Cosmetic procedures: ethical issues

Expert call for evidence

Analysis

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Introduction

On 11 January 2016, the Nuffield Council on Bioethics' Working Party on *Cosmetic procedures: ethical issues* launched an 'expert' call for evidence.[1] In conjunction with the expert call for evidence, the Working Party also launched a shorter survey aimed at members of the public, via the Survey Monkey website.[2] Both surveys were open until 18 March 2016.

Targeted emails were sent to notify over 750 individuals and organisations of the launch of these two questionnaires. In total, 34 submissions were received in response to the expert call for evidence (17 from individuals; 17 from organisations); 448 were received in response to the public survey.

This summary document provides an analysis of responses to the expert consultation. A summary of responses to the Survey Monkey will be undertaken separately.

Questions 1-3: definitions and aims

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

Several respondents felt that a "cosmetic procedure" is something which improves or enhances a person's appearance.

> "… anything that is done for the sole aim to increase attractiveness beyond 'average' as judged by the non-specialist… a revision of a scar (because it is unsightly) is not a cosmetic procedure… because most people (average) would not have a scar to revise."
> *Anonymous respondent*

> "… any procedure that involves invasive surgery or injectables to enhance or change a person's appearance."
> *Dr Jacqueline Sanchez Taylor, Lecturer in Sociology, University of Leicester*

> "… 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."
> *Anonymous respondent*

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1 Nuffield Council on Bioethics (11 January 2016) *Council seeks views on increasing use of cosmetic procedures*, available at: http://nuffieldbioethics.org/news/2016/council-seeks-views-on-increasing-use-of-cosmetic/.

2 Nuffield Council on Bioethics (25 January 2016) *Are cosmetic procedures routine, or extreme? Ethics council seeks your views*, available at: http://nuffieldbioethics.org/news/2016/are-cosmetic-procedures-routine-or-extreme-ethics-council/.

> "… something that is non-essential and is designed to make the person look younger, or 'better looking', or 'feel better'".
> *Dr Anne-Marie Martindale*

> "Any procedure that enhances the physical appearance in accordance with the prevailing beauty norms and helps the individual to feel good in his skin and in his social environment. The cosmetic aspect is more important than the therapeutic aspect."
> *Anonymous respondent*

Wider effects beyond physical changes to a person were also seen as integral to identifying what 'counts' as a cosmetic procedure.

> "… procedures that aim at enhancing the appearance of individuals not because such interventions and body modifications could improve the functions of individuals who undergo such treatments but because of the possible (and foreseen) positive psychological effects of such procedures on the individual's wellbeing, body image… and self-esteem."
> *Francesca Minerva, FWO Post-doctoral fellow, University of Ghent, Faculty of Philosophy and Moral Sciences*

> "… one which is not necessary for the physical health of the patient, rather it is a procedure undertaken by the patient to address a perceived body image issue."
> *Merryl Willis*

Questions of where boundaries lie also featured in respondents' submissions.

> "Some interventions are at the boundary between cosmetic and reconstructive surgery, as for instance some of these interventions aim at giving a certain feature a 'normal' appearance even though the abnormal feature does not cause any malfunctioning of the body part being modified."
> *Francesca Minerva*

> "[anything] that is not medically or clinically necessary. For example a nose straightening operation to aid breathing is clinically necessary. If such an operation is carried out merely because the individual feels unhappy about their nose, it's cosmetic."
> *Lois Rogers*

> "where the nose is reshaped to help the patient to breathe and the added bonus is that it looks 'prettier' then that is an added bonus. The same with blepharoplasty, if it is required because eyesight is being hampered and the added bonus is a better look… I would not classify these as cosmetic [surgeries]."
> *Merryl Willis*

> "… distinguish between interventions aimed at restoration or amelioration, and those aimed at a purely cosmetic effect… So breast reconstruction following mastectomy, or even breast reduction in cases where the size and weight of a woman's breasts are clearly detrimental to health, are therefore (arguably) not primarily cosmetic but 'restorative'."
> *Professor Jackie Leach Scully and Dr Simon Woods (Policy, Ethics and Life Sciences Research Centre (PEALS), Newcastle University*

> "Cosmetic and aesthetic procedures aim to change the appearance. These can be non-invasive — which have to do with the hairstyle, and make up to beautify oneself — or they can be invasive - such as laser application or subdermal injections of various substance to surgical procedures."
> *National Bioethics Commission of Mexico*

> "… 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… 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."
> *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*

A more expansive approach to this question was taken by other respondents. The Mission and Public Affairs Council, Church of England suggests that "rather than making a firm distinction between cosmetic and reconstructive procedures, it is better to place both on the impairment-enhancement continuum. At one end, there are procedures that are aimed at countering the effects of physical injury or abnormality such as facial burns or congenital malformation and at the other end procedures that are aimed at addressing perceived problems associated with external beauty such as the physical signs of ageing."

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

2) What do you see as the underlying aim of cosmetic procedures:

a) From the perspective of those seeking the procedure?

Respondents' views on this sub-question broadly fit into physical, psychological, and social aims.

Physical aims

- To improve looks and attractiveness; enhance physical appearance; "going up the body beautiful hierarchy" (Dr Anne-Marie Martindale)
- To look younger
- "To address perceived 'ugliness'". (Mission and Public Affairs Council, Church of England)
- "… to 'fix' some part of themselves which they think makes them look ugly or different." (Merryl Willis)
- "… to make themselves appear more 'normal'. In any population, there will be those at the extremes of the normal distribution curve, whether in nose size or breast size. It is not unusual for patients with patients with physical features at the extremes of normal… to seek cosmetic surgery to enable them to remain within, or move toward the 'norm' of the population of which they are a part. However, the definition of 'normal' can be very difficult and may be based on idealised perceptions, influenced by film and advertising media." (Christian Medical Fellowship)
- Dr Jacqueline Sanchez Taylor draws on her research in relation to breast augmentation with British women which suggests that women's motivations to undergo breast augmentation are:
    - "to *repair* damage done after child birth - to get their pre-pregnancy body back,
    - to *correct* breasts that have been labelled as 'abnormal' i.e., asymmetrical or to increase the size of small breasts,
    - to *enhance* existing breasts to meet social norms that are desirable and attain a specific status within a peer group (even if their breasts are not particularly small or problematic)."

Psychological aims

- To improve self-confidence / self-esteem (noted by several respondents)
- "… many women believe they are buying a new more successful personality at the same time as a new face." (Lois Rogers, in response to question 5)
- "… practices that alter bodily appearance are inevitably held to directly affect the 'self' and self-perception; in the case of cosmetic procedures, there is a double self involved, in that the latter are usually also as initiated by a person for that person's benefit, ie in self-interest. There is a further loop-back here, since the self may also be regarded as suffering some kind of deficit in negative self-perception that body alteration can alleviate. Seeking a sex-change procedure is often assumed to fall into

this category (e.g. under the rubric of psychological well being)." (Professor Marilyn Strathern)

Social aims

- "… to have a better life. They think that by improving their appearance their lives will be more fulfilled or happier." (Merryl Willis)
- "fundamentally they will be seeking to improve their lives." (Professor Jackie Leach Scully and Dr Simon Woods)
- "to help the individual to feel good in his skin and his social environment." (anonymous respondent)
- "the ultimate aim of leading a happier life." (Anonymous respondent)
- "in China many young women have eyelid surgery to stand out from others in the labour market and present as modern and socially mobile. Skin lightening treatments are also used to increase employability in societies where racism hinders access to some professions." (Dr Jacqueline Sanchez Taylor)
- To compete against others in terms of attractiveness and beauty (Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran))

Other comments

A small number of respondents urged caution against differentiating between intrapersonal and societal aims. For example, the Mission and Public Affairs Council, Church of England noted that "It is something of a cliché to make a distinction between procedures sought for one's own sake (intrapersonal) and those sought for the sake of others (societal). This distinction is difficult to maintain. It is almost impossible to disentangle our perceptions of ourselves from what we believe others' perceptions of us to be. For example, someone might argue that they wish to have their teeth straightened and whitened for their own self-esteem, but if straight and white teeth were not seen as signs of beauty and/or status it is not easy to see why having them would increase one's self esteem." Professor Jackie Leach Scully and Dr Simon Woods also "argue that separating out societal and intrapersonal factors in this way may be useful for analytic purposes but is highly artificial."

b) From the perspective of those providing procedures?

Financial gain

Providers' aims of benefiting financially from undertaking cosmetic procedures were noted by several respondents. Comments included:

> "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."
> *Dr Sara Fovargue and Dr Alexandra Mullock*

> "Ideally, providers would primarily be motivated to alleviate distress, but as, in reality, almost all cosmetic procedures are financed privately it is, perhaps, unrealistic to hope that such would be the case."
> *Mission and Public Affairs Council, Church of England*

> "… profit-minded practitioners should not shelter behind patient autonomy in order to perform procedures that are not medical-indicated and that carry significant risk… if there is an incentive, financial or otherwise, for a doctor to perform a particular procedure, that trust may be threatened."
> *Christian Medical Fellowship*

However, Merryl Willis suggested that this profit-making motive only applies to *some* providers: "… they probably fall into two broad categories - one where they see a dollar to be made and one where they do want to help people 'fix' their appearance."

