communications, Brunel University
- **Sheelagh McGuinness**, Senior Lecturer, University of Bristol Law School
- **José Miola**, Professor of Medical Law, Leicester Law School

20 April 2016: further legal perspectives

- **Melanie Latham**, Reader, Manchester Metropolitan University

6 May 2016: use of dermal fillers

- **Niall Kirkpatrick**, Consultant Plastic Surgeon

8 May 2016: historical perspectives

- **Fay Bound Alberti**, Cultural Historian

22 June 2016: visual culture and cosmetic procedures

- **Rosalind Gill**, Professor of Cultural and Social Analysis, City University London
- **Debra Gimlin**, Professor of Sociology, University of Aberdeen
- **Fiona MacCallum**, Associate Professor, Department of Psychology, University of Warwick
- **Christina Scharff**, Senior Lecturer in Culture, Media and Creative Industries, King's College London
- **Amy Slater**, Senior Research Psychologist, Centre for Appearance Research, University of the West of England

26 August 2016: Advertising Standards Authority

- **Rob Morrison**, Senior Regulatory Policy Executive, Committee of Advertising Practice (CAP), Advertising Standards Authority (ASA)

30 September 2016: professional regulators

- **Richard Barlow**, British Cosmetic Dermatology Group, British Association of Dermatologists

- **Paul Burgess**, Joint Council for Cosmetic Practitioners
- **Julie Inggs**, Senior Designer, Acute Policy Team, Care Quality Commission
- **Caroline Larissey**, Head of Standards and Qualifications, Hair and Beauty Industry Authority
- **Mike Regan**, Aesthetic Surgery and Non-Surgical Devices Committee, British Standards Institute
- **Cristina Sarb**, Senior Policy Officer, Nursing and Midwifery Council
- **Jessica Tye**, Operations Manager – Investigations, Advertising Standards Authority
- **Nilla Varsani**, Cosmetic Guidance Project Leader, General Medical Council

12 October 2016: General Dental Council

- **Janet Collins**, Head of Standards

2 November 2016: Medical Defence Union

- **Mary-Lou Nesbitt**, Head of Governmental & External Relations

8 November 2016: CFC underwriting

- **Sharon Brennan**, Medical Malpractice, Practice Leader, CFC Underwriting
- **Jo Clift**, Medical Malpractice Underwriter, CFC Underwriting
- **Tingy Simoes**, Managing Director, Wavelength Marketing Communications

6 December 2016: medical products

- **Peter Cranstone**, Managing Director, EuroSurgical

8 December 2016: Facebook

- **Aibhinn Kelleher**, Associate Policy Manager for Europe, Middle East & Africa, Facebook
- **Nasser Al-Sherif**, Facebook Ireland

23 January 2017: NHS and private sector perspectives

- **Reza Nassab**, Plastic, Reconstructive and Aesthetic Surgeons

24 January 2017: Lynton Lasers

- **Samantha Hills**, Clinical Director

3 February 2017: GP perspectives

- **Paquita de Zulueta**, member of the Nuffield Council and GP

21 February 2017: beauty therapy perspectives

- **Cheryl Cole**, Independent Beauty Therapist

7 March 2017: Professional Standards Authority

- **Harry Cayton**, Chief Executive
- **Graham Mockler**, Head of Accreditation

9 March 2017: Sk:n

- **Lisa Mason**, Head of Medical Standards, Sk:n

10 March 2017: Harley Medical Group

- **James Farquharson**, Chief Executive, Harley Medical Group
- **Simon Smith**, Medical Director, Harley Medical Group

15 March 2017: Transform

- **Mark Norfolk**, Clinical Services Director, Transform

21 April 2017: Royal College of Surgeons

- **Patrick Leahy**, Head of Press and Public Affairs
- **Simon Edwards**, Executive Director – External Affairs

2 May 2017: Medicines and Healthcare products Regulatory Agency

- **Adrian Bartlett**, Medical Devices, EU Policy Manager
- **Graeme Tunbridge**, Group Manager, Devices Regulatory Affairs
- **Ian Rees**, Unit Manager, Inspectorate Strategy and Innovation Unit (via phone, 19 April 2017)
- **Louise Bisset**, Senior Biologicals Quality Assessor (via phone, 19 April 2017)

10 May 2017: Transport for London

- **Chris Macleod**, Marketing Director
- **Tom Atkinson**, Communications and Engagement Manager

5 June 2017: Private Healthcare Information Network

- **Matt James**, Chief Executive
- **Vaibhav Joshi**, Clinical Informatics Director

Deliberative workshops

Deliberative workshops with nine different groups were carried out by facilitators from the Working Party and members of the Nuffield Council's staff. The outcomes of each workshop were taken into consideration by the Working Party throughout the project.

9 February and 22 March 2016: King's College London

Students studying for an MA in Bioethics and Society at King's College London contributed to two facilitated workshops which covered a range of questions that had been raised by the Working Party's call for evidence documents. Points discussed included: motivations for having cosmetic procedures; wider societal impact on the growth of cosmetic procedures; parental decision-making for children in the context of cosmetic procedures; and the role of advertising and marketing of cosmetic procedures.

11 March 2016: SICK! Festival, Manchester

SICK! Festival brings together arts and healthcare professionals for a range of discussions and events. The Working Party's project featured in a series of 'pop-up' discussions at the festival, each of which lasted for 20 minutes. Participants discussed motivations for cosmetic procedures, the role of the 'natural' in cosmetic procedures, and regulation.

17 June 2016: International Association of Bioethics Congress, Edinburgh

A one-hour workshop was undertaken with a group of nine 16-18-year-old girls from schools in the Edinburgh and Lothian areas of Scotland. The event was organised with the assistance of the International Association of Bioethics. The workshop focused on three core issues drawn from the Working Party's call for evidence:

- Whether changing appearance through the use of cosmetic procedures, as opposed to other methods (e.g. clothing, hairstyles, make-up) means that they are in some way 'different'. And, if they are different, what makes them so.
- What motivates people to have cosmetic procedures, or puts them off. In addition, whether some motivations are 'better' than others.
- Whether the growing use of cosmetic procedures has an impact in society, and whether – if it does – this matters.

