BMA House
Tavistock Square
London WC1H 9JP

T 020 7383 6447

E jsheather@bma.org.uk

Kate Harvey
Senior Research Officer
Nuffield Council on Bioethics
28 Bedford Square
London
WC1B 3JS

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Nuffield Council on Bioethics – Cosmetic procedures: ethical issues

Dear Ms Harvey

Introduction

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow every year.

Thank you for inviting the BMA to respond to your call for evidence concerning the ethical issues raised by cosmetic procedures. The issues are complex and on many of them we do not have established policy. Rather than addressing the questions one at a time we have drafted a more general thematic response that inevitably raises more questions than it gives answers. Our principal concerns are to do with the protection of those who seek cosmetic interventions. As many of these interventions take place in the private sector, this is an area that gives rise to complex and controversial questions about the scope of individual freedoms in a liberal market economy. It is also an area in which appropriate regulation is required to ensure both the skill and safety of practitioners, and to ensure that anyone seeking these interventions is given reasonable, balanced and accurate information about the risks, benefits and likely outcomes of any intervention.

Definitions

As your paper suggests, it is unlikely to be possible to draw a clear distinction between cosmetic and therapeutic interventions, nor between interventions that have some 'clinical' dimension

and more everyday high street 'beauty' interventions. In some ways this mirrors the definitional uncertainties associated with concepts of illness and disease themselves. Bodily features within ordinary distribution ranges can be the cause of disabling distress in some people and there may therefore be some therapeutic justification for an intervention that, in other circumstances, may be purely cosmetic. Ideals concerning human appearance, and to some degree concepts of ordinary human functioning, are subject to cultural change. It is likely as well that media representations can bring about rapid social change and make people feel under pressure to live up to unrealistic ideals. Predominantly cosmetic interventions that may once have been out of the ordinary, such as dental braces, can become routine. Where interventions involve no, or only minimal, risk, their becoming routine need not be problematic. Where entirely cosmetic procedures that do involve risk become routine, or are increasingly seen as 'normal' or desirable, then this would give rise to ethical concerns.

Accepting this complexity, our focus in this response is on interventions involving health professionals – and medical skills – and on those interventions that may present risks of harm.

Autonomy and the limits of personal choice

Ordinarily therapeutic interventions arise as a result of clinical need. A health deficit of some kind is identified by patients and clinicians, and the latter will recommend appropriate treatment to the patient. Cosmetic procedures are different. Individuals seeking to enhance aspects of their bodies or wellbeing will actively seek out professionals who will be willing to provide the necessary service. Although some of these interventions have become reasonably 'mainstream', there have been anecdotal stories in the popular press of people seeking surgery to change their appearance in ways that many would find extreme. The French artist Orlan for example underwent a series of surgical operations in order that her face might resemble famous portraits including the Mona Lisa and Botticelli's Venus.[i] Women remain by far the largest users of cosmetic enhancement. Again there is anecdotal evidence that some enhancements are extreme. This inevitably gives rise to questions of considerable importance to health professionals. For example, given the possible risks associated with some interventions, is there or should there be, a limit to the scope of personal choice of competent adults in relation to cosmetic interventions? If there should be, where should that limit arise and on the basis of what criteria? Is it enough that practitioners should have appropriate skills, that there is a reasonable chance that an intervention will succeed and the patient is competent to choose? It is not clear that there are easy or straightforward answers to these questions although given their importance, we are pleased that the Nuffield is addressing them.

The Nuffield paper raises the question of the motives of those who seek cosmetic interventions and asks whether it is possible, or desirable, to discriminate between them. If somebody wants to look more 'normal', is that more acceptable than someone who seeks to stand out? This is not something we have a view on, but on a practical level it can be extremely difficult, if not impossible, for health professionals to identify, and also morally to assess, the motives of those who seek cosmetic interventions. It is also questionable whether this can ever be a proper role for a health professional.

Impaired capacity

We have particular concerns where individuals may have some impairment of capacity or the presence of some mental or psychological impediment or impairment that might influence their

decision making in ways seriously at odds with their wellbeing. Although this is a challenging area it seems quite natural to raise concerns about the extent to which the presence of a mental disorder, such as depression, should be taken into account when individuals are seeking interventions. Although we do not have policy on this issue, it may be that, as in other areas of practice, there may need to be a role – or a requirement – for some kind of professional and independent assessment where there may be doubts about an individual's ability to consent to the intervention in question. Perceived or actual conflicts of interest might arise for example where a practitioner who would ordinarily assess an individual's capacity to consent may benefit financially from the outcome of the assessment. These issues are likely to be particularly challenging where functional decision-making capacity appears unimpaired, but there may be some underlying psychological concerns.

Children and young people

Normative pressures on appearance seem increasingly to be affecting younger and younger people. When considering the limits of choice, the extent to which children and young people should be able to choose to undergo cosmetic interventions is critical. It can be helpful to distinguish between young people with the capacity to consent on their own behalf – Gillick competent young people – and those for whom parental consent would be required. Both cases however give rise to significant questions about whether purely cosmetic interventions would ever be appropriate for this age group, given that their bodies may still be growing and they may be emotionally and psychologically immature. It may be worth considering therefore whether there should be a minimum age limit, both in terms of whether individuals can consent to cosmetic interventions on their own behalf, and in terms of the scope of parental consent on behalf of children.

