Anonymous

NUFFIELD COUNCIL ON BIOETHICS

Cosmetic procedures: ethical issues

Call for evidence

11 January 2016

(Closing date: 18 March 2016)

Introduction

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

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

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

Definitions and aims

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

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

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

Questions 1-3

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

   The main criterion is that the procedure is intended primarily to improve someone's physical appearance, as judged against either the prevailing aesthetic norms of their community, or against their own perception of what would count as an aesthetic improvement. A cosmetic procedure, on this account, could also have a 'medical' justification or provide some kind of 'medical' benefit, but typically when a procedure is described as 'cosmetic' it is because the *primary* intention is (perceived) aesthetic improvement.

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?**

   See above. One interesting scenario is when different social groups have different aesthetic standards. Among other surgeries, what I focus on in my own ethics research are non-therapeutic modifications of children's genitals (whether male or female, or indeed intersex). Typically, parents elect these procedures for their

children, among other reasons, because they believe they will *improve the aesthetic appearance of their child's genitals*. But this can be problematic for a number of reasons: (1) we don't yet know what kind of genital aesthetics the child itself will adopt upon reaching sexual maturity (aesthetics are often highly individualized; different people prefer different "cosmetic" outcomes, and are also willing to undertake different degrees of risk to achieve such outcomes, which suggests that these procedures should typically be delayed until the individual whose 'private parts' are on the line is in a position to make an informed judgment about whether the risks of surgery are 'worth it' to them, all things considered, in light of *their own* views about what is aesthetically appealing); and (2) different cultural groups sometimes have, on average, different views about what is aesthetically enhancing: in multi-cultural societies where children may later dis-identify with the cultural/religious group of their parents, again, it is better to refrain from irreversible surgeries carried out for perceived aesthetic enhancement in light of the perceived standards of the parents' cultural/religious group: the child can always undertake the surgery later, if it really does endorse the particular (perceived) aesthetic norm of a given group; but the child who does *not* endorse such norms, but who has nevertheless had a permanent alteration carried out on its body, has no recourse. Some key papers making these and similar points in some detail that should perhaps be consulted are these:

Carmack, A., Notini, L., & Earp, B. D. (in press). Should surgery for hypospadias be performed before an age of consent? *Journal of Sex Research*, in press. Available at https://www.academia.edu/13117940/Should_surgery_for_hypospadias_be_performed_before_an_age_of_consent

Earp, B. D. (in press). Between moral relativism and moral hypocrisy: Reframing the debate on "FGM." *Kennedy Institute of Ethics Journal*, in press. Available at https://www.researchgate.net/publication/280080464_Between_moral_relativism_and_moral_hypocrisy_Reframing_the_debate_on_FGM

Earp, B. D. (2015). Sex and circumcision. *American Journal of Bioethics*, Vol. 15, No. 2, 43-45. Available at https://www.academia.edu/9404847/Sex_and_circumcision.

Earp, B. D. (2015). Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework. *Medicolegal and Bioethics*, Vol. 5, No. 1, 89-104. Available at https://www.dovepress.com/female-genital-mutilation-and-male-circumcision-toward-an-autonomy-bas-peer-reviewed-article-MB

Earp, B. D. (2016). In defence of genital autonomy for children*. Journal of Medical Ethics*, Vol. 41, No. 3, 158-163. Available at https://www.researchgate.net/publication/285578712_In_defence_of_genital_autonomy_for_children

Maslen, H., Earp, B. D., Cohen Kadosh, R., & Savulescu, J. (2014). Brain stimulation for treatment and enhancement in children: An ethical analysis.

Frontiers in Human Neuroscience, Vol. 8, Article 953, 1-5. Available at http://journal.frontiersin.org/article/10.3389/fnhum.2014.00953/abstract

Svoboda, J. S. (2013). Promoting genital autonomy by exploring commonalities between male, female, intersex, and cosmetic female genital cutting. *Global Discourse*, *3*(2), 237-255. Available at http://www.tandfonline.com/doi/abs/10.1080/23269995.2013.804757

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?

