

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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Answers to Q16-18

My background: I am answering this question in my own capacity. I am a Consultant Psychiatrist at the South London and Maudsley NHS Trust and a Visiting Reader in Cognitive Behavioural Psychotherapies at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. I am a Fellow of the Royal College of Psychiatrists, a Fellow of the British Psychological Society and Honorary Fellow of the British Association of Behavioural and Cognitive Psychotherapies. I am clinical lead for a national service for people with severe treatment refractory Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD). I am a member of the group revising the diagnostic guidelines for ICD11 for Obsessive Compulsive and Related Disorders for the World Health Organisation. I was a member of the group that wrote the NICE guidelines on OCD and BDD in 2006 and chaired the NICE Evidence Update on OCD and BDD in 2013. I have authored or co-authored over 100 scientific articles, 6 books and 12 book chapters. My scientific articles have included research on the psychological outcome of labiaplasty (Veale, Naismith et al, 2014); the characteristics and motivation of women seeking labiaplasty (Veale, Eshkevari et al, 2014b); the risk factors for women seeking labiaplasty (Veale, Eshkevari et al, 2014a); the validation of a scale to measure outcome for women who are dissatisfied with their genital area (Veale et al, 2013) and a teaching chapter on genital body image for sexual health physicians (Miles et al, 2014). I have also published an unusual case history of a woman after a labiaplasty was seeking cosmetic

clitoridectomy. This occurred and at long term follow up was very pleased by the procedure (both aesthetically and sexually) (Veale & Daniels, 2012, 2013). I have also conducted similar research in men regarding their worries about the size of their genitalia and their shame in terms of the characteristics and risk factors of such men and a nomogram of the normal size (Veale, Miles et al 2014; Veale et al, 2015a, 2015b, 2015c, 2015d & 2016).

Q 16 and Q17 Thinking of cosmetic procedures, are there some parts of the body that are more problematic than others? If so, can you explain why?

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.

Men may seek penis enlargement “solutions” from Internet sites that promote non-evidence based lotions, pills, exercises, or penile extenders (Veale et al, 2015). Such men may also seek help from private urologists or

plastic surgeons, and may be offered fat injections or surgical procedures to try to increase the length or girth of their penis. However, cosmetic phalloplasty is still regarded as experimental without any adequate outcome measures or evidence of safety (Ghanem, 2013). Equally, there are no evidence-based studies that evaluate any psychological intervention for men who are anxious about the size of their penis, although one study reported a case series of counselling and reassurance to avoid penile surgery (Ghanem, 2007). There is evidence for the benefit of cognitive behaviour therapy (CBT) for BDD or body image problems in general (Veale et al, 1996, Veale, et al 2014) but not for CBT in genital shame (with or without BDD). There is also evidence that some people with severe BDD (in general) tend to do badly with cosmetic surgery; alternatively, their BDD symptoms remain the same after surgery.

Between 3,000 and 4,000 labiaplasties (usually excision of the labia minora) are estimated to be performed every year in the UK by gynaecologists in the NHS and by private cosmetic surgeons. The motivation is broadly either for cosmetic, functional or sexual reasons (or a combination of them). The very large majority proceed without any psychological or psychiatric assessment. Since the report on FCGS was published by the RCOG, there is now some evidence base for the positive outcomes after FCGS with only minor side effects in women (Goodman et al 2013, Veale et al, 2014; Goodman et al, in press). It is unlikely that this is any different from cosmetic surgery in general.

I would argue that 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? If the adult consents, and has full capacity and is of "sound mind", I do not believe it is for us to dictate what a person may modify, enhance or change about themselves. Decisions about being of "sound mind" (other than obvious diagnoses such as psychosis or mania) is part of a research agenda. The evidence from our small case series was that women with BDD having labiaplasty did just as well as women without BDD (Veale et al, 2014). However, we are also in process of trying to develop and evaluate a psychological intervention in a pilot case series to help individuals with genital shame in both sexes so that we can start to build an evidence based alternative to surgery. This is no different to cosmetic surgery in general but there are no randomised controlled trials (and they would be difficult to conduct) that compare cosmetic surgery to a psychological intervention. Equally it's not something that will ever be funded by the NHS or the industry!

The Royal College of Obstetricians and Gynaecologists (FCOG) report on cosmetic genital surgery suggests that "*Women requesting labiaplasty should be provided with accurate information about the normal variations in female genitalia and offered counselling and other psychological treatments*

for problems such as body image distress. Education, support and advice should be at the heart of clinical practice, with a sympathetic appreciation of female body insecurities." I do not think anyone would really disagree with this but there is no evidence base for such advice. Many women "know" that their genitalia are within the normal range but still seek modification. However, there is not a single case series measuring genital body image and quality of life before and after been reassured that they are "normal" and given such advice to see whether women still seek FCGS after receiving it. Can one imagine women who seek breast or buttock augmentation being told, as a clinical response to their request for surgery, that their size is within the normal range, and then being counselled on the normal diversity of breast/buttock size?