How free are free choices?

The call for evidence draws attention to a number of rapid cultural changes that are taking place in the west that may be linked to the increased uptake of cosmetic procedures. These include the use of social media, the proliferation of pornography and pornographically-inflected images and the increasing sophistication and availability of cosmetic interventions. Individual choices, particularly among the young, can be strongly influenced by cultural norms and expectations. It could therefore be argued that there are aspects of contemporary culture that may act to some degree coercively to encourage people to undergo cosmetic procedures, particularly the young and vulnerable. Freedom of choice always takes place against a more or less enabling background. Too exclusive a focus on individual decision-making freedom may fail to take into account strong contextual pressures. These issues are complex and raise challenging questions about the legitimate scope of (usually adult) personal freedom in liberal democracies. Commercial organisations, including private providers of cosmetic interventions can however utilise powerful marketing techniques to encourage people to use their services. Although restricting freedom may be contentious, providing realistic, objective, scientifically-based information about body norms, the balance of risks and benefits in relation to cosmetic interventions, as well as realistic information about the likely outcomes can help balance 'informational asymmetry' and is less likely to be contentious. In this way medical and professional bodies could be said to be supporting rather than restricting autonomous choices.

Body areas of particular concern

The call for evidence draws attention to interventions in parts of the body that are often regarded as particularly culturally or personally sensitive, such as, for example, male and female genitalia and female breasts. Our ethics committee has discussed in some depth the ethical issues arising in relation to female genital cosmetic procedures. It is important to distinguish between surgical interventions undertaken to change healthy female genitalia, and reconstructive surgery to repair the effects of prior FGM. We have also sought clarification several times of the lawfulness of these interventions in relation to the Female Genital Mutilation Act (2003) without success and in our guidance we refer practitioners to the Act's explanatory notes. These make it clear that such surgery will be lawful where it is necessary for the patient's physical or mental health.[ii] Concerns have also been expressed by some about the alleged proximity of female genital cosmetic surgery to female genital mutilation, while others regard the interventions as distinct in important ways. This is an area in which regulation has struggled to balance individual freedom with strongly felt moral requirements to protect vulnerable girls and women. Questions naturally arise as to whether there are important moral distinctions between certain areas or parts of the body such that cosmetic interventions in some areas may require greater scrutiny or regulatory control. On the face of it though it is not easy to grasp where those distinctions might lie. Linked to the section above, the RCOG has also expressed particular concerns about the increasing numbers of young women seeking cosmetic genital surgery.[iii]

Regulation and supply

We have seen that the distinction between cosmetic and therapeutic interventions is not precise. In addition, some explicitly cosmetic interventions clearly deploy medical skills – cosmetic rhinoplasty and breast augmentation for example – while others are less obviously medical. Piercing, tattooing and the use of cosmetic sunbeds require no medical involvement at all and tend to have commensurately fewer associated risks – although they are not risk free. As mentioned above, therapeutic medical interventions are (to put it simply) ordinarily governed by consent, or, in the case of adults lacking capacity to consent to the intervention, best interests. Cosmetic medical interventions tend to be initiated by patients and are driven more by the wants and desires of patients than objective assessments of what might be in their interests. Although doctors practising cosmetic surgery in the UK will need appropriate skills, the use of those skills is not therapeutically constrained. This can present regulatory challenges. In addition, although cosmetic surgery can be regulated domestically, it is an increasingly global market and individuals can travel to seek interventions that may not be available at home.

During a recent discussion, our ethics committee raised questions about levels of appropriate training and regulation across the range of cosmetic interventions. Practitioners of aesthetic surgery procedures can pay to register with the British Association of Plastic Surgery (BAPS) or the British Association of Aesthetic Plastic Surgeons (BAAPS). This registration however, does not by itself guarantee a certain standard of training and expertise, particularly if the member carries out procedures on an irregular basis. An unregistered practitioner carrying out procedures on a much more regular basis may, in fact, provide a safer standard of care. If there is to be increased regulation in this field, then the introduction of a 'cooling off' period after an initial consultation should be explored as a useful safeguard for patients.

Advertising

We have mentioned earlier the potentially coercive effects of culture on the uptake of cosmetic interventions, particularly among the young. Advertising can be a powerful tool to influence choice and direct-to-consumer advertising of cosmetic interventions is increasing. During a recent discussion our ethics committee expressed concern about the potential for advertising campaigns for cosmetic interventions to target vulnerable people and this may be an area for the advertising standards regulator to consider. The ethics committee also argued that companies which provided cosmetic products and make-up also had a role to play in encouraging women to use products which had no side effects, in preference to more risky surgical or non-surgical procedures.

Yours sincerely

Raj Jethwa
Head of Public Health and Healthcare Delivery
Policy Directorate

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[i] http://www.theguardian.com/artanddesign/2009/jul/01/orlan-performance-artist-carnal-art
[ii] http://www.legislation.gov.uk/asp/2005/8/notes/division/3/1.
[iii] www.rcseng.ac.uk/publications/docs/professional-standards-for-cosmetic-practice/