This response was submitted to the call for evidence issued by the Nuffield Council on Bioethics' Working Party on Cosmetic procedures. Responses were gathered from 11 January to 18 March 2017. The views expressed are solely those of the respondent(s) and not those of the Council.

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Cosmetic Procedures: Ethical Issues

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

We suggest that the term 'cosmetic procedure' should encompass any procedure which is aimed at enhancing, improving or altering physical appearance and involves piercing and/ or breaking the skin in providing that procedure. Surgical procedures would thus fall within this definition, as would fillers and Botox. Chemical peels or skin-lightening would not, however, fall within this definition. We distinguish not only between the type of procedure but also the objectives or motivations behind it. Where a procedure is sought primarily for aesthetic reasons (rhinoplasty to 'correct' a crooked nose which does not impair breathing), this is a cosmetic procedure. In contrast, where there are therapeutic objectives or motivations, this is not a cosmetic procedure. Breast reconstruction following mastectomy would therefore not count as a cosmetic procedure but rather it would be a reconstructive procedure. While the same surgical procedure and technique may be employed as where breasts are enlarged because of a desire for larger breasts, with reconstruction the surgery is, essentially, sought to put the woman in the situation she was in prior to the mastectomy.

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?

Utilising our definition of cosmetic procedures outlined in (1) above, we suggest that the underlying aim of cosmetic procedures for those seeking a procedure (a), is to achieve a more attractive and/or youthful appearance or an appearance which is more 'ideal' in their view. The aim is thus both subjective and individual-specific. With regards to those providing the procedures (b), we see the underlying aim to be making money. The majority of cosmetic procedures are provided by private providers, rather than the NHS, and are thus commercial

enterprises. Those providing the procedures do so as their job which they need to earn money. There may be an element of providing a service and 'doing good' - helping those who are unhappy with their appearance or an aspect of it – but we suggest that profit is the underlying aim.

The underlying aims may differ for different social groups and this can be seen in the type and nature of the cosmetic procedures requested and performed. In some social groups, having obvious procedures is seen as a sign of wealth and success (exaggerated lips and breasts etc) and also enables those having had them to perform certain, highly sexualised perhaps, gender roles. There is thus a link to status in some groups and being able to afford to have and having such procedures is something to work towards. In other social groups, there is more emphasis on subtle alterations or enhancements, with the aim being to restore a more youthful appearance and to do it more 'naturally'. A group 'in-between' can also be identified, where the aim is not to be so sexualised but at the same time to be noticeably altered. People are supposed to notice and to comment on 'how well you look'.

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?**

Yes because a biomedical or surgical procedure involves an invasion of the body (breaking the skin) and this may be permanent. Any invasion of the body is legally recognised as potentially harmful and risky and where surgery is performed the risks are particularly significant, which is one of the reasons why consent is valued so highly. However, from a legal perspective, consent alone does not render harmful interventions lawful unless they are medical justified. We have questioned whether the assumption that medical public policy justifications automatically apply to non-therapeutic cosmetic surgery – thus making such surgery legitimate because it is proper medical treatment - is a sound and desirable assumption (see S Fovargue, A Mullock (eds) , *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routledge, 2015) http://www.routledge.com/books/details/9781138819634/).

The involvement of others (health care or otherwise, qualified or not) is also different in the biomedical/surgical context as opposed to clothes, hair and make up. There are important ethical considerations involved in providing such interventions that are not present in superficial beauty enhancements.

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

We see media, celebrities, peer pressure and adverts as all contributing to the increasing demand for cosmetic procedures. These combine to make it seem more 'normal' to have such procedures. The fact that Botox and fillers etc are now more affordable is also important and again make it appear that using them is 'normal' ('why would they be so cheap and accessible if there was anything wrong with them?'). While we are living longer, there is a tension between this longevity and youth culture – 'growing old gracefully' is no longer seen as an appropriate response to being 40, 50, 60, 70 etc. At 40 we (predominantly women) must look no older than 30, at 50 we can be thought of as 40ish and so on. There is a lack of respect for age as in other cultures and there is a sense that older people and older looking people are becoming invisible in our society.