To make their patient / client happy

Several respondents drew attention to providers' aims to improve their patients' / clients' happiness, and to please them through 'improving' their bodies, or making them "more beautiful" (anonymous respondent). The Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran), for example, suggested that such an aim addresses the need "to be beautiful as a justified and natural instinct of human[s]."

The 'pride' of providers who undertake cosmetic procedures was also noted by a small number of respondents. For example, drawing on their own research, Dr David Bell (University of Leeds) and Professor Ruth Holliday (University of Leeds) observed that "surgeons in our study expressed a desire to help their patients to achieve their desired outcomes, and considerable pride in their work, though they were sometimes sensitive about the way that cosmetic work is trivialised." Lois Rogers also noted: "I have interviewed many respected plastic surgeons who take a huge professional pride and pleasure in their ability to make subtle improvements to appearance and therefore transform the way an individual feels about themselves."

To undertake procedures that adhere to norms

A small number of respondents highlighted the aim of 'normalising' an aspect of people's appearance. The Christian Medical Fellowship noted, for example, that the underlying aim of providers in carrying out cosmetic procedures is to provide "a means of correcting natural appearances that distress the patient." Also commenting on norms, Dr Jacqueline Sanchez Taylor observed that "[regardless] of which sector of the industry surgeons are in, my research suggests that most surgeons and practitioners believe in particular essentialist gender norms that shape their idea of what constitutes perceptions of ideal female or male body. Surgeons are also embedded in a society that draw[s] on normative understandings about what counts as beautiful or attractive from

cultural and social positioning. Gendered, classed, aged and racialised norms intersect to shape and decide who 'needs' cosmetic procedures and who does not."

How does this differ for different social groups?

Although few respondents directly addressed this sub-question, those who did predominantly highlighted the role of wealth and social status.

> "… there does appear to be more cosmetic surgery required by those with more money. However, this does not mean that those without money don't want cosmetic surgery, it is more likely just beyond their financial means."
> *Merryl Willis*

> "… depending on the social groups, social pressure can lead to unrealistic expectations. Moreover, the relative financial burden is higher for the lower social class."
> *Anonymous respondent*

> "Most cosmetic procedures are conducted by private providers; consequently, recipients tend to be relatively well-off. At present, this means that they are disproportionately affected by both marketing and service provision. As cosmetic procedures become more common, however, the pressure to use them is likely to spread across all social and economic groups, creating new problems."
> *The Mission and Public Affairs Council, Church of England*

> "[aims may differ for different social groups, which] 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'."
> *Dr Sara Fovargue and Dr Alexandra Mullock*

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?

Most respondents who chose to respond to this question argued that changing oneself through biomedical or surgical procedures to beautify themselves *did* make a difference. Several justifications for taking this approach were noted.

Irreversibility vs removability

The irreversibility of biomedical and surgical procedures versus the removability and impermanence of clothes and make-up were highlighted by several respondents. One anonymous respondent suggests that “procedures are at least semi-permanent (Botox / fillers) if not permanent (surgery) whereas clothes can be easily and rapidly changed to cope with fashion (e.g. buttocks and breasts go in and out of size fashion!).” Merryl Willis further notes the case of Michael Jackson as an illustrative point to this effect: “every procedure he had made it more difficult for any mistakes or issues or changes he wanted to be subsequently performed… Clothes, hairstyle and makeup are reversible.” An anonymous respondent also states that “the use of clothes, hairstyle and make up is reversible, and generally does not harm the individual”, a point which is echoed by a further anonymous respondent: “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.” The British Dermatological Nursing Group also observed a difference of “permanence and [irreversibility] versus ability to change daily.”

Risk

The ‘riskiness’ of biomedical or surgical procedures was also commented on by respondents. Dr Sara Fovargue and Dr Alexandra Mullock noted: “Any invasion of the body is legally recognised as potentially harmful and risky and where surgery is performed the risks are particularly significant”. Lois Rogers further observed that “results are unpredictable and the long-term effect of surgery combined with the underlying ageing process, is completely unknowable.” An anonymous respondent also highlighted that “cosmetic procedures often break the skin barrier and therefore bring along infectious risks.” Longer-term risks are also highlighted by Dr Jacqueline Sanchez Taylor: “surgery and other cosmetic procedures often involve lifelong risk and a commitment to other procedures.”

The involvement of others

Dr Sara Fovargue and Dr Alexandra Mullock who observed that “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.”

Social acceptance

Social acceptance was also noted as a point of difference by one respondent who observed that “society is far more accepting of practices (hair styling, make up) that [are] utilised to improve appearance and are not invasive in nature.”

No difference

One respondent felt that there was no difference between the two methods of beautification. An anonymous respondent answers “No. However, neither the

NHS nor insurance policies pay for clothes or hairstyles. They are personal choice."

Other comments

A small number of respondents questioned the premise outlined in the question that "most people use their clothes, hairstyle, and make up to beautify themselves." For example, the Mission and Public Affairs Council, Church of England noted that "many people do not do so either routinely or consistently. Clothing, for example, varies according to context with functionality being much more important than aesthetics on most occasions. It is more accurate to suggest that clothes, hairstyles and make up are used by many people to project the image of themselves that they want other to see." Dr David Bell and Professor Ruth Holliday also suggests that this question is "vague", and asked: ""difference" to whom?"

Questions 4-8: 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?

General observations

General overarching comments on the increasing demand for surgical and non-surgical cosmetic procedures were made by a number of respondents.

> "It is difficult to say which came first: the procedure or the demand."
> *Dr Jacqueline Sanchez Taylor*

> "In the past facelifts were treated with derision; the last resort of those willing to risk grotesque disfiguration in order to remain wrinkle-free. Now cosmetic surgery is viewed as an almost normal part of anti-ageing body maintenance."
> *Lois Rogers*

> "The increasing demand for cosmetic procedures is not, per se, a bad thing, and it is definitely not a new phenomenon. People have tried to improve their looks for millennia, through means which were much less effective and way less safe than the ones provided by current cosmetic trends."
> *Francesca Minerva, FWO Post-doctoral fellow, University of Ghent, Faculty of Philosophy and Moral Sciences*

Consideration of demographics

Professor Marilyn Strathern suggested that responses to this question will depend on the demographics in question. Professor Jackie Leach Scully and Dr Simon Woods similarly noted that "the significance of factors will differ in different social or cultural groups." Dr Jacqueline Sanchez Taylor also

suggested that "[in] the UK, body image has been shaped by long-term historical processes. On the one hand these histories relate to the social construction of gender, but they are also greatly influenced by government policies that have shaped poverty levels, health and well being, food cultures, transport, access to sport and mobility, as well as gendered and racialised cultures. Political and economic agendas therefore create the forms that bodies take. Marketing some procedures as aids to self-confidence suggests that they are solutions to poor body image, but the root causes of 'poor' bodies or body image is ultimately a political, economic and social issue."

Drivers identified by respondents

'Normalising' / adhering to beauty 'standards'

- "there is enormous pressure to appear not so much 'normal' as 'ideal'." (Christian Medical Fellowship)
- The "narrow standard of beauty society currently enforces." (Francesca Minerva)
- "there seems to be pressure from somewhere within society that we need to look a certain way to be considered acceptable. There is an homogenisation of society in general which seems to be occurring and looks is part of that." (Merryl Willis)
- "Individuals with an appearance differing from… ideal appearance get frustrated and want to change their appearance." (anonymous respondent)

Media influence

The media's influence on generating an increasing demand for cosmetic procedures was highlighted by several respondents. Comments included:

- "… [an] emphasis on female presenters appearing young and beautiful." (Dr Anne-Marie Martindale)
- Celebrity worship". (Merryl Willis)
- "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." (Dr Sara Fovargue and Dr Alexandra Mullock)
- "While many people will not consciously try to mirror media or celebrity representations of beauty, a significant number will. The pressures to do so are often more complex than a simplistic desire to imitate the rich and famous." (Mission and Public Affairs Council, Church of England).
- (Noting the "flawless" images of women in magazines post-photoshopping): "setting such impossibly high standards, actually standards that cannot be matched even with a number of cosmetic interventions, makes people feel constantly below the standard". (Francesca Minerva)
- "What girls see in the media has a big influence on body image. 37% feel they should try to look more like the pictures of girls and women they

see in the media, and 33% think they are more likely to be successful it they look like celebrities, rising to 43% among those aged 17 to 21." (Girlguiding, noting its Girls' Attitudes Surveys)

- "The continuation of unrealistic body sizes and facial appearances in Hollywood actors / actresses." (Dr Anne-Marie Martindale)
- The role of pornography (not expanded on by respondents who addressed this question).
- Advertising, particularly the ubiquity of advertisements for cosmetic procedures (e.g. on modes of transport, as well as in written publications)

Social media

- "Oft repeated messages of 'real beauty' are, frankly, overshadowed by mass-media visual representations of 'beauty' which are replicated constantly on social media." (Mission and Public Affairs Council, Church of England)
- "… [the use of] Instagram in the younger ages bracket". (British Association of Cosmetic Nurses)
- "… people are more conscious about how they are portrayed. People's vulnerabilities and 'imperfections' are increasingly on display to all, which naturally leads people to want to find ways to improve their appearance. There is also the natural human element of competition at play here; people want to be and look better than the next person, which is only fuelled further by social media". (Anonymous respondent)
- "the instant nature of group communication can contribute to peer pressure, particularly among younger people. Anyone can post on Facebook or upload a video to YouTube. Where once professional standards (and libel laws) were protections against irresponsible writing and film-making, none of these effectively exists in the world of social media." (Mission and Public Affairs Council, Church of England)

Social pressure to look young

- "Due to an increase in life expectancy the productive years of individuals increase accordingly creating the need to maintain a youthful and healthy appearance." (National Bioethics Commission of Mexico)
- "The promotion of healthy old-age is to be welcomed, but again, this can give rise to pressures to seek cosmetic procedures. What was once the preserve (and concern) of film stars might readily become a new norm for those who want to be thought of as ageing healthily and well." (Mission and Public Affairs Council, Church of England)
- "… much of the stimulus is ageism in society, vanity and media images of the perfect human." (Professor Dennis Baker, School of Law, University of Surrey)
- "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…" (Dr Sara Fovargue and Dr Alexandra Mullock)

Availability of finance plans / credit agreements

- The availability of finance plans / credit agreements for cosmetic procedures; moving away from the past, when cosmetic procedures were associated with the wealthy and famous.
- Cosmetic procedures "become cheaper making it accessible to people who were previously economically excluded". (Dr Jacqueline Sanchez Taylor)

Other drivers identified

A range of other drivers were also identified in single responses.