18 June 2016: Young Persons' Group, Aberdeen

Members of the ScotCRN Young Persons' Group (YPG)⁷⁴⁰ contributed their views on a wide range of issues relevant to the Working Party's project as part of a four-hour workshop which involved small 'breakout' groups, as well as whole group discussions. Discussions included where 'lines can be drawn' between what should and what should not be considered to be a 'cosmetic procedure', the role of celebrities in contributing to appearance expectations among young people, and how social media can affect appearance norms. The young people who took part were aged between eight and 20. The Nuffield Council has previously worked with the YPG as part of its project on *Children and clinical research: ethical issues*.

30 June 2016: Café Scientifique, Manchester

Approximately 20 people attended a discussion event organised by Café Scientifique⁷⁴¹ which focused on the Working Party's project. The discussion focused particularly on the regulation of cosmetic procedures.

⁷⁴⁰ ScotCRN (2017) *Young Persons' Group*, available at: <http://www.scotcrn.org/young-people/>.

⁷⁴¹ Café Scientifique (2017) *Homepage*, available at: <http://www.cafescientifique.org/>.

12 June 2016: Dragon Hall Debates, Norwich

Twenty-five audience members participated in an evening debate where audience members responded to presentations on beauty ideals, and a personal account of providing cosmetic procedures in the NHS and private sector.

13 July 2016 and 9 August 2016: Stitch in Time, Rossendale, Lancashire

A group of women between the ages of 40 and 70 who meet once per month as part of a knitting circle were asked for their views on cosmetic procedures as part of a facilitated discussion. Their discussions included expectations for women to 'look good', media influence, and their own experience of considering or accessing cosmetic procedures.

13 August 2016: Young Persons' Advisory Group, Nottingham

A group of nine members of a Young Persons' Advisory Group⁷⁴² (YPAG) between the ages of 14 and 18 took part in a two-hour workshop to discuss their views on cosmetic procedures. Views were particularly sought on young people's access to cosmetic procedures, and the role of marketing and advertising in the context of cosmetic procedures. The Nuffield Council has previously worked with YPAG members as part of its project on *Children and clinical research: ethical issues*.

14 December 2016: Changing Faces, London

Stakeholders from the charity Changing Faces contributed their views to the Working Party's evidence-gathering activities as part of a two-hour evening workshop. Contributors discussed a range of questions, including whether being able to change oneself through cosmetic procedures is ethically worrisome, neutral, or positive; and how society responds to people who look distinctive, and how social pressures to look a particular way (e.g., as promoted by celebrities or makeover shows) impact on people who look 'different'.

Literature reviews

The Working Party undertook three literature reviews of existing research relevant to its work.

Evidence of harms caused by the use of non-therapeutic cosmetic procedures (2015)

Author: Tom Burton

This review assesses the extent to which harms, if any, are caused by the use of cosmetic procedures. It is divided into three parts: physical harms to the individual; psychological harms to the individual; and wider harms to society. Evidence is drawn from a range of sources that report research ranging from individual case reports, to national surveys.⁷⁴³

⁷⁴² GenerationR (2017) *Nottingham YPAG*, available at: <http://generationr.org.uk/nottingham/>.

⁷⁴³ Nuffield Council on Bioethics (2015) *Literature review: evidence of harms caused by the use of non-therapeutic cosmetic procedures*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Review-of-harms-caused-by-cosmetic-procedures.pdf>.

Cosmetic procedures: demand, motivations, and influencing factors (2016)

Author: Kate Harvey

This review examines available evidence on the demand for cosmetic procedures in the UK and international contexts. It also explores a range of factors highlighted in the academic literature which may influence or motivate individuals to decide to have cosmetic procedures.⁷⁴⁴

Post-procedure experiences (2016)

Author: Kate Harvey

This review summarises available evidence on how individuals describe their experiences of cosmetic procedures. Its analyses include:

- An assessment of the levels of post-procedure satisfaction / dissatisfaction;
- Why users of cosmetic procedures may be satisfied / dissatisfied with their results;
- Whether any dissatisfaction / satisfaction 'lasts';
- Whether users of cosmetic procedures would, hypothetically:
 - undergo a different cosmetic procedure in the future
 - undergo the same procedure again; and
- Whether users of cosmetic procedures would recommend their procedure to other people.

External review

A draft version of the report was circulated in January 2017 to 15 external reviewers with professional expertise in cosmetic procedures. The reviewers were:

- **Deborah Boyle**, Consultant Gynaecologist, Royal Free London NHS Foundation Trust
- **Jonathan Cole**, Author of 'About face'; Consultant in Clinical Neurophysiology, Poole Hospital NHS Foundation Trust
- **Cathrine Degnen**, Senior Lecturer in Anthropology, Newcastle University
- **Julie Doyle**, Professor of Media and Communication, University of Brighton
- **Ros Gill**, Professor of Cultural and Social Analysis, City University of London
- **Ruth Holliday**, Professor of Gender and Culture, University of Leeds
- **Serene Khader**, Assistant Professor of Philosophy, City University of New York
- **Chris Khoo**, Plastic, Reconstructive and Aesthetic surgeon
- **Jackie Leach Scully**, Executive Director, Policy, Ethics & Life Sciences Research Centre, Newcastle University
- **Fiona MacCallum**, Associate Professor of Psychology, University of Warwick
- **Jean McHale**, Professor of Law, University of Birmingham
- **Monica Moreno Figueroa**, Lecturer in Sociology, University of Cambridge
- **Thérèse Murphy**, Professor of Law, Queen's University Belfast
- **Susie Orbach**, Psychotherapist and Commentator
- **Marilyn Strathern**, Emeritus Professor, Social Anthropology, University of Cambridge

⁷⁴⁴ Nuffield Council on Bioethics (2016) *Literature review: cosmetic procedures - demand, motivations, and influencing factors*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Motivations-review.pdf>.

Appendix 2: Wider consultation for the report

Expert call for evidence

The Working Party's expert call for evidence was launched on 11 January 2016 and remained open until 18 March 2016. We received 35 responses to the questions set out in this document: 18 from individuals; 17 from organisations. Respondents included those with professional, personal, academic, legal, and general interest in cosmetic procedures. A summary of respondents' submissions is available on the Nuffield Council's website.⁷⁴⁵

Questions posed

The expert call for evidence set out 18 questions which were divided into five distinct sections, as set out below.

