

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

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NUFFIELD COUNCIL ^{ON} BIOETHICS

Cosmetic procedures: ethical issues

Call for evidence

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(Closing date: 18 March 2016)

Introduction

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

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

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

<u>Definitions and aims</u>	<u>Increasing demand for cosmetic procedures</u>
<u>The supply and regulation of cosmetic procedures</u>	<u>Different parts of the body</u>
<u>Any other comments?</u>	
<u>How to submit your response</u>	

Definitions and aims

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

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

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

Questions 1-3

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

To some extent it's an arbitrary divide, all procedures seek to enhance social acceptability. However, if I had to define a cosmetic procedure, something that is non-essential and is designed to make the person look younger, or 'better looking', or 'feel better', though I admit these are vague terms.

2. What do you see as the underlying aim of cosmetic procedures (a) from the perspective of those seeking a procedure and (b) from the perspective of those providing procedures? How does this differ for different social groups?
 - a) Esteem, social acceptance, going up the body beautiful hierarchy, a form of body status, i.e. they can afford to do it.
 - b) To provide patient satisfaction, to get well paid,
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?

It is an extension of this conformity to appearance related norms though with costs, embodied disruption and pain, and a longer term effect.

Increasing demand for cosmetic procedures

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

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

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

Questions 4-8

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

The rise of the influence of the media, and television/internet advertising has led to more (unrealistic) emphasis on female presenters appearing young and beautiful. This pressure has now shifted to men, to an extent. An increase in beauty salons providing more varied treatments including medicalised treatments, an increase in celebrity culture and its prevalence across TV and the internet, and print media, the ease in which people can get credit. The continuation of unrealistic body sizes and facial appearances in Hollywood actors/actresses. It is also compounded by the lack of older, and more diverse role models on British television. Let me qualify. Older, less attractive men seem to be ok, where as middle aged women and older seem to become invisible, unless they reach a certain age and are deemed to be useful as 'character' actors. This also needs to be challenged. One only has to look at Scandinavian TV to see how narrow our TV characters are. Let's see people of all ages, and illustrate that everyone ages and that bodily diversity is the norm.

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

Yes, because the social pressures that underlie many procedures are not being tackled and the fantasy of procedure can remain unattainable, so the person has more.

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

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. This section is taken from my PhD.

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'Where once the apparent truth of the Cartesian body as the unified and fundamentally unchanging material base of continuing existence could be taken for granted, the development of both contemporary biosciences and post-conventional models of theoretical inquiry have radically undone that illusionary certainty' (Shildrick, 2010, p.11).

As Shildrick (2010) alludes, there is no single type of body to which experiences occur. In the West, the myth of the universal 'body' type has arisen with the development of the biomedical sciences and their increasing focus on normative form and function throughout the nineteenth and twentieth century's (Wendell, 1996). The myth centres around the imperial, patriarchal 'ideal' of the young, white, able-bodied male which is self-contained, bounded from others and unlocated in time and space (Grosz, 1994; Wendell, 1996). Social scientists and disability rights activists have challenged the idea that there is a single 'ideal' body type, which should speak for all bodies (Haraway, 1991; Wendell, 1996; Shildrick, 1997). Consequently, there is no such thing as a universal, abstracted, or timeless face to which experiences occur. As ethicist Perpich (2010) states bodies are perpetually in a state of becoming, changing in size, shape, abilities and component part. In addition, there are many types of corporeality, for example transgendered people, those born with congenital conditions or those with acquired disabilities as well as people who undergo transplant surgeries (Shildrick,

2002). For Perpich (2010), to be a body is to be exposed, a solid mass but also to be vulnerable. This is true of faces, as they are always on show and generally uncovered. Shildrick (1997) goes so far as to suggest that bodily vulnerability is an essential condition of corporeality. Concurring with these sentiments Grosz (1994, p.19) argues that as bodies are always gendered, ethnically and sexually distinct and embedded in strata and cultural worlds, they are incapable of being incorporated into a single universal model to be generalised from. Not only are our bodies diverse, we are also subject to multiple identity influences. As Van Wolputte (2004) argues 'we are all creoles of sorts' (p.263).

We need to do more to celebrate and publicize things like the Paralympics and bring bodily diversity into schools, repeatedly from an early age.

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

I'm not sure we should judge, this puts the blame for not feeling or looking good enough back onto individuals. We need to tease out where the 'need' for the procedure comes from, and perhaps offer counseling before hand?

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

I don't know how they advertised in any depth. However, I'm sure this needs to be considered.