- Peer pressure
- Hedonism
- Perception that cosmetic procedures are part of normal self-care / well-being. (Professor Jackie Leach Scully and Dr Simon Woods)
- Partners' pleasure in the recipients' appearance
- Improving self-esteem and confidence. E.g.: "the quest for a 'perfect body' may, in reality, be the quest for self-esteem, value and acceptance. Such basic human needs are better and more naturally provided through loving and affirming relationships… and/or, if necessary, psychological interventions." (Christian Medical Fellowship)
- New technologies: "new technologies have made such procedures safer and easier to change aspects of a person's body they may be unhappy with for whatever reason". (Dr Jacqueline Sanchez Taylor)
- The availability of procedures at beauty salons.
- Raising social status: "procedures are increasing used as markers of status and becoming normalized among some communities. (Dr Jacqueline Sanchez Taylor)

Limitations of evidence on 'drivers'

The quality of evidence on drivers for generating increasing demand for cosmetic procedures was observed by Professor Jackie Leach Scully and Dr Simon Woods: "we have found it hard to find rigorous examination of possible drivers in the literature, suggesting that this aspect of cosmetic procedures requires closer attention." Dr David Bell and Professor Ruth Holliday similarly suggested that "[the] whole issue of "increasing demand" needs careful handling, as data is notoriously unreliable". Francesca Minerva also noted the "general lack of data about the number of cosmetic procedures performed in Europe".

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

Most respondents answered the first part of this question in the affirmative, and used a range of points to illustrate their view.

> "… it is becoming routine, to the extent that in some social circles women and girls believed by their peers to be in need of 'improvement', are objects of derision."
> *Lois Rogers*

> "… [the] pervasiveness of cosmetic procedures gradually makes it [a] predominant value and culture which may change the cosmetic criteria in any society."
> *Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran)*

> "Until a few years ago these practices were quite exceptional. Now it gets more and more accepted to have this kind of treatment. This increases the pressure on persons with a negative self-esteem to have this kind of treatment."
> *Anonymous respondent*

> "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."
> *Dr Sara Fovargue and Dr Alexandra Mullock*

A response from the Mission and Public Affairs Council, Church of England, however, notes that the routineness of undertaking cosmetic procedures is affected by the particular procedure in question.

> "Teeth whitening is an example of a procedure that is routinely offered by many dentists even though there are no health benefits to having white (as distinct from clean) teeth. While very many people seem to respond positively to white teeth, it is not clear that as many find the results of other procedures quite as attractive. 'Face-lifts' and the use of Botox… are not uniformly seen as producing enhanced looks although the recipients of these procedures often initially perceive themselves to be better looking. Similarly, breast, buttock and muscle implants are increasingly common, but there is a disparity between the positive perception of these procedures by recipients and a more mixed reception by others."

Ethical issues

Several ethical issues were raised by respondents.

Concerns about risk

An anonymous respondent stated that "it [undergoing cosmetic procedures] is getting more common […] it increases the potential number of possible

complications, risks or failures." The British Medical Association qualifies this approach through its suggestion that "[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."

A related point was raised by an anonymous respondent: "it is better to change structural forces and problematic social norms that drive people to undertake risky surgeries in the first place… 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 of autonomy." However, the British Medical Association further asked: "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?"

Social stratification

The issue of social stratification between those who can and those who cannot afford to undergo cosmetic procedures was raised by the Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran). This respondent argued that "people who cannot afford to perform cosmetic procedures… shall be deprived of social honor and respect as well as self-confidence."

Dr Jacqueline Sanchez Taylor also noted that "procedures are becoming normalised for some, but not all. The messages in the UK are very classed and racialised and it is mostly the white working, aspirant classes and newly affluent who are turning to cosmetic procedures. There is little evidence that the established middle classes or Black British or Asian communities are turning to the cosmetic market in large numbers as cultural value is obtained through other means and privilege is marked in other ways."

Narrowing the 'normal'

The Mission and Public Affairs Council, Church of England stated that "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." Dr Jacqueline Sanchez Taylor also suggested that "[medicine] is no longer about healing or mending bodies but about changing and modifying them so that they fit in or are normalized, but there has been little discussion about how these norms are justified and what is shaping them." Dr Sara Fovargue and Dr Alexandra Mullock also noted "the perpetuation of the idea that it is 'normal' now to have cosmetic procedures and that these are a demonstration of beauty." They also observe that there "are… issues with such procedures being culturally harmful and the possibility of stigma if [people] don't do it and remain 'unenhanced' and so less attractive, not performing appropriate gender role".

Concerns about 'vulnerable' groups

The routineness of cosmetic procedures was also felt to "[allow] less ethical providers to entrap naïve and young clients." (Anonymous respondent) Further concerns for 'vulnerable' patients / consumers were also highlighted as an ethical issue by an anonymous respondent who noted that the availability of promotional offers and other enticements "should not be permitted as… they increase the risk factor for vulnerable people." (However, the same respondent qualifies this but noting that for "a person with full mental capacity that is able to weigh up the risks and benefits of a cosmetic procedure, I do not see there being an ethical issue with that person being able to purchase such a product.") Merryl Willis also asks: "who, and how protect the individual who wants the cosmetic procedure?" Similarly, Professor Jackie Leach Scully and Dr Simon Woods noted "a particular concern is the trend towards procedures being taken up at lower ages", and Dr Jacqueline Sanchez Taylor stated that "we should also be concerned that this market is not exploiting those who are vulnerable and ill informed. We should be discussing whether there is a need to protect young people who are insecure about how they look".

The issue of undergoing repeat procedures

The need to keep returning to have further cosmetic procedures in perpetuity in order to maintain or improve initial results was also raised. Lois Rogers, for example, notes that "once people have undergone one operation they are more or less condemned to keep going back." This issue was also noted in response to other questions raised by the call for evidence document.

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.?

Most respondents who chose to answer this question felt that social norms were, or could be, affected by the increasing availability of cosmetic procedures. Comments received included:

> "There has been a narrowing of what is acceptable or considered beautiful. Femininity demands a range of adjustments to hair, body and skin. It is not just breast augmentations that are linked to femininity. Gender also cuts across racialised ideas about womanhood so that cosmetic surgery procedures are racialised as well as gendered."
> *Dr Jacqueline Sanchez Taylor*

> "Will someone who chooses not to have cosmetic surgery be marginalised or discriminated against? Will we cease to celebrate differences? […] I worry that whilst we are saying that people are equal regardless of age race, ability, etc., we are not backing that up vis a vis cosmetic surgery - you are equal but you would be more equal if you had these procedures to make you fit in better."

Merryl Willis

"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… then, of course, this can lead to a sort of self-fulfilling prophecy 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."
Anonymous respondent

"In principle, cosmetic techniques give the ability to transform bodies in all sorts of ways, including *away* from the standard, but are generally being used to bring the deviant body into conformity with the norm."
Professor Jackie Leach Scully and Dr Simon Woods

"It perpetuates the myth of a single, universal able bodied, beautiful body type, which was never the case, and puts people under unrealistic pressure to conform."
Dr Anne-Marie Martindale

Assumptions about age

A small number of respondents commented specifically on the issue of age in the context of increasingly available cosmetic procedures. Comments included:

"Much has been written about people undergoing cosmetic surgery to look much younger and more attractive so as to stay competitive in the work place upon the notion that (right or wrong), younger, more attractive people are more likely to succeed. This is one way cosmetic procedures can change social norms."
Anonymous respondent

"Aging well' is a marker of wealth as well as health. There will be more pressure on the older to engage in the cosmetic market not just to look acceptable but also to prolong working lives and erase signs of ageing."
Dr Jacqueline Sanchez Taylor

"There is a greater expectation that looking older is an option."
Anonymous respondent

Assumptions about gender

The impact on gender was a highlighted as a concern for a small number of respondents. The Health and Human Rights Unit at the School of Law at Queen's University Belfast noted, for example, "both men and women can be

understood as being encouraged by social norms to maintain their bodies in ways that conform with prevalent ideas of gender, beauty and their link to heterosexual desire."