Definitions and aims

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

Increasing demand for cosmetic procedures

4. What do you think are the main drivers generating the increasing demand for cosmetic procedures, both surgical and non-surgical?
5. Do you think it is becoming more routine to undertake cosmetic procedures? If so, in your view, does this raise any ethical issues?
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.?
7. Are some motivations for having a cosmetic procedure 'better' than others? If so, what are they, and who should judge?
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

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

⁷⁴⁵ Nuffield Council on Bioethics (2017) *Cosmetic procedures: ethical issues - expert call for evidence: analysis*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Expert-consultation-analysis.pdf>.

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?
12. To what extent should parents be allowed to make decisions about cosmetic procedures for their children?
13. Should there be any guidelines or regulation on who can provide non-surgical cosmetic procedures?
14. What are the responsibilities of those who develop, market, or supply cosmetic procedures?
15. Do you believe that current regulatory measures for cosmetic procedures are appropriate, too lax, or too restrictive?

Different parts of the body

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

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.

List of respondents to the expert call for evidence

Individuals (18)

- Anonymous (1)
- Professor Dennis Baker
- Dr David Bell, University of Leeds, and Professor Ruth Holliday, University of Leeds
- Johane Brockfield
- Brian D. Earp, Resident Visiting Scholar, The Hastings Center Bioethics Research Institute, Garrison, New York, USA
- Marcos Eleftheriou (of Irwin Mitchell Solicitors)
- Dr Sara Fovargue, Law School and Lancaster Centre for Bioethics and Medical Law, Lancaster University, and Dr Alexandra Mullock, School of Law and Centre for Social Ethics and Policy, University of Manchester
- Dr Melanie Latham
- Professor Jackie Leach Scully and Dr Simon Woods, Policy, Ethics and Life Sciences Research Centre (PEALS), Newcastle University
- Dr Anne-Marie Martindale, The University of Manchester
- Clare McKeaveney, QUB Belfast
- Francesca Minerva, FWO Post-doctoral fellow, University of Ghent, Faculty of Philosophy and Moral Sciences
- Dr Ashley Morgan, School of Art and Design, Cardiff Metropolitan University
- Lois Rogers, specialist journalist

- Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester
- Professor Marilyn Strathern
- Dr David Veale
- Meryll Willis

Organisations (17)

- Action against Medical Accidents (AvMA)
- Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran)
- British Association of Cosmetic Nurses – BACN
- British Dermatological Nursing Group
- British Medical Association
- Christian Medical Fellowship
- Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians
- Faculty of General Dental Practice (UK) / FGFP
- General Medical Council
- Girlguiding
- Health and Human Rights Unit, School of Law, Queen's University Belfast
- Mission and Public Affairs Council, Church of England
- National Bioethics Commission of Mexico
- Standing Working Group 'Cosmetology and cosmetic devices, including cosmetic surgery' of the Superior Health Council of Belgium
- The Primary Care Dermatology Society
- The Scottish Government
- University of Edinburgh, class of 'Contemporary issues in medical jurisprudence (Honours)'

Published material submissions

The Working Party also received submissions of published materials from:

- Professor Dennis Baker
- Dr Virginia Braun
- Brian D. Earp
- Professor Ros Gill

Online public questionnaire

The Working Party's online public questionnaire was launched on 25 January 2016 and remained open until 18 March 2016. In total, 448 people answered at least one question, and many responded to each of the 15 survey questions. A summary of responses to the online public questionnaire is available on the Nuffield Council's website.⁷⁴⁶

⁷⁴⁶ Nuffield Council on Bioethics (2017) *Cosmetic procedures: online questionnaire - analysis*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Online-questionnaire-analysis.pdf>.

Questions posed

Introduction

1. Have you ever had, or thought seriously about having, a cosmetic procedure?⁷⁴⁷

Attitudes to cosmetic procedures – for you

2. Please say why you haven't had, or wouldn't consider having, a cosmetic procedure. (Only visible to those who answered 'no' to question 1.)
3. Which procedure(s) have you had or thought seriously about having? What prompted you to have it or consider having it? (Only visible to those who answered 'yes' to question 1.)
4. What prompted you to have a cosmetic procedure, or to consider having a cosmetic procedure? (Only visible to those who answered 'yes' to question 1.)
5. Would / did you tell people that you had a cosmetic procedure, or keep it secret? (Only visible to those who answered 'yes' to question 1.)
6. Do you think like might be different after a cosmetic procedure? (Visible to all respondents, regardless of response to question 1.)

Attitudes to cosmetic procedures – for a friend or relative

7. Imagine a good friend or relative has a facial or bodily feature that is not regarded as conventionally attractive. Do you think they would be happier if they had a cosmetic procedure to change their appearance?
8. Imagine a good friend or relative has a facial or bodily feature that is not regarded as conventionally attractive. If they chose to have a procedure, would it change your feelings about them?
9. How about children? Should parents arrange for their child's appearance to be changed if it's unusual?

Attitudes to cosmetic procedures – influences and regulation

10. What / who do you think influences people's attitudes to cosmetic procedures? (Tick as many as you think apply.)⁷⁴⁸
11. Do you think cosmetic procedures have become more or less acceptable in the last ten years?
12. Do you think people have become more or less critical about the appearance of others in the last ten years?
13. Who do you think should have the main responsibility for making sure that cosmetic procedures are carried out safely? (Please choose just one.)⁷⁴⁹

Other comments

14. Is there anything else important that you think we should know about cosmetic procedures?

⁷⁴⁷ Where questions were only visible depending on whether respondents answered 'yes' or 'no' to question 1, it is noted above; otherwise, all questions were visible to all respondents, regardless of their response to the first question.

⁷⁴⁸ Options available to respondents are listed in the summary of the online call for evidence: Nuffield Council on Bioethics (2017) *Cosmetic procedures: online questionnaire - analysis*, available at: <http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-Online-questionnaire-analysis.pdf>.

⁷⁴⁹ *ibid.*

About you

15. Please tell us anything about yourself which you think may be relevant to your views about cosmetic procedures (e.g., age, gender, etc.).