The supply and regulation of cosmetic procedures

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

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

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

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

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

- Health Education England has been commissioned by the Department of Health to develop accredited qualifications for providers of non-surgical procedures, and its final report, including implementation proposals, was published in January 2016.¹⁴

- The General Medical Council (GMC) is developing a system of 'credentialing' so that doctors with a credential in a particular field of practice, such as cosmetic practice, can have this recorded in their entry on the medical register.¹⁵ The GMC has also issued draft ethical guidance for all doctors who offer cosmetic procedures.¹⁶
- The Royal College of Surgeons has established a Cosmetic Surgery Interspecialty Committee (CSIC) with a remit to develop standards for training and certification across the range of specialties offering cosmetic surgery; develop high quality patient information; and develop clinical outcome measures.¹⁷

Particular regulatory issues may arise with respect to access to cosmetic procedures by children and young people, or by others regarded as vulnerable in some way, such as people with body dysmorphic disorder (BDD). With respect to children, while parents are legally entitled to provide consent for their children's medical treatment, their authority to provide consent for invasive procedures undertaken for cosmetic purposes is more uncertain. Comparisons may be drawn with other areas of regulation, such as the *Tattooing of Minors Act 1969* which specifically prohibits practitioners from tattooing persons under the age of 18.¹⁸ Similar regulations apply to the use of sunbeds by children and young people under the age of 18, other than when under medical supervision.¹⁹

Questions 9-15

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

Both, and neither, they are always embedded citizens subject to western, social and peer pressures and influences.

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

Who will carry out the procedure, what training and experience they have, if there have been any problems or complaints, what to do if you have a complaint. How much it will cost, if there are any after effects. Perhaps counseling firms that specialize in body related issues.

11. Are there (a) any people or groups of people who should not have access to cosmetic procedures or (b) any circumstances in which procedures should not be offered?

It's a tricky one, 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 theory those who are vulnerable who cannot speak for themselves should not have procedures done, but that contradicts my earlier point. 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.

I do not think boob enhancements, dermal fillers or botox should be offered to women under 18.

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

Purely cosmetic procedures should be very restricted for children under the age of 18, regardless of parental wishes. Parents should not be able to shop for a business that will do their bidding. Companies found to be providing services to under age clients should be fined and named and shamed.

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

Yes, absolutely, either train people up or only have medically qualified people conducting some procedures.

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

To provide potential clients with a range of information, or make it publically available, like a CQC or OFSTED report, so that people can be informed.

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

I don't know enough to comment.

Different parts of the body

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

Questions 16-18

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

My area of interest is faces, this is the abstract from my PhD. In short faces carry a range of social values and are inherently embedded in social reproduction, they carry meanings far beyond the unit of the individual.

Abstract

With the advent of facial transplantation some academic authors have suggested that faces

are significant for humans and that identities are located corporeally within faces and therefore transplantable. However, there has been little evidence to support these claims, particularly from a qualitative, theoretically informed social science background.

Responding to this hiatus, in this thesis I set two interconnected research objectives:

□ to examine socio-cultural values associated with human faces in predominantly Western societies using secondary sources;

□ to explore the relationship between acquired facial 'disfigurement' and embodied identity shift using a narrative methodology.

The first objective was addressed in full through an analytical review of largely Western secondary sources. It has become clear that faces, as part of bodies, are imbued with a variety of socio-cultural meanings on multiple levels. Individually people experience the world through their body and their face, making it a significant site for perception and sense making. On a societal level, faces and facial appearance have been associated with social reproduction (Giddens, 1991). For example, inaccurate and harmful historical associations between facial appearance and moral character still pervade British society. And, utilising the concept of faciality (Deleuze and Guattari, 1987, p.168) Twine (2002), Dudley (2002) and Benson (2008) have illustrated that the faces of people in sub-sections of society, generally those with very little power, can be conceptualised negatively and used to serve the interests of powerful elites.

In terms of the second objective, most facial 'disfigurement' research has been completed using quantitative methods, resulting in partial knowledge and the disconnection of persons. Through the use of a phenomenological epistemology, embodiment position and a narrative methodology I have put the experiences of the 13 participants at the heart of the research. The analysis chapters focus on the participants' embodied identities before, during and after an acquired facial 'disfigurement'. In terms of conclusions, I have found that faces are important however, identities are not located within them but created and reshaped through embodied life experiences. I have also found that the relationship between embodied identity shift and acquired facial 'disfigurement' is one of contested negotiation between wider socio-cultural facial values, transitional/liminal identity states during and after the event(s) and the aim of previous identity restoration'.

So, faces are never neutral canvases waiting to be beatified, they are powerful purveyors of embodied identities and aspirational societal identities. Better looking faces are associated with success, where-as damaged or different looking faces have negative associations. (See Changing Faces organisation). Perhaps this is where we need to do more work, whilst regulating work at the knife's edge?