Noting the impact on women in particular, Lois Rogers stated:

> "Increasingly it is considered a duty for women to 'sort themselves out'; to take any steps available, however drastic, to improve their presentability."

The Health and Human Rights Unit at the School of Law at Queen's University Belfast also stated that "the aim of the majority of cosmetic procedures is to allow women to better conform to social norms regarding feminine gender and its intersection with age, (dis)ability, race, and other identity forms… Cosmetic procedures are presented as a choice women as consumers can select in order to 'enhance' their appearance. This presentation often hides the problematic ways in which gender is encouraged or maintained by social norms and expectations, as opposed to selected free choice." However, the same respondent also states that "it is also important to note that increasing access to cosmetic procedures can at times be seen as positive… Those who identify with a gender that is different from that socially assigned to them at birth may often benefit from access to cosmetic procedures."

Assumptions about race

> "Discriminatory stereotyping can limit opportunities for some ethnic minorities and requests for such procedures as eyelid surgery to create a more 'Caucasian' eye among East Asians may reflect this."
> *Christian Medical Fellowship*

> "… people may resort "to buying illegal produces to [lighten] skin colour as lighter skin is more highly valued in some cultures."
> *The British Association of Cosmetic Nurses*
> "the increase of requests [for] eyelid surgery from Asian people… is not due to anything like an objective degree of attractiveness of the Caucasian eye-shape over the Asian eye-shape, but (most likely) to the fact that Caucasian features dominate the media and are commonly portrayed as more attractive in magazines, movies and in general in the media."
> *Francesca Minerva*

Dr Minerva continued: "the increased request for cosmetic treatments aiming at the 'caucasization' of people… should make us think about the negative influence of medial on non-Caucasian populations. Portraying people from different ethnical backgrounds would come at no cost or very little cost for the fashion industry and for the media".

Disability

On the issue of the effect of increasing availability with respect to assumptions about disability, Dr Sara Fovargue and Dr Alexandra Mullock noted that "some parents have sought surgery for their children with Downs in order to help them look more 'normal'." The Mission and Public Affairs Council, Church of England also observed that: "were a wide range of cosmetic procedures to become routine there is a real risk that those living with disabilities would be pushed further to the margins of society."

Noting in particular the case of Down syndrome, the Christian Medical Fellowship suggested that "society needs to recognise that 'different' is not 'abnormal', and that personal identity and social acceptance must not depend on individual conformity to some idealised norm when it comes to appearance." To address such concerns, Dr Anne-Marie Martindale suggested that "we need to do more to celebrate and publicise things like the Paralympics and bring bodily diversity into schools, repeatedly from an early age."

Other consideration: changing fashions

The effect of 'changing fashions' was an issue of concern for Merryl Willis: "who dictates what is currently acceptable, what if you use cosmetic procedures to change your appearance and then the fashion changes, do you then undergo more cosmetic surgery?" Similar points were echoed by Dr Jacqueline Sanchez Taylor in response to question 16: "consumer/social tastes can change and what might be fashionable and hip now might not be in twenty or fifty years' times […] People also once had their teeth pulled out and replaced with dentures to present as modern and this would not have the same meaning today. I believe that many of the procedures on offer in 2016 will be regarded as the same as having teeth pulled out in the 1930s."

Qualifications

A small number of respondents urged that the question of impact on social norms is qualified. For example, Dr David Bell and Professor Ruth Holliday stated that "this is a very complicated set of issues, and it is important not to blame cosmetic surgery for broader changes in "social norms", for example around ageing." Dr Ashley Morgan also advised that "there is a widespread idea that many thousands of people undergo cosmetic procedures, while this is true, more people do not undergo cosmetic procedures than those who do."

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

Some respondents suggested that motivations pertaining to function or medical necessity might be thought of more favourably than 'purely aesthetic' impetuses.

> "reasons that lie towards the impairment end of the impairment-enhancement continuum and that are in response

> to distress rather than discontent are likely to encounter fewer psychological, ethical and social problems than reasons that lie towards the other end of these spectrums."
> *Mission and Public Affairs Council, Church of England*

> "… in the eyes of a rational physician the best motivation is to restore dysfunctions or abnormalities and create a normal (=acceptable) appearance and functionality in order to give the patient a 'normal' life."
> *Anonymous respondent*

> "We remove warts and other minor skin problems without thinking of these procedures as cosmetic. At the moment we do justify helping to change of the appearance of some people who are disfigured, disabled and regarded as deformed. This type of surgery is viewed as having a value and a good because it improves the social life of the individual. However there are many ethical questions about taking this approach and it is increasingly contested that this is best for the patient and society. What counts a deformity also depends on normative visual conventions that are being questioned."
> *Dr Jacqueline Sanchez Taylor*

> "some motivations can occur from a longstanding deep psychological unhappiness from childhood or a traumatic life event."
> *British Association of Cosmetic Nurses*

Merryl Willis also suggested that motivations which pertain to function, in order to alleviate medical problem (such as a rhinoplasty to fix a broken nose and associated breathing problems), are 'better' than others. However, the same respondent asks "when does it become less better[?]… a lady with significantly asymmetrical breasts, feels different, feels she can't be intimate with someone easily, wants to have breast augmentation to even things up - is that acceptable? It is not for health reasons, well not physical health, but I would argue that it is acceptable surgery. But someone who wants their C cup breasts to be enlarged to a J cup - I would question why? What is happening in her life that she feels this would improve their life?"

Other respondents stated that motivations were all of equal standing. Using their own definition of 'cosmetic procedures (see question 1 above), Dr Sara Fovargue and Dr Alexandra Mullock suggested that "all motivations should be regarded in the same way". However, Dr Fovargue's and Dr Mullock's response is qualified by the observation 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."

A further question was raised in response to this question by the British Medical Association, which asked: “If somebody wants to look more ‘normal’, is that more acceptable than someone who seeks to stand out?” Other areas of exploration were also suggested by Lois Rogers, including the issue of the modification of features associated with disabilities such as Downs syndrome, and procedures that seek to conceal or disguise racial origin.

Who should judge?

Few respondents directly addressed this sub-question. Of the responses received, however, three sub-categories might be determined.

No one should judge

An anonymous respondent argued that “it is [not] fair to judge one reason against the other. It is a very personal matter to the individual and so long as they can demonstrate reasonable judgment the I don’t think some motivations should be deemed better than others.” (This respondent also qualifies that this must be the case, as long as the motivation of a patient is not “short-lived” and that risks and benefits have been considered thoroughly.) Dr Anne-Marie Martindale also noted “I’m not sure we should judge, this puts the blame for not feeling or looking good enough back onto individuals.” Equally, the British Association of Cosmetic Nurses stated that “no one should judge”.

Professional bodies

One response, from Dr David Bell and Professor Ruth Holliday, suggested that “[professional] bodies such as BAAPS are keen to legitimize their role as “responsible providers” who can therefore make such judgements, but they are clearly compromised by commercial pressures and by the protection of their professional identities.”

The recipient of the procedure

Two anonymous respondents ascribed to this view. The first stated that “the person to judge should be the person undergoing the surgery”; echoed by the second: “the person having it done should judge.” A further anonymous respondent also observed that “social pressure on the patient can be leading to a disappointing final result if the motivation of the patient himself is not firm.”

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

Several respondents expressed negative perceptions and experiences of advertising, marketing and promotion of cosmetic procedures in the UK. Comments included:

> "Large companies often run cosmetic surgery roadshows with sales people, rather than surgeons or people who have undergone cosmetic surgery at the front."
> "They are interesting, abstract and relentlessly positive."
> *Dr Ashley Morgan*

> "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)."
> *Dr Sara Fovargue and Dr Alexandra Mullock*

> "The trouble is with the internet and, in Australia, the ease of people being able to Google cosmetic surgery holidays and being targeted with advertising which is not strictly monitored. Consumers know about this sort of thing by the media being ever so helpful and doing stories on it in current affairs type shows… But even a negative story tells people that it is available and so then they Google it to see what else there is."
> *Merryl Willis*

Professor Jackie Leach Scully and Dr Simon Woods also highlighted the "double-bind message in cosmetic advertising exemplified by "because you're worth it": that it is important to have self-respect, to love yourself and your body, and yet paradoxically a way to demonstrate this care for your body is to alter it to satisfy an external norm."

Vulnerable people were, in particular, highlighted as a group to which the issues raised by this question should pay especial concern. An anonymous respondent suggested that offers which 'entice' potentially vulnerable people should not be permitted, for example. Dr Jacqueline Sanchez Taylor also notes "although there has been a stop to marketing techniques such as two for one breast augmentation on Groupon, prices for cosmetic procedures are generally getting lower as the market is competitive." The British Association of Cosmetic Nurses raise a similar concern regarding "e-voucher companies which advertise treatments… reducing process from between 90% to 64%."

However, an anonymous respondent suggested that there may be a spectrum of acceptability across various forms of advertising and marketing:

> "I believe that discrete advertising (for example, on a surgeon's own website or focused publications) is acceptable because, if people are considering such a procedure, they will

> easily seek out and find the information. However, I do not think it is appropriate to advertise invasive procedures to the general public (e.g. billboards, TV, etc.). Fortunately, this is relatively rare in the UK."
> *Anonymous respondent*

Respondents also made suggestions for how marketing and advertising of cosmetic procedures might be changed in the future. For example, the Mission and Public Affairs Council, Church of England urged "that cosmetic procedures are advertised, marketed and promoted in the same ways as other private healthcare procedures: as a means of treating physical or psychological distress, rather than as beauty treatments." The British Association of Cosmetic Nurses also suggested that "celebrities should not be used to endorse advertising" and that "advertising should not promote a glossy or stylised lifestyle aspiration that having a particular treatment could bring."