List of abbreviations

ACOG	The American Congress of Obstetricians and Gynecologists
ALCL	anaplastic large cell lymphoma
APPG	All-Party Parliamentary Group
ASA	Advertising Standards Authority
ASAPS	American Society for Aesthetic Plastic Surgery
ASPS	American Society of Plastic Surgeons
BACN	British Association of Cosmetic Nurses
BAAPS	British Association of Aesthetic Plastic Surgeons
BAPRAS	British Association of Plastic, Reconstructive and Aesthetic Surgeons
BCAP	Broadcast Committee of Advertising Practice
BDD	body dysmorphic disorder
CAP	Committee of Advertising Practice
CLP	cleft lip and / or palate
CPSA	Cosmetic Practice Standards Authority
CQC	Care Quality Commission
CSIC	Cosmetic Surgery Interspecialty Committee
CSR	corporate social responsibility
DSM	Diagnostic and Statistical Manual of Mental Disorders
EHRC	Equality and Human Rights Commission
EMA	European Medicines Agency
FDA	US Food and Drug Administration
FGCS	female genital cosmetic surgery
FGM	female genital mutilation
GDC	General Dental Council
GMC	General Medical Council
HABIA	Hair and Beauty Industry Authority
HCPC	Health and Care Professions Council
HEE	Health Education England
HIV	human immunodeficiency virus
IPL	intense pulsed light
ISAPS	International Society of Aesthetic Plastic Surgery
ISCAS	Independent Sector Complaints Adjudication Service
JCCP	Joint Council for Cosmetic Practitioners
MDU	Medical Defence Union

MHRA	Medicines and Healthcare products Regulatory Agency
MRI	magnetic resonance imaging
NHS	National Health Service
NMC	Nursing and Midwifery Council
NSPCC	National Society for the Prevention of Cruelty to Children
OCD	obsessive compulsive disorder
PHIN	Private Healthcare Information Network
PHSO	Parliamentary and Health Service Ombudsman
PIP	Poly Implant Prothèse
PRASIS	Plastic, Reconstructive and Aesthetic Surgeons Indemnity Scheme
PROMs	patient reported outcome measures
PRP	platelet-rich plasma
PSA	Professional Standards Authority
PSHE	personal, social, health, and economic (education)
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCOG	Royal College of Obstetricians and Gynaecologists
RCS	Royal College of Surgeons
SCIEG	Scottish Cosmetic Interventions Expert Group
TIG	Training Interface Group
TfL	Transport for London

Index

Note: Locators are to paragraph numbers or box numbers.

3D printing Box 3.5

access to cosmetic procedures 2.18–2.19, 4.45–4.50, 7.40–7.41, 8.41–8.45

accreditation 4.16, Box 4.3, 4.16, Box 4.4, 4.20, 8.37

additive manufacturing Box 3.5

admitting privileges 3.23

adolescents 1.7, 2.18, 5.28, 7.36, 8.14;

see also: children and young people

advertising

associating cosmetic procedures with happiness 1.16

examples of online adverts Box 2.3

increase in appearance-related images 1.12

recommendations for 8.10–8.13

regarding cosmetic procedures as a consumer good 2.17

regulation 4.51–4.58, Box 4.9

social media polices 4.58, Box 4.9

Advertising Standards Authority (ASA)

4.52, 4.54, Box 4.8, 4.55–4.56, 8.10, 8.13

affordability of procedures 5.32–5.33

ageing Box 1.1, 1.12, 1.15, 2.3, 5.6, 5.15, 5.37 (population), 6.22, 7.17

airbrushing 1.12, 2.14, 8.5

All Party Parliamentary Group (APPG) on

Body Image 1.9. Box 1.3

American Society for Aesthetic Plastic Surgery (ASAPS)

procedures performed on children and young people 3.12

published data on numbers of cosmetic procedures Box 2.2, Box 3.1

American Society of Plastic Surgeons (ASPS)