It is also important to consider the role of genital body modification. Body modification is a term used to describe the deliberate altering of the human body for non-medical reasons (e.g., self-expression). It is invariably done either by the individual concerned or by a lay practitioner, usually because the individual cannot afford the fee of cosmetic surgery or because it would transgress the ethical boundaries of a cosmetic surgeon. It appears to be a lifestyle choice and, in some instances, is part of a subculture of sadomasochism. It has existed in many different forms across different cultures and ages. In a minor form, it consists of tattooing or piercing any part of the body, including the genitalia. Extreme examples of body modification in non-psychotic individuals include tongue splitting (bisection of the tongue similar to a snake), branding, or scarification (controlled burning of tissue to create scarring). Women may seek lay practitioners to remove or partially

remove the clitoral hood to increase sensitivity or make it easier to place a clitoral piercing. Men may do penile subincision (splitting of the underside of the penis), penectomy or scrotal implants or removal. Both sexes may undergo pearling (permanent insertion of small beads made of various materials beneath the skin of the labia in women or the foreskin of the penis). The website <http://wiki.bmezone.com> is an encyclopaedia of body modification, including the genitalia. There is, however, very little research on psychological aspects of body modification. Lemma (2010) has suggested that, in some individuals, it is a way of trying to modify the self that is felt to be unacceptable. Body modification is not very different from the procedure of FCGS except that the latter is professionally regulated and is likely to be safer.

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? 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?

There is a political dimension to this debate as the Director of Public Prosecutions appears to be under pressure to get convictions from the FGM Act. The Act states that “A person is guilty of an offence if he aids, abets, counsels or procures a person to excise, infibulate or otherwise mutilate the

whole or any part of her own labia majora, labia minora.” The FGM bill states that “1.1 A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl’s labia majora, labia minora or clitoris. But no offence is committed by an approved person who performs a surgical operation on a girl which is necessary for her physical or mental health.’ The explanatory notes to the Bill (“Home Office (2002) Female Genital Mutilation Bill Explanatory notes. Bill 21-EN House of Commons.”), state “..operations necessary for mental health could include, for example, cosmetic surgery resulting from the distress caused by a perception of abnormality or gender reassignment surgery”. There is no other source of official guidance. A Parliamentary Select Committee recently recommended that the Government should consider making female genital cosmetic surgery an offence in those under the age of 17 and considered whether there was any difference between FGM and cosmetic labiaplasty.

I am also of the view that FCGS under the age of 18 is unwise. The Home Secretary and Government’s response was of interest: “*Section 1(2) of the Female Genital Mutilation Act 2003 provides a defence for medical professionals carrying out surgical operations that are necessary for a girl’s physical or mental health or carried out in connection with childbirth. The 2003 Act does not contain any exemption for cosmetic surgery. So, if a procedure involving any of the acts prohibited by section 1 (cosmetic or otherwise) is unnecessary for physical or mental health, and is not carried out in connection with childbirth, then it is an offence even if the woman on whom the procedure is carried out consented. Ultimately, it would be for a court to decide if purely cosmetic surgery constitutes mutilation and is therefore illegal. The courts*

could be asked to rule whether "purely cosmetic surgery" falls into the same category of crime as female genital mutilation (FGM)." This seems to be a different interpretation than that offered by the Home Office guidelines before the Act was passed in 2002. It also seems to be encouraging the Director of Public Prosecutions to test the law. In my opinion, 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 (in terms of what is done surgically, the motivation behind the procedure and the psychological and possible physical effects of the procedure). Some gynaecologists campaign in the literature for FCGS to be made illegal under the FGM Act. I would argue that the ethical issues behind FCGS or genital body modification are no different from any other cosmetic procedure or body modification. 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 of products that claim to increase size?

I personally find it sad that some people cannot be happy as they are and so seek cosmetic genital surgery. However, as I argued above, if as a society we believe that adults have the freedom to do what they will with their own body, provided they are over the age of 18, have capacity and are of "sound mind" then any decision on cosmetic genital surgery should be up to them with the appropriate medical advice. Individuals seeking FCGS should

have good information about the likely risks and benefits (like any other cosmetic procedure, which the industry should fund in the way that NHS funds research on effectiveness) and we need to build an evidence base for psychological alternatives to surgery; patients should be evaluated pre-operatively by a practitioner for any known contra-indications; they should provide informed consent and surgeons offering FCGS should be adequately regulated (as for any other cosmetic procedure). Lastly the promotion and advertising of FCGS should be adequately regulated (as with any other cosmetic procedure).

David Veale

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