An example of the approach of another country was also raised Dr Jacqueline Sanchez Taylor: "In Germany, cosmetic surgery is not advertised on billboards so that people and especially young people, are not subject to this type of marketing. Of course it does not mean that people do not have cosmetic procedures, but it does mean that they have to be much more committed to the idea in order to seek out clinics."

Questions 9-15: the supply and regulation of cosmetic procedures

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

Both

Most respondents who addressed this question indicated that people who sought cosmetic procedures were both patients and consumers. Comments to highlight this view included:

> "As with many areas of healthcare today – arguably all of them – most people are hybrids, so we tend to use the term patient-consumer. Their practices are not fully reducible to the term consumer, but they are not patients in the traditional sense."
> *Dr David Bell and Professor Ruth Holliday*

> "Both; a patient because they are owed a duty of care and consumer because they are a paying customer […] Patients may start as consumers coming to their consultation with a level of knowledge or anecdotal evidence from friends but just because they pay for their treatment doesn't mean that is the influencing factor."
> *British Association of Cosmetic Nurses*

Some respondents also suggested that their answer to this question depended on the situation in which the procedure takes place. For example, Merryl Willis suggested that it "if a person is seeking to modify their appearance because they want to look different, then they are consumers. If a person has had an injury or an illness or something along those lines and is looking to repair the injury, then they are a patient." A similar approach was taken by the Mission and Public Affairs Council, Church of England:

> "… it is important to view people seeking such treatments as either patients who seek help for a physical condition or clients who seek cosmetic procedures because of psychological distress."

An anonymous respondent also suggested that a person's role as patient or consumer may change as the procedure progresses: "Both: they are consumers when they seek this kind of procedure… They might become patients as some of the procedures are invasive." A similar view was noted by Dr Jacqueline Sanchez Taylor: "[doctors may] perform procedures they may be uncomfortable with doing, but as the client is paying they may feel that if they do not do it someone else less skilled might end up doing it. So they do what the patient wishes even if they do not wholly recommend it. Consumers of cosmetic procedures become patients only when the surgery is being performed and during the aftercare."

Patients

A small number of respondents suggested that people who access cosmetic procedures should be defined exclusively as 'patients'.

For example, the Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians, suggested that "there may be no medical basis for the individual to request the procedure, which is carried out within a commercial sector, implying that the individual is a 'consumer'. However, as these interventions are based on medical practices, and carry clinical risks to the individual, the individual must be regarded and treated as a 'patient'." The Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran), similarly noted that "as receiving cosmetic procedure services not only include beauty interventions, but also some clinical services and considerations… it seems that they should be counted as patients not consumers." The same respondent further suggested that consumers have absolute decision-making powers to choose what they access, whereas people who wish to undergo cosmetic procedures will only be able to do so if clinically appropriate - a decision which rests with other people, and thus therefore takes these people into a 'patient' category. National Bioethics Commission of Mexico also noted that "persons applying or requesting cosmetic procedures (surgical and nonsurgical) are by definition "patients", since these procedures must be done by health professionals." Professor Jackie Leach Scully and Dr Simon Woods observed:

> "It has been argued that a patient stands in a very different position of responsibility and dependence to the provider than does a consumer; and so people who elect for a non-necessary intervention might be considered primarily consumers, with the different relationship that entails. Nevertheless, when undergoing an invasive surgical procedure, even if by choice rather than need, it's a patient who is on the operating table and in the recovery room, irrespective of why they are there, or indeed who is paying for it."

The Faculty of General Dental Practice also suggested that "… people seeking cosmetic procedures should be considered as patients, and not as consumers. The notion that cosmetic treatments deliver no health benefit, and are concerned only with the improvement of appearance, is contestable, as to the extent that they contribute to a person's sense of general wellbeing and social confidence". FGDP also raised concerns about describing those who have cosmetic procedures as 'consumers': "[it is] vital that a healthcare professional's duty of care is not seen to be lesser because a person is seeking a cosmetic treatment, yet use of the term 'consumer' in this context could have just that effect."

Consumers only

Although a small number of respondents stated that people who seek cosmetic procedures are consumers, few substantive remarks were submitted. However, Dr Ashley Morgan notes that "It depends on what kind of procedure is sought. If they are paying for it, rather than it being provided for them, they are definitely consumers. This is also true in the way that they access the procedure."

In addition, again drawing on their definition of 'cosmetic procedures', Dr Sara Fovargue and Dr Alexandra Mullock also suggested that those who seek cosmetic procedures are consumers. The expand further to note that in the context of cosmetic surgery, "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."

Other comments

Some respondents also provided supplementary comments in response to the issues raised by this question. For example:

> "As 'consumers' people who have procedures are viewed under a corporate agenda as empowered and as 'clients' or 'patients' they are seen as vulnerable. But it is clear that the boundaries between professional medicine and the neo-liberal market has become more blurry and this has also resulted in blurry boundaries around who is a client and who is a patient."

Dr Jacqueline Sanchez Taylor

Respondents also suggested that this question might be conceived in a different way. Merryl Willis noted, for example, that "perhaps a better question is to ask is cosmetic surgery a health related procedure or a commodity." Professor Marilyn Strathern also suggested that an answer to this question is "heavily dependent on what population (what demographics) we are talking about. One might even approach the question the other way round, from the perspective of well-being rather than remedy as an aim of medical interventions".

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

Respondents noted that a range of information should be made available to those considering undergoing a cosmetic procedure. This information might be subdivided into three broad categories: information about the practitioner; information about the procedure; and administrative information and sources of further advice.

Information about the practitioner

Suggested points of information on practitioners included:

- qualifications / memberships of relevant professional organisations
- their experience; e.g. how many times they have performed the procedure in question
- insurance status
- whether any complaints have been made about them in the past

In a substantive response to this question, the Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians also suggested that:

> "The public has the right to expect good quality, evidence-based practice from those who deliver non-surgical cosmetic procedures. The practitioner should work within their competences; in order to do so the practitioner must have some insight and understanding of clinical circumstances which fall outside of these boundaries and be able to identify situations where it is appropriate to refer on.
> As such, all patients should be provided with information on the practitioners' training and qualifications, and how these compare to the full spectrum of training and qualifications currently available.
> In the absence of a mandatory register, a voluntary register of practitioners undertaking non-surgical procedures is essential."

Information about the procedure

Several suggestions were made by respondents on information which should be made available about the procedure in question, including:

- if there will be any after effects of the procedure, and how long those effects should last
- information re. contraindications, including a suggestion by Dr Sara Fovargue and Dr Alexandra Mullock that "the provider (with consent) should have access to the patient's medical records to ensure that there are no contraindications to the procedure."
- details about aftercare or self-care following a procedure (Faculty of General Dental Practice)
- whether a new procedure would be needed in x years' time. E.g. Dr Jacqueline Sanchez Taylor noted: "for breast augmentations, many of my interviewees were unaware that they would need surgery again at some point and had been told that their breast implant was for life. They should be sure that they have enough saving to remove/remove and replace their breast implants if they need to at any time after having surgery."
- full information on risks, potential harms, and benefits of the procedure in question
- statistics on levels / types of complications associated with a particular procedure
- The amount of time off work required before and after the procedure
- Alternatives to undergoing cosmetic procedures

Substantive comments on the information about the procedure itself were also submitted by respondents, including that submitted by the Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians:

> "Patients should also be fully briefed on the potential risks of any procedure they are considering. This should be mandatory, not provided on request. Such mandatory information should be evidence-based, and written in plain language to cover 1) the scope/aim of each leaflet, 2) details of the "treatment"/procedure, 3) alternative "treatment"/procedure options, if applicable, 4) potential risks and side effects with indication on their severity and prevalence, 5) self-care for after the treatment."

Administrative information and further advice

A range of suggestions for administrative information and further sources of advice were made by respondents, including:

- Details of complaints procedures
- Information on financial costs of the procedure

- Provision of counselling, or details of counselling providers on body-related issues
- Details on onward referral, if required
- Information about adverse events
- A register to note which procedures people have undergone, and to contact individuals should an adverse event occur.

Lois Rogers suggests that a patient information leaflet should be provided which includes information such as that listed above.

11) Are there:

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

Most responses to this question focused on children and young people, or those with a psychological disorder and / or limited capacity. However, many of these responses highlighted the necessity to recognise the context within which cosmetic procedures might take place.

Children and young people

Several respondents suggested that young people should not have access to cosmetic procedures.