Key considerations are: (1) is the intervention carried out under conditions of informed consent (in which case, in my view, people should have wide latitude to modify their bodies through biomedical or non-biomedical means; see, e.g., Earp, B. D., Sandberg, A., Kahane, G., and Savulescu, J. (2014). When is diminishment a form of enhancement? Rethinking the enhancement debate in biomedical ethics. *Frontiers in Systems Neuroscience*, Vol. 8, Article 12, 1-8. Available at http://journal.frontiersin.org/article/10.3389/fnsys.2014.00012/abstract); and (2) is the procedure *reversible* – the thing that often makes surgical interventions more suspect is that they cannot easily be undone if, in the adult case, the person simply regrets having undergone the intervention, or, in the case of parents making a change to the bodies of their children, the child grows up to resent what was done to them. Hair can grow back if it is cut; clothes can be changed; but in the case of a contested genital surgery, say, male circumcision, the foreskin is lost forever.

Increasing demand for cosmetic procedures

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

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

The substantial increase in the number of cosmetic procedures performed has led to some commentators to argue that these procedures are becoming 'normalised': that is, that both cosmetic surgery, and invasive non-surgical procedures such as the use of injectable fillers and Botox, are increasingly perceived as routine, rather than exceptional, ways of changing one's appearance.[7] This perception has, in turn, led to concerns that what is regarded as a desirable, or even acceptable, appearance may become increasingly narrow, increasing pressure on those whose appearance does not conform to these norms, and reinforcing stereotypes with respect to factors such as age, gender, sexuality, race, ethnicity, class, disability, and disfigurement.[8] It is also argued that the risks involved are increasingly likely to be overlooked or downplayed, if having a procedure is seen as something 'normal' or 'routine'.[9] In contrast, others take the view that the increasing use of cosmetic procedures should be seen as positive and empowering: enabling people to access procedures to change aspects of their appearance that they do not like, or that cause them distress.[10]

Questions 4-8

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

   There is a lot of money to be made in convincing people that their bodies are "abnormal" or "ugly" – preying on their self esteem – and then offering them a

"solution" to the problem in the form of cosmetic surgery. Now, I do think that adults, all else being equal, should be able to modify their bodies in accordance with their own considered values, if they are willing to take on the relevant risks, and if they are doing so under conditions of truly informed consent. But I also strongly support educational and social/cultural campaigns to combat invidious social norms that cause people to feel ugly or need of surgery in the first place, based on arbitrary aesthetic standards, or standards that disproportionately disadvantage individuals on the basis of their sex or gender. For related discussion see:

Earp, B. D. (2014). Hymen 'restoration' in cultures of oppression: How can physicians promote individual patient welfare without becoming complicit in the perpetuation of unjust social norms? *Journal of Medical Ethics*, Vol. 40, No. 6, 431. Available at https://www.researchgate.net/publication/238427747_Hymen_'restoration'_in_cultures_of_oppression_How_can_physicians_promote_individual_patient_welfare_without_becoming_complicit_in_the_perpetuation_of_unjust_social_norms

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

Typically, it is better to change structural forces and problematic social norms that drive people to undertake risky surgeries in the first place, and this should be a priority. At the same time, some individuals will conclude that, all things considered, undertaking a surgery will help bring their appearance in line with their own values, and they should be able to do this, based on respect for autonomy. For a related discussion see:

Earp, B. D., Sandberg, A., & Savulescu, J. (2015). The medicalization of love. *Cambridge Quarterly of Healthcare Ethics*, Vol. 24, No. 3, 323–336. Available at https://www.academia.edu/7066855/The_medicalization_of_love

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

If people are constantly bombarded with (financially motivated) advertisements suggesting that they are ugly, need changes to their body to be perceived as attractive/valuable to others, and so on, then, of course, this can lead to a sort of self-fulfilling prophesy whereby the standards of appearance continually shift toward something that can only really be achieved, in most cases, with exactly the sort of surgery that is being hawked by these financially motivated providers. So there are good reasons to try to limit advertising of this kind, and to engage in proactive social and education campaigns to address invidious/ unjust/ unrealisitic norms of physical appearance.