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

We are unclear here whether 'undertake cosmetic procedures' refers to the person performing the procedure or the person requesting it. If it is the person performing it, then the proliferation of places offering cosmetic procedures would suggest that it is becoming more routine. This is of concern to us because of the lack of regulation in this area and evidence of less than ideal practice, particularly around consent and information provision. Nevertheless, it is becoming more 'normal' for practitioners (health care or otherwise, qualified or not) to offer such procedures. We suggest that cosmetic procedures, especially surgery, do not fall within the legal exception to the criminal law of proper medical treatment because they are not medically justified and thus require a separate regulatory regime.

From the perspective of the requester, it appears to be more 'normal' for people to ask for cosmetic procedures, particularly non-surgical procedures. Any shame or stigma that may once have surrounded such requests appears to have diminished for many.

The ethical issues raised by this include matters of safety and risk, consent, responsibility (is it an acceptable thing for the person performing it to do?), the perpetuation of

the idea that it is 'normal' now to have cosmetic procedures and that these are a demonstration of beauty. There are also issues with such procedures being culturally harmful and the possibility of stigma if don't do it and remain 'unenhanced' and so less attractive, not performing appropriate gender role etc. Furthermore, it is surely a matter of ethical concern if there is a sense of 'anything goes' as long as you can pay for it. This appears to be the direction of travel.

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?**

We have addressed points re: age and gender in (2) and (4) above. With regards to race, there are undoubtedly culturally specific-issues and pressures re: certain cosmetic procedures and unhealthy stereotypes which impact certain races. We are less clear with regards to disability, although we note that some parents have sought surgery for their children with Downs in order to help them look more 'normal'.

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

Excluding procedures which have a therapeutic motivation from our focus, our answer is 'no' - all motivations should be regarded in the same way using our definition of cosmetic procedure in (1) above. We do, however, recognise that some procedures (e.g. rhinoplasty to reduce a very large nose, breast reduction or modest breast implants) may be viewed generally as more socially acceptable, understandable and justifiable than extreme cosmetic surgery, such as having very large breast implants or extreme and obvious facial surgery. Social judgements are unavoidable and part of human nature so while we would want to avoid saying that anyone 'should' judge, it is, in reality, not possible. There is also professional judgement and some surgeons, for example, might be willing to perform some types of cosmetic surgery but not others. We suggest that any judgement should be linked to risks and benefits and that given why the cosmetic procedure is being sought in the first place, it would not make sense to impose an objective standard on a subjective matter.

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 provision of cosmetic procedures is predominantly a commercial venture in the UK and so the advertising, marketing and promotion reflect this. There is a surfeit of such adverts in magazines aimed at women, with 'before' and 'after' shots common, along with testimonials on how the procedure has changed the recipient's life for the better. Prices, risks, after care and the like are not usually included unless there is some promotional offer on price. Our understanding is that the procedures are 'sold' and only afterwards, once the consumer has arranged to go ahead, is information about risks, side-effects and results communicated. Our understanding is that much of the information provided prior to the procedure being performed is intended to 'manage expectations' so that the consumer is less likely to have unrealistic hopes (and less likely to complain or bring legal action). The commercial marketing and selling of such procedures does not reflect the risks associated and in our opinion precautionary regulation is needed to better reflect these risks and the ethical implications of selling invasive cosmetic enhancements.

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

In line with our definition in (1) above, we see those seeking cosmetic procedures as consumers. With cosmetic surgery, however, this is a particularly problematic issue because the consumer effectively becomes a patient when undergoing surgery because they are placed in a medically vulnerable position as a result of the serious and potentially life-threatening risks. The cosmetic surgeon has the same obligations as any surgeon performing medically necessary surgery and the need for caution (e.g. to check a patient's medical history and safeguard against risks), and confidentiality, for example, within the doctor/patient relationship are present. The fact that many patients seek treatment on the NHS following substandard treatment and aftercare further demonstrates the tension between being a consumer and a patient.