> "I think I might set the bar quite high, and in either case restrict procedures to those over 18 [or arguably 16]. The teenage years [in EI [European indigenous]] are years of extremely fluid and uncertain self-definition, and I wouldn't argue that because people are already mature in many respects they are mature in all."
> *Professor Marilyn Strathern*

> "Breast augmentations should not be offered to children. However, there needs to be a wider discussion about how cosmetic procedures is beneficial or not to those who are disfigured."
> *Dr Jacqueline Sanchez Taylor*

> "I do not think boob enhancements, dermal fillers or Botox should be offered to women under 18."
> *Dr Anne-Marie Martindale*

Merryl Willis, who also suggested that under 18s should not be able to access cosmetic procedures qualified this view: "if the child has a deformity, such as hair lip, then I would consider this reconstructive surgery in the best interest of the child, so acceptable." An anonymous respondent also noted that "children should not be able to access cosmetic surgery. If a child has a disfiguring burn or large mole, removal is not cosmetic because the sole aim of removal is not to increase attractiveness beyond 'average' as judged by the non-specialist."

The British Medical Association suggested that it may be worth considering "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."

For breast augmentations, Dr Jacqueline Sanchez Taylor suggested that they "should not be offered to anyone under 25 or anyone who has had a major life event within the last two or three years", such as anyone who is recently divorced, separated, or bereaved, or who has had a child within the last two to three years: "women need time to adjust to their post-partum body and the focus on the body at this time can often be related to a lack of control more generally after having a child."

Dr Anne-Marie Martindale noted the role of the context of the cosmetic procedure in question: "[it] depends who is advocating work being done and why. Adults wanting to make their children look like Barbie and Ken should always be refused", whereas "some Downs children have cosmetic procedures to reduce the size of their tongue to make it easier to talk and so they fit in more with their peers in mixed schooling environments. I guess context is key." In related comments, Professor Jackie Leach Scully and Dr Simon Woods suggested a more moderate exposition to address this question: "It might be preferable to say 'should not normally have access'. This could include minors and those with compromised capacity."

People with psychological disorders

Several respondents also highlighted people who might be psychologically 'vulnerable' (e.g. lacking mental capacity, or with a suspected or confirmed diagnosis of BDD or other psychological disorder which can affect the patients' / consumers' ability to make decisions). For example, the British Medical Association observed that "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."

The Christian Medical Fellowship also suggested that "some people seek cosmetic procedures as the 'solution' to needs that cannot be successfully addressed by such procedures. Those most vulnerable to exploitation by profit-motivated providers are the very ones least likely to be helped by the 'product." (Dr Sara Fovargue and Dr Alexandra Mullock, however, urge caution against the use of the term 'vulnerable': "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 needs for such exclusion.")

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

Few respondents directly responded to this part of the question.

Merryl Willis suggested that "[if] the practitioner thinks that the patient has unreal expectations or choices put the patients' health at risk, then it behoves

the practitioner to deny treatment." This view was echoed by an anonymous respondent who stated that "it should not be offered to any person who has unrealistic expectations."

Professor Jackie Leach Scully and Dr Simon Woods also suggested that "[examples] of such circumstance would be when it is clearly not in the best interests of the *patient*… However, we suggest that there needs to be a discussion of when access to cosmetic procedure is not in the interests of society more broadly." Processor Scully and Dr Woods noted further that "people with the classic features of Down syndrome have been given facial cosmetic surgery to make these features less noticeable. It has been argued that however beneficial to the individual person, it is ultimately not in best interests of society or of Down syndrome people themselves to collude with rather than challenge discriminatory social responses."

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

A number of respondents noted that their answer depended on the purpose of the cosmetic procedure in question.

> "Purely cosmetic procedures should be very restricted for children under the age of 18, regardless of parental wishes."
> *Dr Anne-Marie Martindale*

> "Parents should always be involved in decisions about the care and welfare of their children. However, parents should not be able to 'force' a purely cosmetic procedure upon their child. Neither should they dismiss the concerns of a child who complains of relentless teasing or bullying on account of his or her appearance."
> *Christian Medical Fellowship*

> "… when the purpose of the transformation is solely to achieve a "socially acceptable ideal of beauty", it is best to persuade the parents and the child to wait until the child is of age and then he/she can choose freely and autonomously."
> *National Bioethics Commission of Mexico*

Other respondents felt that age was a determinative factor:

> "… there should be a distinction before and after the age of seven. Until the age of seven, parents should be considered as the main deciders for their children, after the age of seven consent of the child should be considered necessary."
> *Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran)*

> "Except for situations where postponing the procedure would imply more risks and less efficacy, parents should not take

> decisions and should wait until the child is old enough to make its own decision."
> *Anonymous respondent*
>
> "… parents should [not] 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."
> *Dr Sara Fovargue and Dr Alexandra Mullock*
>
> "it is important to consider that children's facial and body features change quite dramatically up to the age of 20, so it is possible that a characteristic that looks unattractive at a younger age does not look so when the child grows up". *Francesca Minerva*

Dr Jacqueline Sanchez Taylor observed that "parents generally want to do the best for their child and there are many procedures where parents might feel that their child would suffer less social exclusion if they had cosmetic procedures. However, the value of such procedures are socially constructed and I would be concerned that parents are engaging with the long term impact of any procedure for the child rather than trying to expand the narratives about self worth to include people who do not present as 'normal'."

Suggestions for decision-making criteria for children's access to cosmetic procedures were also raised by respondents. These requirements included:

- "It should be illegal without the consent of two separate independent cosmetic plastic surgeons who agree that treatment is necessary because the child is suffering severe psychological harm as a result of congenital disfigurement." (Lois Rogers)
- "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." (Anonymous respondent)
- "In some cases where the procedure only has cosmetic aspects and not related to the health of the child at all, clinics and hospitals should have definite guidelines for themselves according to which some clinical procedures are forbidden for children, [e]specially invasive ones." (Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran))
- "If the cosmetic surgery is in the best interest of the child, where if any person would, on the balance of probability make the same decision, then the parents should be able to make a decision on behalf of their child." (Merryl Willis)
- "Parents ought to be permitted to apply for cosmetic procedures for their children, but treatment ought only to be given if medical / dental professionals are assured that it is in the best interests of their prospective clients. The onus ought to be on the relevant professional to

indicate why any procedure is deemed to be in a child's best interests." (Mission and Public Affairs Council, Church of England)

- "… I would suggest that current protocols of parental consent in many other spheres could well serve as models." (Professor Marilyn Strathern)
- "while parents should be allowed to make these decisions about cosmetic procedures, they should be subject to the same limitations and criteria we have for controlling parental decisions in many other areas of life." (Professor Jackie Leach Scully and Dr Simon Woods)

In response to the fourth section of the call for evidence document, Professor Dennis Baker highlights how "other jurisdictions have invoked the criminal law to protect minors from non-therapeutic cosmetic surgery." Similarly noting other countries' approaches to cosmetic surgery and minors, Francesca Minerva observed that "in 2008 the State of Queensland passed a restrictive law regulating purely cosmetic surgery on children… in Italy an underage person cannot undergo breast enlargement surgery… for purely cosmetic reasons."

13) Should there be any guidelines or regulation as to who can provide non-surgical cosmetic procedures?

Several respondents called for regulation to specify the requirements of providers of non-surgical cosmetic procedures. Comments included:

> "The Government's response to the Keogh report has been disappointing… 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."
> *Dr Sara Fovargue and Dr Alexandra Mullock*

> "… any procedure that is carried out on someone's body and has the potential to cause harm should come under statutory regulation in order to protect patients and uphold standards. We are disappointed that the opportunity to introduce statutory regulation for Botox and dermal fillers and even procedures such as laser treatment have not been taken… this leaves patients at unnecessary risk. We have advised a number of people whose lives have been ruined by such procedures."
> *Action against Medical Accidents*

> "There should be regulation in place, not only for providing/performing non-surgical cosmetic procedures, but also for the supplies used in them. Such procedures should be provided by a certified surgeon, or at least by a health professional and not by improvised personnel at unregulated facilities with uncertified equipment and doubtful hygiene."
> *National Bioethics Commission of Mexico*

Suggestions for what these guidelines or regulation could comprise included:

- Requirements for a registered list of practitioners who hold industry-recognised qualifications.
- "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." (Faculty of General Dental Practice)
- "… a body can supervise the actions and the situations in which non-surgical cosmetics are done... people, clinics and generally everyone who supplies cosmetic procedures can be observed and screened due to the required standards that they have to meet." (Bio Law and Ethics Department of Avicenna Research Institute (I.R. Iran))
- "… there is a need for a basic training (e.g. training as a nurse, M.D., aesthetician), a specific training (e.g. concerning laser treatment) and a tool-related training (e.g. training to work with a certain laser device)." (anonymous respondent)
- A voluntary register of practitioners; adherence to Health Education England (HEE) curriculum; standard setting and oversight; clear signposting for practitioners; a code of conduct. (Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians)
- A requirement that licences should be issued to all premises which provide non-surgical cosmetic procedures (Dr Jaqueline Sanchez Taylor)

Professor Marilyn Strathern, however, argued that there are "more urgent things to do. And one would quickly run into all kinds of grey areas. So my response is a pragmatic one."