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

The person to judge should be the person undergoing the surgery, and this should be done under conditions of informed consent.

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

Not really … I see such advertising as being much more aggressive in the U.S. compared to the U.K., but this is a non-scientific sample.

The supply and regulation of cosmetic procedures

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

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

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

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

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

- Health Education England has been commissioned by the Department of Health to develop accredited qualifications for providers of non-surgical procedures, and its final report, including implementation proposals, was published in January 2016.[14]
- The General Medical Council (GMC) is developing a system of 'credentialing' so that doctors with a credential in a particular field of practice, such as cosmetic practice, can have this recorded in their entry on the medical register.[15] The GMC has also issued draft ethical guidance for all doctors who offer cosmetic procedures.[16]
- The Royal College of Surgeons has established a Cosmetic Surgery Interspecialty Committee (CSIC) with a remit to develop standards for training and certification across the range of specialties offering cosmetic surgery; develop high quality patient information; and develop clinical outcome measures.[17]

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

Questions 9-15

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

   "Patient" seems an inappropriate label for someone seeking a 'purely' cosmetic procedure.

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

    Individuals *must* be fully apprised of the risks of the procedure, and also, with the option of *no surgery* (and any alternatives to surgery that are less risky that could be pursued instead).

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?**

    Cosmetic surgeries carried out on especially very young children should be regarded with extreme skepticism and caution, if they can be delayed until such a time as the child can determine what is in his/her own best interests.

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

    The test I have proposed is this: if the surgery can be delayed without losing the very properties that are supposed to make it an enhancement in the first place, and if the very status of the intervention *as being* an enhancement (as opposed to a diminishment or even a mutilation) is contentious, then it should ideally be delayed.

Detailed arguments for this view, with supporting examples, are in the following papers:

Earp, B. D. (in press). Between moral relativism and moral hypocrisy: Reframing the debate on "FGM." *Kennedy Institute of Ethics Journal*, in press. Available at https://www.researchgate.net/publication/280080464_Between_moral_relativism_and_moral_hypocrisy_Reframing_the_debate_on_FGM

Maslen, H., Earp, B. D., Cohen Kadosh, R., & Savulescu, J. (2014). Brain stimulation for treatment and enhancement in children: An ethical analysis. *Frontiers in Human Neuroscience*, Vol. 8, Article 953, 1-5. Available at http://journal.frontiersin.org/article/10.3389/fnhum.2014.00953/abstract

Earp, B. D. (2016). In defence of genital autonomy for children*. Journal of Medical Ethics*, Vol. 41, No. 3, 158-163. Available at https://www.researchgate.net/publication/285578712_In_defence_of_genital_autonomy_for_children

Earp, B. D. (2015). Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework. *Medicolegal and Bioethics*, Vol. 5, No. 1, 89-104. Available at https://www.dovepress.com/female-genital-mutilation-and-male-circumcision-toward-an-autonomy-bas-peer-reviewed-article-MB

Carmack, A., Notini, L., & Earp, B. D. (in press). Should surgery for hypospadias be performed before an age of consent? *Journal of Sex Research*, in press. Available at https://www.academia.edu/13117940/Should_surgery_for_hypospadias_be_performed_before_an_age_of_consent

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

Yes – they should be trained and certified to the level of any surgeon or doctor who would be performing such surgeries or comparable surgeries for so-called "medical" reasons.

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?**

Too lax.