17. The *Female Genital Mutilation Act 2003* prohibits the excision or mutilation of "any part of a girl's [or woman's] labia majora, labia minora or clitoris", unless this is held to be necessary for her physical or mental health. What are the implications of the Act for female genital cosmetic surgery?

Female genital surgery should not be considered as cosmetic in any case, its about power and the lack of it.

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?

Different parts of the body are valued differently, yet they are also parts of persons, which are embedded in social and power networks. The danger is that we disconnect people from their body parts and do not fully take account of wider national or global inequalities.

Any other comments?

Clarification about what is a cosmetic procedure should also involve who should do it, how practitioners are regularly assessed and what opportunities clients have for redress if something happens.

Please highlight any relevant areas you think we have omitted, or any other views you would like to express about the ethical issues arising in connection with cosmetic procedures.

I'm sure you've already done this but if not 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, a face equality and support organisation.

References

- ¹ See, for example, the 2010 Mintel market intelligence report on cosmetic surgery, which highlighted that the value of the cosmetic sector in the UK had risen from £720 million in 2005 to £2.3 billion in 2010, and was estimated to grow to a value of £3.6 billion by 2015 (cited in: Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>). The British Association of Aesthetic Plastic Surgeons (BAAPS) collects its own figures on the number of procedures carried out by surgeons who are members of the Association, with figures rising from 16,367 procedures in 2004 (see: The British Association of Aesthetic and Plastic Surgeons (24 January 2005) *British Association of Aesthetic Plastic Surgeons announce annual audit results*, available at: <http://baaps.org.uk/about-us/audit/779-british-association-of-aesthetic-plastic-surgeons-announce-annual-audit-results>) to 45,506 in 2014 (see: The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>). The 2014 figures in fact showed the first annual *decrease* (down 9% from 2013) after a decade of increases, a change ascribed to a ‘post-austerity’ boom in 2013 leading to double-digit rises, now “returning to a more rational level.”
- ² 91% of procedures carried out by members of the British Association of Aesthetic Plastic Surgeons in 2014 were on women, and this ratio between men and women seeking procedures has remained constant over a number of years. See: The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>.
- ³ See, for example, Hurd Clarke L, and Griffin M (2007) The body natural and the body unnatural: beauty work and aging *Journal of Aging Studies* **21(3)**: 187-201; Swami V (2009) Body appreciation, media influence, and weight status predict consideration of cosmetic surgery among female undergraduates *Body Image* **6(4)**: 315-7; Menzel J, Sperry S, Small B *et al.* (2011) Internalization of appearance ideals and cosmetic surgery attitudes: a test of the tripartite influence model of body image *Sex Roles* **65(7-8)**: 469-77; and Nabi RL, and Keblusek L (2014) Inspired by hope, motivated by envy: comparing the effects of discrete emotions in the process of social comparison to media figures *Media Psychology* **17(2)**: 208-34.
- ⁴ See, for example, Markey CN, and Markey PM (2009) Correlates of young women’s interest in obtaining cosmetic surgery *Sex Roles* **61(3-4)**: 158-66; Goodman MP, Placik OJ, Benson III RH *et al.* (2010) A large multicenter outcome study of female genital plastic surgery *The Journal of Sexual Medicine* **7(4)**: 1565-77; Eriksen S, and Goering S (2011) A test of the agency hypothesis in women’s cosmetic surgery usage *Sex Roles* **64(11-12)**: 888-901; and Tranter B, and Hanson D (2015) The social bases of cosmetic surgery in Australia *Journal of Sociology* **51(2)**: 189-206.
- ⁵ Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>, paragraphs 1.5-1.6, citing research commissioned from Creative Research Ltd. with the general public, GPs, and teenagers.
- ⁶ See: YouGov (21 July 2015) *Over a third of Brits are unhappy with their bodies*, available at: <https://yougov.co.uk/news/2015/07/21/over-third-brits-unhappy-their-bodies-celebrity-cu/>. This survey indicates that 37% of British people were not very happy or not happy at all with their body image and weight. The highest rate of positive body image was found in Indonesia, where 78% claim to be happy with their body weight and shape.
- ⁷ Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>, at paragraph 1.4; Creative Research (2013) *Regulation of cosmetic interventions: research among the general public and practitioners*, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192029/Regulation_of_Cosmetic_Interventions_Research_Report.pdf, at paragraph 1.2.1.
- ⁸ See, for example, Hurd Clarke L, and Griffin M (2008) Visible and invisible ageing: beauty work as a response to ageism *Ageing & Society* **28(5)**: 653-74; Sanchez Taylor J (2012) Fake breasts and power: gender, class and cosmetic surgery *Women’s Studies International Forum* **35(6)**: 458-66; Gulbas LE (2013) Embodying racism: race, rhinoplasty, and self-esteem in Venezuela *Qualitative Health Research* **23(3)**: 326-35.