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

We suggest that, at the very least, information on risks, benefits and aftercare should be provided prior to the consent process beginning. The law on consent to *treatment* has developed within a medical context where there is a presumption that the procedure is in the patient's best medical interests. Because cosmetic procedures are not only non-therapeutic but also risky and potentially detrimental to health (e.g. the risks of unnecessary surgery), we suggest that the approach to consent needs to be even more robust than it is in the medical context. There should be time for consideration and reflection prior to undergoing the procedure, and more than one opportunity for questions to be asked and answered. At the very least, the common law standard on the information required for consent to be valid (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11) must be met.

On a separate note and with regards to those providing cosmetic procedures, we question whether, given the invasive nature of some procedures, the provider (with consent) should have access to the patient's medical records to ensure that there are no contraindications to the procedure. We also wonder whether a register of cosmetic procedures should be established and maintained to ensure that if an incident occurs, such as that relating to PIP breast implants, those affected can be identified and contacted. Such a register would also serve to note consumers who were undergoing multiple cosmetic procedures or multiple uses of one procedure, and this could give the responsible provider an opportunity to explore with the consumer their choices.

11. **Are there**

(a) any people or groups of people who should not have access to cosmetic procedures or

(b) any circumstances in which procedures should not be offered?

(a) We suggest that those who lack capacity under the Mental Capacity Act 2005 and children under 16 should not have access to cosmetic procedures. We have deliberately not used the term 'vulnerable' here because there are issues with the term itself, and it can also be used as a blanket to deliberately exclude entire groups of people without serious consideration of the reason and need for such exclusion.

(b) If there are circumstances suggesting that, although the patient does have capacity, the desire to seek enhancement (especially more serious surgical enhancement) is driven by

mental illness, we suggest this should be a situation in which providers are extremely cautious about agreeing to perform the procedure.

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

We do not think that parents should be allowed to make decisions about cosmetic procedures for their children under 16. From 16 onwards, the law on consent and capacity should apply so that a 16 year old with capacity can consent to a cosmetic procedure. We appreciate that this may be controversial but it is difficult to think of a compelling reason to suggest otherwise, unless 'vulnerability' is used here.

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

Yes. The Government's response to the Keogh report has been disappointing and we agree that there is a need to impose restrictions on who can provide fillers and Botox etc, so that only people with medical training (e.g. nurses, dentists, doctors) are permitted to provide these invasive and potentially harmful treatments. If specialist medical training for beauty therapists wishing to provide such procedures could be developed, leading to a well-regulated specialist qualification, this might be capable of bridging the gap between the need for some medical expertise and the current free market 'Wild West' approach.

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

Currently, it is too easy for those responsible for providing unsafe and harmful procedures to avoid responsibility. From a legal perspective, better regulation is needed to prevent harms (by ensuring safer practices) in the first place and, when harm does occur, to make the perpetrator responsible and accountable and to ensure the victim is compensated.

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

We think that the current regulatory measures for cosmetic procedures are currently minimal and too lax - see our responses to (10)-(14) above.

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

No, although the possible dangers of genital surgery on women, reflected in the prohibition on FGM, are highlighted below.

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 implication of this Act for female genital cosmetic surgery?**

Those seeking to perform such surgery *as cosmetic* surgery will need to be aware of and adhere to the provisions of the Act. Any genital cosmetic surgery must be performed for the girl or woman's physical or mental health and the surgeon should be clear that this is why the surgery is being requested and performed. Records should be kept reflecting this.

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

In addition to the concerns raised in (17) above, there are particularly sensitive concerns about sending unethical messages about physical variation and normalising 'perfect' ideals. The danger is that allowing the free market to provide such surgery on demand encourages some women (perhaps especially very young women) to see themselves as 'abnormal' or 'deficient' in some way.