most popular non-surgical procedures in US Box 3.3

published data on numbers of cosmetic procedures Box 2.2, Box 3.1

value of cosmetic procedures market 3.6

anaplastic large cell lymphoma 6.11

anxiety about appearance 1.6–1.15, 2.8, 2.10, 6.22

appearance

anxiety about 1.6–1.15, 2.8, 2.10, 6.22, Box 1.2

happiness and 1.12, 1.16–1.19, 2.11

ideal 1.1–1.5

apps 1.12, 2.2, 4.60, 7.36, 8.15

audit Box 4.2, 4.13, 4.17, 4.36, 8.39

Be Real Campaign Box 1.3, 8.14, 8.17, 8.18, 8.21

beauty maintenance 1.22

beauty myths 1.12, 8.4

beauty salons 2.16, 3.23, 7.24, 7.28, 8.45

benefit 7.29–7.31

blame culture 2.6

bloggers 3.22, Box 4.8

blogs 4.52, 4.59, 5.28

body dysmorphic disorder Box 6.2, 6.18

body image

concerns about 1.9, 1.11, Box 1.4, 2.5

effects of advertising 4.55–4.57

effects of social media use 4.60

motivation for cosmetic procedures 5.13–5.14

summits 1.9

terminology Box 1.2

work in schools Box 1.3

body projects / work 1.12

body shape Box 1.1, 1.12, 4.57, 5.26, 6.21, 8.11, 8.13

body surgery, types of Box 1.6

botox Box 1.6

alternative to surgery Box 3.6

different uses of 5.5–5.6

published data on 1.14, 3.12, Box 3.3

in dental surgeries 2.16

inappropriate access to 8.34

global market value 3.6

growing popularity 2.4

home-based use 3.17

motivations to have 5.24

new uses of Box 3.4

normalisation of 2.9

parties 3.17, 4.10

prescribing versus administering 4.4, 4.10

professional qualifications required to administer 4.9, Box 4.4, 4.32

questions for providers / practitioners 8.1

- regulation 4.27, 4.51
- repurposed use of botulinum toxin 3.14, Box 3.4
- risk 7.12
- scope of this report 1.20
- self-injection 3.17
- breast implants
 - 3D printing of Box 3.5
 - commercial competition 3.18, 3.20
 - defined as medical devices 4.33
 - follow-up data 3.21
 - manufacturers of 3.21
 - Poly Implant Prothèse (PIP) 2.6, 3.20, 4.36, 6.11
 - registry 4.38
 - regulatory requirements 8.26
 - risk of physical harm 6.11
 - suicide rates 6.18
- breast lifts, vampire procedures Box 3.4
- breast reconstruction Box 7.4, 4.33, 7.7
- breast reduction 1.21, 1.24, Box 1.6, Box 3.2, 3.10–3.12, 5.9, 6.5, 5.30
- breast surgery, types of Box 1.6
- British Association of Aesthetic Plastic Surgeons (BAAPS)
 - information to prospective patients / users 8.48–8.49
 - most popular cosmetic surgeries performed by members Box 3.2
 - patient safety 4.29
 - published data on numbers of cosmetic procedures Box 3.1, 3.9
 - MoU with the Joint Council for Cosmetic Practitioners 4.19
- Broadcast Committee of Advertising Practice (BCAP) 4.51–4.54, 4.57,
- bullying Box 1.4, 4.61, 5.25, 7.8
- business practice models 3.23–3.24
- buttock augmentation / lifts Box 1.1, Box 1.6, 3.10
- campaigns
 - Be Real Box 1.3, 8.17, 8.18, 8.21
 - Body Confidence 1.9, Box 1.3
 - Face Equality 8.17, 8.18
 - Models of Diversity 8.17
- Care Quality Commission (CQC) 4.23–4.30, 7.28, 8.34, 8.36, 8.37, 8.38, 8.57
- categorisation of cosmetic procedures 1.20–1.25, 7.24
- CE mark 4.34, 4.35, 4.37, 8.28
- celebrity influences 1.12, Box 1.4, 5.26
- certification (RCS) Box 4.2, 4.13, 8.32, 8.38
- children and young people
 - access to cosmetic procedures 2.18–2.19, 4.46–4.48, 7.40–7.41, 8.41–8.45
 - behavioural impact of appearance dissatisfaction 1.9
 - consent issues 2.19, 4.46, 7.37, 7.38
 - family-centred approach 7.39
 - gender differences in appearance dissatisfaction 1.7
 - happiness 1.19
 - increase in appearance dissatisfaction 1.11
 - multidisciplinary approach 7.39, 8.43, 8.45
 - parents' role 2.19, 4.46, 5.21, 7.17, 7.37, 7.38, 8.44
 - perceptions of appearance pressures Box 1.4
 - procedures performed by ASAPS members 3.12
 - reduction in age of appearance dissatisfaction 6.22
 - state's responsibility towards 7.36–7.37, 8.20–8.22
- circumcision
 - female (FGM) 1.25, 4.49, 4.50, Box 4.6, 8.29
 - male 1.25, 7.3
- cleft lip and palate 5.21, Box 7.3, 7.39, 8.43
- clinical settings 2.16
- commercial competition 3.18–3.21
- Committee of Advertising Practice (CAP) 4.51–4.54 Box 4.7, Box 4.8, 4.57, 4.59, 8.11,
- communication, initial point of contact 8.51
- community interest company (CIC) Box 4.3
- compensation claims 4.42, 4.43, 8.56
- competence 4.5, 4.46, Box 4.1, Box 4.2, 7.37, 7.45, 8.32
- competition between manufacturers 3.18–3.21
- complaints systems 4.40–4.44, 8.57
- confidence 5.10–5.12
- consent 2.17, 2.19, 3.1, Box 4.1, 4.17, 4.24, 4.42, 4.46–4.48, 7.19 7.37, 7.38, 7.45–7.47, 7.49, 8.41, 8.47, 8.52–8.55
- consumer goods 2.17, 4.2, 7.1, 7.24 7.34, 8.46
- contextual issues

- multiple continuums 7.11, 7.14–7.15
- provision of procedures 2.16–2.17
- social context 1.1–1.5, Box 1.1, 1.17, 7.16, 8.1, 8.4–8.22
- CoolSculpting 3.6, Box 3.4
- corporate social responsibility 7.22, 7.29, 7.44, 8.6, 8.14 8.49
- corticosteroids 6.15
- Cosmetic Practice Standards Authority (CPSA) 4.21
- cosmetic procedures
 - categorisation 1.20–1.25
 - growth in 1.14, 5.36–5.39
 - key drivers 5.37–5.39
 - volume 3.7–3.12
- cosmetic procedures industry
 - business practice models 3.23–3.24
 - challenging claims of 8.4–8.19
 - competition between manufacturers 3.18–3.21
 - demand side pressures 7.24–7.26
 - developmental drivers 3.13–3.17
 - market value 3.4–3.6
 - volume of procedures 3.7–3.12
- Cosmetic Surgery Interspecialty Committee (CSIC) 4.13, Box 4.2
- credentialing Box 4.3, 8.32
- cryolipolysis Box 3.4
- cultural issues
 - body perception 1.12
 - motivation for cosmetic procedures 5.16–5.17
 - normality 6.21
- demand side issues 7.16, 7.21–7.26, 8.1, 8.4–8.22
- dental braces 1.22, Box 3.4
- dental practices
 - botox in 2.16
 - regulation 4.28
- dermal fillers
 - categorisation 1.20, Box 1.6
 - commercial competition 3.18–3.19
 - data available on 1.14, Box 3.1, Box 3.2
 - global market value 3.6
 - Keogh recommendations 4.17
 - marketed as alternative to surgery Box 3.6
 - motivations to use 5.24
 - new uses of Box 3.4
 - prescription-only status 4.39, 8.28
 - regulation 4.4, Box 4.4, 4.27, 4.33, 4.37, 4.39
 - risk of physical harm 6.12–6.13
 - safety and effectiveness issues 7.31
 - self-injection 3.17
 - unregulated products 3.19, 4.33
- designer vaginas 2.9, Box 2.2, 4.50; *see also: female genital cosmetic surgery*
- developmental drivers 3.13–3.17
- digitally-enhanced images 1.12, 8.13
- disability 2.3, 2.4, 4.57, 4.62, 7.6, 7.8, 7.17, 8.9, 8.17, 8.19
- discrimination Box 2.1, 2.5, 2.13–2.15, 4.62, 7.8, 7.17–7.26, 8.4–8.19
- diversity
 - in fashion and beauty industries 2.13
 - promotion 4.57, 8.17
 - society's acceptance of 2.4
- duty 'to make best of oneself', implied 1.13
- ears
 - eartox Box 3.4
 - otoplasty Box 1.6, 5.9, 5.13, 5.25, 5.30
- employment
 - discrimination 2.13
 - labour market 1.12
 - success in 5.15
- empowerment 8.46–8.51
- Endangered Bodies 4.60, 8.15
- enterprising self 1.12
- Equality Act 2010 2.13, 4.62, 8.7, 8.19
- EU regulation 4.34, 4.35, 4.37, 6.15
- expectations 6.8, Box 6.3
 - of outcome / patients 4.17, 4.43, 7.47, Box 8.2, 8.54, 8.56
 - society's / social Box 1.4, 2.2–2.3, 7.9, 7.17, 7.18
 - unrealistic 6.8, 6.19, Box 6.3, 8.16
- face
 - thread lifts Box 3.6
 - types of surgery Box 1.6
 - vampire procedures Box 3.4
- Face Equality 8.17–8.18
- Facebook
 - advertising policy Box 4.9
 - appearance pressures Box 1.4, 8.16
 - campaigning work 8.14
 - educational work 8.14
 - removing inappropriate images 4.61
 - researching a surgeon 5.33
- family-centred approach 7.39