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

Several responsibilities were identified by respondents, including:

- Avoiding targeting vulnerable groups
- To ensure safety, and to avoid putting "profit before patient safety (i.e. the 'conveyor belt' approach)" (Anonymous respondent)
- To consider each patient / consumer as individuals
- "Manufacture[r]s must take responsibility to ensure that individuals to whom they distribute their products are suitable." (Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians)
- To provide people seeking to access cosmetic procedures with information in the form of a report (e.g. similar to s or OFSTED)
- To test and trial cosmetic procedures, and to base their use on evidence (e.g. clinical studies)

- To be subject to accreditation
- To provide money-back guarantees: “you get money back guarantee with furniture, etc., same should apply to cosmetic procedures.” (Merryl Willis)
- To use high-quality materials, devices, and procedures.
- To ensure transparency (University of Edinburgh, class of ‘Contemporary issues in medical jurisprudence (Honours)’)
- Honesty about the successes and failures of outcomes (anonymous respondent)
- For suppliers to ensure that “injectable cosmetic materials should only be available to supply such materials to individuals who are permitted to use them.”
- “the way in which many of these procedures are advertised implies that they [are] without risk, and on a par with less invasive beauty treatments such as facials and waxing. Existing advertising recommendations and restrictions should be updated and better enforced.” (The Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians)
- “… 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.” (British Medical Association, noting discussions of its ethics committee)

However, Professor Marilyn Strathern suggested that the age of the consumers / patients in question would make a difference to the question of responsibilities in this context.

In addition, the Mission and Public Affairs Council, Church of England stated that “responsibilities are identical to those of all other private healthcare providers”.

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

No respondents stated that current regulatory measures were too restrictive or appropriate. Of those who stated that the measures were too lax, comments included:

> “Regulation needs to be tightened up so that only those with specialised and proven skills can perform the procedure in question. A register of approve practitioners is a must”.
> *Anonymous respondent*
>
> “There seems to have been little scrutiny on the provision of these services.”
> *Professor Dennis Baker*
>
> “Only qualified and registered healthcare professionals ought to administer cosmetic procedures.”
> *The Mission and Public Affairs Council, Church of England*

> "This type of cosmetic procedure does not fall under any medical regulatory system […] [There] is no requirement that such procedures must be carried out by medical professionals - and in fact no requirement that people carrying them out must have attained any kind of standard in training at all. 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."
> *Expert Council on Cosmetic Interventions (ECCI), formally endorsed by the Royal College of Physicians*

> "In general there is little regulation of cosmetic procedures from the Care Quality Commission and no system in place (outside the civil courts) to compensate patients who may be harmed. Neither is there any national evidence base tracking implants or procedures."
> *Christian Medical Fellowship*

However, Professor Jackie Leach Scully and Dr Simon Woods note that their "main concern… is less with regulatory measures than with public acceptance of and attitudes towards cosmetic procedures."

Dr David Bell and Professor Ruth Holliday note that, "as the PIP issue showed, regulation is needed, but is difficult to implement. Regulation needs to be developed with patients, rather than assuming they are either victims or to blame. The PIP scandal began to mobilise patients' groups in this field, and rather than dismissing or demonizing these, the providers should work with them to understand their perspectives. It is totally unacceptable that some clinics sold breast implants off cheaply once the MHRA finally declared them unsafe. It is totally unacceptable that some of these clinics declared bankruptcy instead of arranging for patients with PIP implants to have them replaced. Clinics should be forced to insure against such eventualities so that patients on low incomes are protected."

Questions 16-18: 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?

No difference

Some respondents, such as Merryl Willis, felt that "all parts are problematic." Dr Sara Fovargue and Dr Alexandra Mullock similarly responded: "No, although the possible dangers of genital surgery on women, reflected in the prohibition on FGM, are highlighted". The Mission and Public Affairs Council, Church of England also noted that "certain parts of our bodies tend to be invested with

particular significance by most people, but it is difficult to argue that they ought, therefore, to be treated differently by health professionals or that procedures on them ought to be subject to different regulation."

Parts associated with high risk of damage

The Christian Medical Fellowship stated that 'problematic' parts of the body "are those where intervention carries the greatest risks of collateral damage or poor outcomes, particularly if the procedures are being carried out by those without the necessary training and skills. Procedures involving eyelids, nasal and facial reconstruction, and genital surgery are of particular concern." Similarly, Dr Ashley Morgan suggested that more problematic parts of the body are "anything which involves [a] higher number of blood vessels than other parts of the body, i.e. the penis."

Genitals

The issue of genital procedures was raised by several respondents.

> "I cannot give an explanation why I personally find FGM / FGCS hard to think about, or why I should regard the genitals as a special area of the body (by contrast with breasts, say). But it would have to do with the place of sex and the body in EI cosmology, and all the connotations of secrecy and privacy that arise, plus the gendering of personal identity… Social practices are likely to vary almost as much as individual proclivities (e.g. consider the Latin American acceptance in some circles that a woman prepares her pubic area through shaving etc. because it 'belongs' to her husband / partner - not to do so is 'dirty' and insulting to the partner)."
> *Professor Marilyn Strathern*

> "genital procedures involve the most 'intimate' areas of the body and poor outcomes undermine confidence at a fundamental level."
> *The Christian Medical Fellowship*
> "it is clear that male and female genitals are culturally sensitive in a way that other areas of the body are not (at least not in western cultures). Given that this is an area of the body that is virtually never on public display, there are stronger reasons to question the rationale/motivation for these interventions than there would be for (say) liposuction or rhinoplasty."
> *Professor Jackie Leach Scully and Dr Simon Woods*

Dr David Veale argued:

> "Female cosmetic genital surgery (FCGS) is considered by some as more problematic than cosmetic surgery on other areas of the body. I am not of this opinion. Objections to FCGS

> do not tend to be mirrored in attitudes to male cosmetic genital surgery (MCGS). My own research suggests that men with genital shame have more psychological and sexual problems than do women. There is very little research into genital body image for either gender to guide us over the psychological aspects of cosmetic genital surgery or indeed any psychological intervention for genital shame. Men generally have more psychological problems with genital shame than women and the outcomes for cosmetic genital surgery in men are probably worse than they are in women."

Dr Veale continued:

> "… for an adult who has full capacity to seek FCGS or MCGS is not different in essence from them seeking any other cosmetic procedure. The motivation for FCGS / MCGS is largely a desire to increase one's sexual attractiveness and reduce the perceived risk of rejection or humiliation. My view is that such procedures should be investigated scientifically in terms of outcomes and risks but that there is no logic behind suggesting that FCGS / MCGS is more problematic than surgery to any other area of the body. If you believe an adult has the freedom to do what they will with their body, why should having a cosmetic genital procedure be policed by others' morality or distaste about procedures to the genitalia?"

Faces

Dr Anne-Marie Martindale highlighted people's faces in response to this question, noting that "faces carry a range of social values and are inherently embedded in social reproduction, they carry meanings far beyond the unit of the individual." Further, Dr Martindale observes that "better looking faces are associated with success, whereas damaged or different looking faces have negative associations."

The visibility of the body part in question was also raised in response to this question. An anonymous respondent noted: "The visible parts may be more problematic, although this is relative (e.g. genital treatment can also be very problematic)."

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 minor 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?

Respondents noted that the application of the Act to female genital cosmetic surgery (FGCS) is widely ignored.

> "Both result in long-term harm (admittedly to different degrees) to the same bodily part, but only one is criminalised."
> *Professor Dennis Baker*

> "… a contrast is made in the terms themselves between procedures interpreted as 'cosmetic' and enhancing (FGCS) and those interpreted as 'abusive' or mutilative (FGM). A comparison is useful - each helps us understand the other. Thus whatever one thinks about them the aesthetic motives of those seeking FGCS helps [European indigenous] people to understand the aesthetic motives of FGM, while the fact that FGM is often carried out under coercive conditions help us to think about the social coercion behind FGCS. In my opinion, they should be treated alike."
> *Professor Marilyn Strathern*

The legal ramifications of the provisions of the FGM Act were noted by an anonymous respondent: "my understanding is that this can trigger criminal proceedings. I expect this means that there will be fewer surgeons willing to undertake this type of surgery." Similarly, the Christian Medical Fellowship stated that the implications of the Act "mean that procedures beyond its provisions are illegal. As a result, those seeking genital 'rejuvenation' procedures may be 'forced' into the hands of private practitioners, more skilled in self-promotion than surgical technique. The answer is not to soften the terms of the Act, but to tighten the regulation of such private practitioners."

The British Medical Association noted that it has "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."

Dr David Veale noted the wording of FGM Act 2003 that no offence will be committed if a procedure is undertaken "which is necessary for her physical or mental health." Dr Veale stated: "trying to define cosmetic procedures being "necessary for mental health reasons" would be completely unworkable. Virtually all patients who seek cosmetic surgery (on whatever part of the body do so from a desire for psychological or social benefit. I am certainly no apologist for cosmetic surgery, but I would strongly argue that cosmetic genital surgery in an adult woman who has full capacity is a world apart from FGM". Similarly, the British Association of Cosmetic Nurses state: "we are not sure there is any implication as there is no indication of 'mutilation' for a woman who electively requests a labiaplasty". The same respondent notes further that "female cosmetic surgery… is seen to be vastly different from FGM as those opting for this type of surgery are usually adult women who have given their informed consent". Similarly, the National Bioethics Commission of Mexico stated that "genital surgery - basically genitals rejuvenation - is a cosmetic procedure that can be performed under the same canons as other cosmetic procedures. For example, as women get older sometimes labia become prominent and this causes some discomfort to some women. However, genital

mutilation is a whole different issue, because it is usually performed based on religious or cultural dogmas that must be analysed in context."