Different parts of the body

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

Questions 16-18

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

I have argued that interventions into the genitalia are specifically problematic and should be discouraged before an age of consent. The following quotation is from this paper: Earp, B. D. (2015). Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework. *Medicolegal and Bioethics*, Vol. 5, No. 1, 89-104. Available at https://www.dovepress.com/female-genital-mutilation-and-male-circumcision-toward-an-autonomy-bas-peer-reviewed-article-MB

The question of rights is arguably central to this issue. In Western societies, we teach our citizens (including our children) that they have a right to bodily integrity:[117] "a right to make decisions about what happens to [their] own body, [a] right to say no to unwanted touching, [a] right not to be physically or sexually assaulted."[136] This, Ludbrook argues, is "the most personal and arguably the most important of all human rights," next to the right to life itself.[136] Some authors have argued that FGA performed before an age of consent is a violation of such a right, "regardless of the degree of cutting or the extent of the complications that may or may not ensue."[1] Undoubtedly, such a view is motivated at least in part by the fact that such cutting involves a very "private" part of the body – ie, a part with unique psycho-sexual significance – and that it is done before a girl can understand what is at stake in such a procedure, much less offer effective resistance. Indeed, genitals are not like other parts of the body. This can be seen in the fact that sexual assault, in Western societies, is typically regarded as a more severe and more personal violation than other kinds of bodily assault. Accordingly, the outright cutting and/or alteration of a child's genitals seems much more likely to be the sort of interference that would later be experienced as a harm, compared against various other childhood bodily alterations that are sometimes raised in the literature.

A child's right to bodily integrity: genital cutting vs. other alterations

Consider vaccinations, which some authors have suggested are morally, or even physically, equivalent to male circumcision.[137] Against this view, critics point out that vaccination does not remove erogenous tissue (nor any healthy tissue), nor does it risk harming sexual function, sensation, or satisfaction. In addition, it does not result in a visible change to the appearance of the body, much less a part of the body with respect to which aesthetic norms, feelings of self-esteem, etc, vary considerably from person to person, and often inspire very strong feelings.[62,137,138]

Orthodontic treatment is another childhood bodily modification that is sometimes compared with genital cutting.[139] Similar to vaccinations, dental braces do not remove nor risk damaging erogenous tissue,[k] and (moreover) they are usually put on with the age-appropriate consent of the affected individual. Although braces may be uncomfortable, and although they do make a difference to physical appearance, both the degree of discomfort and the type of alteration to appearance fall well within the child's understanding. In contrast, the permanent modification of genital tissue prior to an age of sexual debut is not something whose significance a child of any sex or gender is in a position to fully understand.[11]

Finally, consider minor cleft lip repair – another common "analogy" to male circumcision.[31] While this is typically done before a child understands what is at stake in the procedure, it likewise does not remove functional tissue that he or she might later value (and wish to have experienced intact); indeed, it is universally regarded as a means of repairing a defect and thus as a form of cosmetic enhancement. This is in contrast to both FGA and MGA, whose respective statuses as being enhancements (as opposed to diminishments,[140] or even mutilations[106,138]) are contentious even within the societies in which they have traditionally been performed.[11,37,58]

These (and other) differences between genital cutting and other types of body modification may help to explain why there is an active "genital autonomy"[141] movement in the United States, Europe, and elsewhere that is fueled by women, men, and intersex people who are extremely resentful about their childhood genital surgeries, but not an anti-orthodontics movement or an anti-cleft lip-repair movement.[23] (There is, of course, a very controversial anti-vaccination movement, but this is motivated, not by concerns about violations of a child's right to bodily integrity, but rather by unfounded concerns about vaccines contributing to an increased risk of autism and other problems).

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?**

For detailed discussion of just this point, please see: Earp, B. D. (in press). Between moral relativism and moral hypocrisy: Reframing the debate on "FGM." *Kennedy Institute of Ethics Journal*, in press. Available at

https://www.researchgate.net/publication/280080464_Between_moral_relativism_and_moral_hypocrisy_Reframing_the_debate_on_FGM

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

See above discussion and reference, see also: Earp, B. D. (2015). Sex and circumcision. *American Journal of Bioethics*, Vol. 15, No. 2, 43-45. Available at https://www.academia.edu/9404847/Sex_and_circumcision

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.