- family
 - influence 5.21–5.23, 6.21, 7.3
 - involvement in decision-making 7.39
- fashion
 - blogs 5.28
 - changes Box 1.1, Box 1.4, Box 2.2, 3.9, 5.29, 8.46
 - diversity in 2.13, 8.17
 - ideals 1.4, 1.13, 2.14
 - industry 2.13, 7.18, 7.22, 8.17
 - responsibilities 7.18
 - working in sector 2.9, 2.13
- fat freezing Box 3.4
- feet fillers Box 3.4
- female body shape Box 1.1
- female genital cosmetic surgery (FGCS) Box 2.2, 3.10, 4.49–4.50, Box 4.6, 5.9, 5.10, 5.13, 5.29, 5.30, 6.5, 7.32, 7.33, 7.34 Box 7.2, 7.33, 8.29
- female genital mutilation (FGM) 1.25, 4.49, Box 4.6, 4.50, 8.29
- Female Genital Mutilation Act 2003 Box 4.6, 4.50, 8.29
- Fixers 8.22
- follow-up 3.21, 4.41, 8.40, 8.53
- 'for themselves', as motivator 5.12
- friends
 - influence of 5.24, Box 6.3, 6.21, 7.18
 - rating on social media by 1.12, Box 1.4
- games 1.12, 4.60, 8.15
- gay community Box 1.1
- gender
 - differences 1.7
 - appearance dissatisfaction 1.7, 1.10
 - appearance judgments 7.17
 - happiness 1.19
 - discrimination 2.14, 4.62, 7.17, 8.19
 - motivation for undertaking procedure 5.7
 - reassignment / assignment 1.25, Box 4.6
 - social structures and norms 1.5, 2.3
 - stereotyping 4.56, 8.10
- General Dental Council (GDC), regulatory body 4.5
- guidance on prescribing 4.10
- General Medical Council (GMC)
 - role in regulating practitioners 4.5, 4.7, 8.30
 - credentialing Box 4.3, 8.32
 - guidance for doctors offering cosmetic procedures 4.6, Box 4.1, 4.7, 4.10, Box 4.2, 4.15, 4.25, 4.47, Box 4.8, 8.33, 8.34, 8.53
 - guidance on prescribing 4.10
 - Keogh report 4.13
 - Specialist Register 4.13
- Gillick* judgment 4.46
- Girlguiding
 - organisation surveys 1.9, 1.11
 - promoting safe social media use 8.14
- global value of cosmetic procedures market 3.6
- glutathione Box 1.6, 3.17, 6.14
- governance
 - of non-surgical procedures 4.5–4.10
 - of surgery 4.11–4.15
 - self-governance 4.11; *see also: self-regulation*
- government intervention 7.19, 7.33; *see also: state*
- GPs
 - models of practice 3.23
 - obtaining patient information from 8.53
 - regulation of practices 4.28, 4.29, 4.30
 - 'special interest' 4.11
- group providers Box 3.1, 3.9, 3.23, 4.43
- gyms 3.23
- happiness 8.5
 - after cosmetic procedures 6.8
 - appearance and 1.12, 1.16–1.19, Box 1.5, 2.11, 6.2, 6.22, 8.4–8.6
 - marketing 7.24
 - motivation for cosmetic procedures 5.10–5.12
- harm
 - 'harm principle' 7.19
 - multiple continuums 7.10–7.16
 - public health 7.21, 7.23
 - physical 2.12, 3.16, 6.9–6.15
 - psychological 2.12, 6.9, 6.16–6.19, 6.22
 - redress 4.40–4.44
 - risk of 6.1, 6.9
 - role of the state 7.21, 7.27
 - to society 2.7, 6.20–6.23, 7.1–7.2
 - types of 2.5
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4.23
- Health Education England (HEE) 4.16–4.18, Box 4.4, 4.19–4.22, 8.35
- Healthcare Improvement Scotland 4.26, 4.31

- home-based procedures 3.16–3.17
- hydroquinone 6.15
- images
 - airbrushed 1.12, 2.14, 8.5
 - digitally-enhanced 1.12, 8.13
 - in advertisement 4.55, 8.8, 8.18
 - of beauty Box 2.1
 - on social media Box 1.4, Box 4.9, 4.63, 8.14
 - sharing 4.59–4.61
- implant card 4.38
- inclusivity 8.9, 8.17
- indemnity insurance Box 4.3, 4.21, 8.28, 8.38
- Independent Sector Complaints Adjudication Service (ISCAS) 4.44, 8.57
- information provision Box 4.1, 8.47–8.49
- Instagram
 - advertising policy Box 4.9
 - posting images on Box 1.4
 - campaign work 4.60, 8.14
 - contribution to appearance anxiety 8.16
 - education work 8.14,
- insurance 3.22, 4.14, Box 4.3, 8.28, 8.38
- International Society of Aesthetic Plastic Surgery (ISAPS), published data Box 2.2, Box 3.1, 3.10, 3.12
- internet
 - examples of online adverts Box 2.3
 - increase in appearance-related images 1.12
 - purchasing products from 3.17, 4.4
- intimate relationships 5.34–5.35
- intimate waxing 4.48, 5.29, 7.40
- Joint Council for Cosmetic Practitioners (JCCP) 4.19–4.21, 8.33, 8.35, 8.37, 8.38, 8.49
- key drivers of cosmetic procedures 5.37–5.39
- knee wrinkles (kninkles) Box 3.4
- labiaplasty Box 1.6, Box 2.2, 3.10, Box 4.8, 5.29
- labour market 1.12
- Latisse 3.14
- leg rejuvenation 2.9, Box 3.4
- lip fillers Box 1.1, 6.6
- local authorities 4.28, 8.37
- looking younger (or older) 5.6
- 'lunch hour' procedures 1.15, 3.16–3.17, 7.34
- lymphoma 6.11
- machine learning 3.15, Box 3.5
- magazines
 - focus on youthful appearance Box 1.1
 - influence on having a cosmetic procedure 5.27
 - young people's perceptions of appearance pressures Box 1.4
- male gay community Box 1.1
- manufacturers of products 3.18–3.21, 3.22, 4.34, 4.35, 4.38, 8.25
- market value of cosmetic procedures sector 3.4–3.6
- media
 - focus on youthful appearance Box 1.1
 - impact on body image 8.8, 8.14–8.16
 - influence on having a cosmetic procedure 5.27
 - young people's perceptions of appearance pressures Box 1.4
- Medical Defence Union (MDU) 8.28
- medical devices
 - definition 4.33
 - regulation 4.34, 4.37, 8.26, 8.27, 8.28
 - use in cosmetic procedures 4.32
- Medical Devices Regulation (MDR) 4.37–4.38, 8.27
- medicalised environment 2.16
- medicines
 - definition 4.32
 - inappropriate access to 8.34
 - licensing 4.32, 4.34
 - prescription 4.4, 4.10
 - regulation Box 4.1, 4.24, 4.33, 4.39, 8.28
- Medicines and Healthcare products Regulatory Agency (MHRA) 4.34, 4.35, 4.38, 8.28
- mental health 2.8,
 - anorexia nervosa Box 6.2,
 - body dysmorphic disorder (BDD) 6.18, Box 6.2
 - children and young people 8.20
 - impact of social media 4.60
 - justification for cosmetic procedure Box 4.6
 - outcomes 6.7, 6.16, 6.18–6.19
 - responsibility of the state 8.6