Professor Jackie Leach Scully and Dr Simon Woods also commented on 'mental harm' requirement, noting that it "can be liberally interpreted if not rigorously defined and monitored. There is a suspicion that many women presenting for labiaplasty are experiencing a wish rather than great mental anguish, and as a result both provider and client are colluding in a fiction in order to stay within the law."

Supplementary comments

Supplementary comments related to the issue of FGCS and FGM were also put forward by a number of respondents:

> "I think it is important that women who wish to have surgery to make their labia / clitoris more attractive are counselled and / or have psychological assessment before they have such drastic, most likely, unnecessary surgery. This is one of those surgeries that cannot be reversed."
> *Merryl Willis*

> "We should be careful about how cosmetic markets create a 'need' for procedures when there has otherwise been none. As the Act stands there is a way of legitimising vaginal procedures as long as they are linked to issues around well-being and mental health. All a woman has to do to have vaginal surgery is to express the 'pain' of not feeling 'normal'."
> *Dr Jaqueline Sanchez Taylor*

> "I have interviewed a number of suggestible women who have had such surgery because of exposure to pornographic images of pre-pubescent female genitalia which they are seeking to emulate."
> *Lois Rogers*

> "female genital surgery should not be considered as cosmetic in any case, it's about power and the lack of it."
> *Dr Anne-Marie Martindale*

Male genital surgery was also raised by a small number of respondents.

> "Why leave men out of the equation? They have far more problems than women and penile augmentation is of dubious benefit - should they not be protected and with a male genital surgery law or banning products that claim to increase size?"
> *Dr David Veale*

> "There is also an issue about how this impacts on procedures such as penis enlargement and modification. This is also a

> growing market and linked to gendered status and value. Perhaps the Act should be extended to also cover penis enlargements as both procedures are gendering and reinforce essentialist gendered identities that are normalised."
> *Dr Jaqueline Sanchez Taylor*

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?

Several respondents addressed this question, and raised a number of ethical issues.

Gender reassignment surgery

Gender reassignment surgery was raised by a number of respondents who addressed this question.

> "Clearly gender reassignment surgery has further reaching consequences than surgery on any other parts of the body but I think the same ethical considerations apply; it falls back to the mental state of the patient and their reasons for undergoing the surgery."
> *Anonymous respondent*

> "… gender reassignment surgery and feminisation require careful additional ethical analysis and require interdisciplinary work for its execution."
> *National Bioethics Commission of Mexico*

> "Our gender identification is tied up with our sex organs, the visible organs being the ones which people with gender issues find they ned addressed. I was born a woman and I am happy being a woman. So, I really don't understand how it must be for someone with gender issues. But, I do think that as it is such a major decision to have the surgery, then the patient must seriously want that gender reassignment… [There] needs to be very strict guidelines, regulations, etc., as to how this occurs."
> *Merryl Willis*

However, the Christian Medical Fellowship states that "gender reassignment surgery should not be seen as a cosmetic procedure."

Messages about 'normal' genitalia

> "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."
Dr Sara Fovargue and Dr Alexandra Mullock

"they are usually… invisible areas… normally not on public view except in very specific circumstances (pornography, art, medical contexts). As a result, accurate information about what is normal/abnormal for genitalia (and hence when intervention might be considered) is less prevalent and harder to disseminate by public health efforts, especially among some cultural groups. The lack of knowledge means that people's ideas about genital normality/abnormality are strongly influenced by media imagery and pornography".
Professor Jackie Leach Scully and Dr Simon Woods

"It appears the impetus for girls and women demanding this procedure is the increase in pornography material online and their desire to conform to the norms set by the pornography industry."
Professor Dennis Baker

"pornography and the link between women being unhappy with their vaginas thinking they are abnormal or ugly because of comments made by their boyfriends or husbands who are judging their normal anatomy to the pornographic images they have seen."
The British Association of Cosmetic Nurses

"Vaginas, penises and the genitals are less visible [than breasts] but equally linked to constructions of womanhood and manhood and how we feel about these parts of the body should not be left to the market alone to decide. There is therefore an ethical debate to be had about the direction we allow this market to take and how we engage with the demand for such procedures and how it will shape our ideas about gender in the future." *Dr Jaqueline Sanchez Taylor*

Professor Marilyn Strathern highlighted a series of ethical issues:

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

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

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

(d) Finally, by not treating these practices together, we fail to seize the opportunity of understanding just what may lie behind FGM. That is, perhaps those who seek the same mutilation for cosmetic reasons (FGCS) might give us some insight into the appeal and value of FGM cutting. Indeed one might regard some of the reasons given for the latter as ethically more acceptable in local terms, as when it is justified in terms of increasing fertility or making a woman marriageable.

Genital procedures on children and young people

The issue of "non-therapeutic modifications of children's genitals (whether male or female, or indeed intersex)" was raised by an anonymous respondent in response to question 1. The same respondent stated that "typically, parents elect these procedures for their children… because they believe they will improve the aesthetic appearance of their child's genitals. But this can be problematic… we don't yet know what kind of genital aesthetics the child itself will adopt upon reaching sexual maturity…"

No distinct issues

The Mission and Public Affairs Council, Church of England suggested that, "in principle, there are no distinctive issues, but particular care ought to be taken by the relevant health professionals that any intervention is genuinely in the prospective patient's best interests and that all implications have been taken into account."

Other comments

A range of unrelated comments were submitted by a number of respondents, including:

> "There is an urgent need for a proper legal framework around this whole industry. It cannot be discussed in terms of achieving 'stakeholder agreement' before any action can be taken, it should simply be imposed."
> *Lois Rogers*

> "Perhaps an established ethics committee in all hospitals (or available to day surgery centres) for practitioners to access with regards patients whose cosmetic surgery sits outside an established 'norm'."

Merryl Willis

"Clear guidelines for practitioners who feel that a previous practitioner has operated inappropriately to follow. Perhaps even the ability to contact the registration board to talk to someone anonymously re. concerns."
Merryl Willis

Amputation for psychological reasons: there are clearly some very interesting points of comparison regarding the role / limits of medicine and the ethical challenges that arise when interventions are requested by patients / consumers rather than those which are suggested in accordance with a diagnosis.
Professor June Andrews

Further factfinding suggestions

Respondents also highlighted groups of people which the Working Party might find it useful to speak to as part of its deliberations.

"… is there any way to include the views of people who have been satisfied and unsatisfied with cosmetic procedures in the past, including medical negligence lawyers? Perhaps also the views of people from the organisation Changing Faces".
Dr Anne-Marie Martindale

Further questions to consider

In extensive further comments provided in response to this last question, Merryl Willis lists the following prompting questions / points:

- "We generally accept that we should respect the person's right to autonomy, i.e., where a capable individual can act freely in accordance with a self-chosen plan. So, when does someone become incapable of acting on their own behalf?"
- "How does the practitioner reconcile his / her obligation to do no harm when it comes to cosmetic surgery? How does he establish this when deciding to perform cosmetic surgery?"
- "Do we need to look at intent? Patient's intent, practitioner's intent? How does this relate to intended consequences?"
- "Does having cosmetic surgery improve the patient's quality of life? Who determines this?"
- "Do we have an obligation to rescue people from unnecessary cosmetic surgery?"
- Is interfering with someone's wish for cosmetic surgery a form of paternalism?
- "Should we respect the choice of the patient even if it is irrational when the patient cannot be persuaded to change their mind?"
- "Is cosmetic surgery health related or a commodity?"

- “Can we compare a patient’s right to refuse end of life treatment, e.g., terminally ill patient who opts for palliative care, which is debatably, universally acceptable now, to the patient’s right to modify their body as they see fit, even if we think the body modification is irrational?”
- “Is giving in to a patient’s wish to have cosmetic surgery, which the practitioner feels, on balance, that it is inappropriate, a breach of duty of care?”

Professor Jackie Leach Scully and Dr Simon Woods also suggest that that there is “a need for further exploration of healthcare professionals’ responses to the growing use of cosmetic procedures, in a wider sense than simply looking at the responsibilities of cosmetic practitioners themselves.”

Omissions

Professor Jackie Leach Scully and Dr Simon Woods stated that: “We noted that there is no mention in this document of the specific cases of gender modification (i.e. for transgender individuals), the normalisation of appearance or function for people with disabilities, and the rare but intriguing phenomenon of people wanting interventions that are actively disabling, and which would be judged as not just medically unnecessary, but in breach of the physician’s obligation to ‘do no harm’. While we appreciate that the focus of this call for evidence has been on the more familiar forms of common cosmetic procedures, it would be a mistake if only these were to shape the parameters of our thinking about cosmetic interventions.”

An anonymous respondent suggested that the questions “skirt the issue of why people feel cosmetic procedures are normatively freighted in a way that other procedures are not.” This respondent further suggests that a further exploration of this issue might include the role of the threat of and jealousy towards “enhanced physical sexuality”; the question of whether the “pursuit of characteristics linked with sexuality might be considered intrinsically morally problematic”; and the question as to whether “mental attributes are inherently more valuable than physical attributes”. On this last point, the respondent noted the “unspoken assumption that the pursuit of the physical (often in terms of sexual desirability) is inappropriate, somehow crass. Why not read a good book instead of worrying about your weight? Why not study another language instead of working extra hours to afford liposuction? What is breast size next to academic attainment? In certain segments of society, these sentiments are exceptionally common”.