9 Creative Research (2013) *Regulation of cosmetic interventions: research among the general public and practitioners*, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192029/Regulation_of_Cosmetic_Interventions_Research_Report.pdf, pp29-30.

10 See, for example, the discussion in Gagne P, and McGaughey D (2002) Designing women: cultural hegemony and the exercise of power among women who have undergone elective mammoplasty *Gender and Society* **16(6)**: 814-38.

11 Including: Department of Health (2005) *Expert Group on the Regulation of Cosmetic Surgery: report to the Chief Medical Officer*, available at:
http://webarchive.nationalarchives.gov.uk/20081105143757/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4102046 (the Cayton report); NCEPOD (2010) *On the face of it: a review of the organisational structures surrounding the practice of cosmetic surgery*, available at: <http://www.ncepod.org.uk/2010cs.htm>; and Department of Health (2012) *Poly Implant Prosthèse (PIP) breast implants: final report of the Expert Group*, available at: <https://www.gov.uk/government/publications/poly-implant-prothese-pip-breast-implants-final-report-of-the-expert-group>.

12 Department of Health (2013) *Review of the regulation of cosmetic interventions*, available at: <https://www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions>.

13 Department of Health (2014) *Government response to the review of the regulation of cosmetic interventions*, available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf.

14 Health Education England (8 January 2016) *New qualifications unveiled to improve the safety of non-surgical cosmetic procedures*, available at: <https://hee.nhs.uk/news-events/news/new-qualifications-unveiled-improve-safety-non-surgical-cosmetic-procedures>.

15 General Medical Council (2015) *Credentialing*, available at: http://www.gmc-uk.org/education/continuing_professional_development/27258.asp.

16 General Medical Council (2015) *Guidance for all doctors who offer cosmetic interventions: a public consultation on our draft guidance*, available at: http://www.gmc-uk.org/Guidance_for_all_doctors_who_offer_cosmetic_interventions_consultation_english__2__distributed.pdf_61281552.pdf.

17 Royal College of Surgeons (2015) *Cosmetic surgery: certification updates*, available at: <https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/certification-updates>.

18 *Tattooing of Minors Act 1969*, available at:
<http://www.legislation.gov.uk/ukpga/1969/24/introduction,section.1>.

19 *Sunbeds (Regulation) Act 2010*, available at:
<http://www.legislation.gov.uk/ukpga/2010/20/contents,sections.2.and.3>.

20 The British Association of Aesthetic and Plastic Surgeons (26 January 2015) *Tweak not tuck*, available at: <http://baaps.org.uk/about-us/audit/2040-auto-generate-from-title>.

21 One UK provider of cosmetic procedures observed a 45 per cent increase in enquiries for female genital cosmetic procedures between 2010 and 2013. The provider also found that recipients of this range of procedures were getting younger: the average age of patients in 2010 was 35; in 2013, this had fallen to 28. See: Transform (30 August 2013) *Transform reports surge in enquiries for vaginoplasty procedures*, available at:
<https://www.transforminglives.co.uk/news-blog/news/2013/08/transform-reports-surge-in-enquiries-for-vaginoplasty-procedures/>.

22 International Society of Aesthetic Plastic Surgeons' (ISAPS) data show a near 400% increase between 2010 and 2014. See: International Society of Aesthetic Plastic Surgery (2014) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2014*, available at: <http://www.isaps.org/Media/Default/global-statistics/2015%20ISAPS%20Results.pdf>; International Society of Aesthetic Plastic Surgery (2013) *ISAPS' international survey on aesthetic / cosmetic procedures performed in 2010*, available at:
<http://www.isaps.org/Media/Default/global-statistics/ISAPS-Results-Procedures-2010.pdf>.

23 ISAPS annual statistics include the figure of 10,053 penis enlargement operations in 2014, but do not list this procedure in 2010. See: International Society of Aesthetic Plastic Surgery (2014) *ISAPS international survey on aesthetic / cosmetic procedures performed in 2014*, available at: <http://www.isaps.org/Media/Default/global-statistics/2015%20ISAPS%20Results.pdf>; International Society of Aesthetic Plastic Surgery (2013) *ISAPS' international survey on*

aesthetic / cosmetic procedures performed in 2010, available at:

<http://www.isaps.org/Media/Default/global-statistics/ISAPS-Results-Procedures-2010.pdf>.

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See, for example, the concerns expressed about motivations for female cosmetic genital surgery, as in Royal College of Obstetricians and Gynaecologists (2013) *Ethical opinion paper: ethical considerations in relation to female genital cosmetic surgery (FGCS)*, available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf>: it is difficult to imagine concerns being expressed in the same way about cosmetic procedures undertaken on the face or breasts.