- mercury 6.15
- Mill, John Stuart 7.19
- Models of Diversity 8.17
- Montgomery* judgment 4.42, Box 4.5
- motivations for cosmetic procedures 1.21, 5.5–5.17, 7.6, 7.9, 7.15, 7.45,
 - influence of parents on 5.21
 - influence of partner on 5.23
- multidisciplinary approach 4.47, Box 7.3, 7.39, 7.40, 8.43, 8.45, 8.53
- multiple continuums 7.10–7.16

- negligence 4.17, 4.40, 4.42, 4.43, 8.56
- neo-liberalism 1.12
- new procedures 3.14, Box 3.4
- new products and techniques 3.15, Box 3.5
- non-health professionals
 - accreditation 4.16
 - offering cosmetic procedures 4.4
 - regulation 4.16–4.22, 4.27, 4.31
- non-surgical cosmetic procedures
 - examples Box 1.6
 - growth in 1.14
 - most popular in US Box 3.3
 - professional regulation 4.5–4.10
- normality 5.8–5.9, 6.21, Box 7.1, 7.7, 7.17
- numbers of cosmetic procedures Box 2.2, 3.7–3.12, Box 3.1, 3.23

- Ofcom 4.51, 4.52, 8.16
- orthodontics 1.22, Box 3.4
- otoplasty Box 1.6, Box 3.2, 5.9, 5.14 5.25, 5.30, Box 6.1

- outcome
 - measures 4.13 Box 4.2, 4.21, 8.28, 8.39–8.40
 - satisfaction with 6.2–6.8
- parents 2.19, 4.46–4.48, 5.21, 7.17, 7.37–7.39, 8.14, 8.42–8.44
- Parliamentary and Health Service Ombudsman (PHSO) 4.44, 8.57
- partners 5.22–5.23
- patient-reported outcome measures Box 4.2
- peer
 - influences Box 1.4, 1.16, 2.18, 3.22, 5.5, 5.8, 6.21, 7.36, 8.22
 - review 7.31, Box 7.2, 8.29
 - support 7.45, 8.53
- penis enlargement Box 1.6, 3.10
- personal, social, health and economic (PSHE) education Box 1.3, 8.21
- physical discomfort 5.30, 6.5, 7.5, Box 8.1,
- physical harm 6.9–6.15
- physical satisfaction 6.5
- picosecond lasers Box 3.5
- PIP implants 2.6, 3.20, 4.1, 4.36, 6.11
- platelet rich plasma (PRP) injections Box 3.4
- political economy 1.12
- Poly Implant Prothèse (PIP) implants 2.6, 3.20, 4.1, 4.36, 6.11
- pornography Box 2.2, 5.29
- post-pregnancy body 1.8, 5.31
- post-production techniques 4.53, 8.13; *see also: airbrushing; digitally enhanced images*
- practitioner / user relationship 7.42–7.49, 8.46–8.57
- PRASIS Box 4.3
- pregnancy 1.8, 5.9, 5.29, 5.31, Box 7.3
- premises, regulation of 4.1, 4.16, 4.23–4.31, 7.28, 8.36–8.38
- prescribing, GMC and GDC guidance 3.17, 4.8, 4.9–4.10
- prescription-only status 4.32, 4.39, 8.28
- Private Healthcare Information Network (PHIN) Box 4.2, 8.39
- private hospitals / clinics 3.23, Box 4.3, 4.23, 8.39
- professional indemnity Box 4.3, 4.21, 8.28, 8.38
- professional regulation 4.5–4.15, 7.28
- Professional Standards Authority (PSA) 4.20–4.21, 4.30, 8.35
- promotion
 - of appearance ideals 1.20, 2.12, 4.2, 8.1, 8.7, 8.22
 - of cosmetic procedures 2.5, 2.9–2.12, 2.17, 3.22, Box 4.1, Box 4.8, 8.1, 8.52
 - of diversity 8.17
- PSHE education Box 1.3, 8.21
- psychological harm 6.9, 6.16–6.19, 6.22
- psychosocial satisfaction 6.4, 6.6–6.8, 6.17, 6.18, Box 6.3, Box 8.2,
- public health 2.5, 2.8–2.12, 7.20
- public policy response 1.9

- quality of life 1.17, Box 4.2, 6.5, 6.7, Box 7.1, Box 7.4
- questions to ask providers and practitioners Box 8.1

- reality television Box 1.4, 5.27
- redress 3.22, 4.40–4.44, 8.38, 8.56–8.57
- regulation
 - access to procedures 4.45–4.50
 - advertising 4.51–4.58, Box 4.9
 - demand side 7.21–7.23
 - enforcement 4.63
 - equality 2.13, 4.62, 7.8, 8.7, 8.19
 - image sharing 4.59–4.61
 - inadequacy of 8.2
 - inconsistency and incoherence 7.28
 - non-health professionals 4.16–4.22, 4.27, 4.31
 - practitioners 8.30–8.35
 - premises 4.1, 4.16, 4.23–4.31, 7.28, 8.36–8.38
 - products and devices 4.32–4.39
 - professional 4.5–4.15, 7.28
 - providers 8.38
 - redress 3.22, 4.40–4.44, 8.38, 8.56–8.57
 - safety 7.27–7.35, 8.23–8.40
 - self-regulation 7.22, 7.23
 - supply side 7.27–7.41, 8.23–8.40
 - who can provide cosmetic procedures 4.3–4.4
- Regulation of Care (Scotland) Act 2001 4.31
- religious beliefs 1.25, 7.3
- repurposed procedures 3.14, Box 3.4, 7.35
- research and development 3.13–3.17, 8.55
- risks 6.9–6.23
 - multiple continuums 7.13
 - versus benefits 7.29–7.30
- rituals 1.25, Box 4.6
- role models 5.18–5.35, 8.17
- Royal College of Obstetricians and Gynaecologists (RCOG) 4.11, Box 7.2, 8.29
- Royal College of Surgeons (RCS)
 - outcome measures 8.39
 - certification system Box 4.2, 8.32, 8.38
 - Cosmetic Surgery Interspecialty Committee (CSIC) 4.13, Box 4.2
 - Guidance on cosmetic practice 4.25, 8.53
 - information for prospective patients 8.48, 8.49
 - recommendations for 8.24, 8.32
 - regulation 8.30
- safety issues 7.27–7.35, 8.23–8.40
- sales staff 8.51, 8.54
- satisfaction with outcomes Box 3.4, 5.1 6.1–6.8
- schools Box 1.3, 8.21, 8.22
- Scotland, regulation in 4.22, 4.26, 4.31
- Scottish Cosmetic Interventions Expert Group (SCIEG) 4.31
- scrotox Box 3.4
- self, neoliberal notions of 1.12
- self-employed health professionals 3.23, 4.43, 8.57
- self-esteem 1.10, 1.16, 2.18, 5.6 5.10–5.13, 5.18, 6.3, 6.6, Box 6.1, 8.5, 8.14
- self-injection 3.17
- self-monitoring apps 1.12
- self-regulation 4.15, 4.51 7.22, 7.23
- self-worth 1.18, 5.27 6.22
- sex life 5.34–5.35, 6.5
- shared decision-making 4.17, 7.37, 7.47–7.49, 8.53, Box 8.2
- skin colour 1.12, Box 2.1, 5.17, 8.13
- skin lightening products 3.17, 5.17, 6.14–6.15
- Snapchat
 - advertising policy Box 4.9
 - impact on perceptions of appearance Box 1.4, 8.16
- social acceptance 6.22
- social context 1.1–1.5, Box 1.1, 1.17, 7.16, 8.1, 8.4–8.22
- social ideals 5.16–5.17
- social media
 - advertising 4.53, 4.58, Box 4.9, 5.37
 - image sharing 4.59–4.61
 - impact on appearance dissatisfaction 1.9, Box 1.3, 1.12, 1.16, 6.21, 7.36, 8.16
 - increase in appearance-related images 1.12
 - influence on having a cosmetic procedure 2.11, 5.28
 - input to this report 2.1
 - use in awareness raising 2.1
 - wider context 2.2, 4.63
 - young people's perceptions of appearance pressures Box 1.4
- social responsibility 4.55, 7.22, 7.44, 8.6, 8.12, 8.49
- society
 - acceptance of diversity 2.4
 - attitudes to disability 2.4, 8.9

- harms to 6.20–6.22
- pressures to conform to appearance
- ideals 2.15
- young people's perceptions of appearance pressures Box 1.4
- spas 2.16, 3.23
- Specialist Register (GMC) 4.13, Box 4.2
- state
 - responsibility to protect from harm 8.30
 - responsibility towards children and young people 2.19, 7.36–7.37, 7.41, 8.20–8.22, 8.41
- stewardship model 7.19–7.21, 7.23, 7.27, 7.36, 8.6, 8.7
- sunbeds 2.19, 4.48, 7.12, 7.40, 8.41
- supply side issues 7.16, 7.27–7.41, 8.1, 8.23–8.40
- surgical cosmetic procedures
 - examples Box 1.6
 - professional regulation 4.11–4.15
- tattoos 1.2, 1.22, Box 3.5, 4.48, 8.41
- teasing 5.25, 8.14
- teeth alignment 1.22, Box 3.4, 7.17
- television
 - impact of appearance-related images 1.12, box 2.1, 8.16
 - influence on having a cosmetic procedure 5.27
 - young people's perceptions of appearance pressures Box 1.4
- therapeutic procedures
 - distinction from 'cosmetic' procedures 1.21, 1.23, 2.12, 7.2–7.5, 7.10, 7.15, 7.24, 7.29, 7.34, 7.48
 - repurposing of Box 3.4, 7.25, 7.35
- thread lifts Box 3.6
- three-dimensional printing 3.15, Box 3.5
- toys Box 1.4
- training
 - access to 8.32, 8.53
 - initiatives Box 2.2, Box 4.3, Box 4.4
 - lack of programmes 4.12
 - provision of 3.22, 4.16, 4.18, 8.55
 - standards 4.13, Box 4.2, 8.35
 - young people 8.22
- Training Interface Group (TIG) Box 4.3
- Transport for London (TfL) 4.57, 8.11, 8.13
- trust-based practice 2.17, 7.1, 7.24–7.26
- 'tweakments' 3.16
- tweets 1.12, 4.52, 4.59
- Twitter,
 - advertising policy Box 4.9
 - impact on appearance anxiety 8.16
- UK Safer Internet Centre 8.14, 8.22
- unrealistic expectations 6.8, 6.19, Box 6.3, 8.16
- values 1.12, 1.17, Box 1.5, 2.3, Box 4.9, 5.17, 5.19, 7.38, 8.46
- vampire procedures Box 3.4
- visual diet 1.12
- volume of cosmetic procedures 3.7–3.12
- voluntary sector 8.22
- workplace
 - discrimination 2.13
 - pressures 5.15
- young people: *see children and young people*
- YouTube
 - advertising policy Box 4.9
 - impact on appearance anxiety 8.16