

NUFFIELD
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BACKGROUND PAPER

Aesthetic/Cosmetic Procedures

*Donna Dickenson, Emeritus Professor of Medical Ethics and
Humanities, University of London*

**Forward Look
7-8 May 2013**

Note

The author was commissioned by the Nuffield Council on Bioethics to write this paper in order to inform the Council's discussions about possible future work on this topic. The paper is intended to provide an overview of key clinical, ethical, social, legal and policy issues, but is not intended to offer any conclusions or recommendations regarding future policy and practice. Any views expressed in the paper are the author's own and not those of the Nuffield Council on Bioethics.

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Summary

1. This paper sets the growth of aesthetic or cosmetic procedures in their social, legal and medical context. It outlines the complex ethical issues raised by aesthetic procedures, including but transcending the issues of autonomy, consent and choice, by also considering the duties of a doctor and the goals of medicine.

Background

Terminology and coverage

2. There is no widely agreed, objective term to describe the phenomena covered by this background paper. 'Plastic surgery' is too broad because it includes medically identical procedures performed as restorative operations (for example, breast implants after mastectomy) but also too narrow because it does not cover non-surgical procedures such as dermal fillers. 'Elective surgery' has the additional disadvantage of shutting down the debate from the start about whether aesthetic surgery is genuinely consensual. 'Enhancement' likewise covers too much, by also referring to neurocognitive or pharmaceutical techniques aimed at improving not only appearance but also intelligence or even moral virtue.¹ 'Cosmetic surgery' is disliked by some because it appears to trivialise the procedures, while 'aesthetic surgery' does the opposite by elevating them to the level of art. This report will use the terms 'cosmetic procedures' and 'aesthetic procedures' interchangeably, and likewise, when surgery is specifically at issue, either 'cosmetic surgery' or 'aesthetic surgery'.
3. Because of the enormous potential breadth of this topic and the limited space available in this background paper, restorative plastic surgery, male circumcision on religious or cultural grounds, and gender reassignment will not be covered. The concrete specifics and legalities of regulation are being considered by a Department of Health review, including the regulation of non-medical practitioners offering non-surgical procedures. This background paper will instead concentrate on the wider philosophical and legal issues involving consent, paternalism, gender, ethnicity, identity and 'normality'.

¹ Douglas T (2008) Moral enhancement *Journal of Applied Philosophy* **25(3)**: 228-45.

The limitations of the evidence

4. It is difficult to estimate the true extent of aesthetic procedures because so many are performed outside the National Health Service and beyond the remit of the professions. There is no recognised specialty or specific standards for cosmetic surgery: much of it is provided by surgeons who have qualified in other specialties, such as plastics, ear, nose and throat, or ophthalmic surgery.² The British Association of Aesthetic Plastic Surgeons stated that its members carried out over 43,000 surgical operations in 2011, an increase of 12 per cent on the previous year.³ However, it has no data on cosmetic surgery carried out by the 60 to 70 per cent of UK providers who do not belong to the association, let alone on the 'medical tourist' market for procedures carried out abroad on UK residents. The 2010 Mintel Report (Cosmetic Surgery, Market Intelligence) estimated that in that year approximately 1.35 million cosmetic surgical interventions were performed in this country, and that by 2015 the UK aesthetic surgery market would be worth £3.6 billion.⁴
5. A 2010 report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) sent questionnaires to 548 clinics performing cosmetic surgery.⁵ Over two-thirds (68%) of the clinics, a total of 371, either did not answer or refused to take part, suggesting "that they are unaware of their obligation to take part in the work of the confidential enquiries or take a nonchalant attitude to such obligations". Although the report's authors declined to speculate on "whether the 32% who responded are likely to be more conscientiously organised than their less co-operative peers", they added: "One wonders whether this report may give a misleadingly reassuring impression of what is really happening in this market place. If so, it only adds force to the findings and recommendations of the authors."⁶
6. The NCEPOD report found that many cosmetic surgery sites were offering a 'menu' of procedures, some of which were only performed infrequently, contravening good practice guidelines established at the time of the Bristol children's heart surgery crisis to ensure that surgeons had frequent practice in the operations they performed. The report also found that routine psychological evaluation prior to cosmetic surgery was only carried out in 119 (35%) of those sites that did respond (which would now contravene the draft European standards for cosmetic

² Department of Health (2012) Minutes: review of the regulation of cosmetic interventions December 2012 meeting, available at: <http://transparency.dh.gov.uk/2013/01/15/rcci-21dec2012/>, item 2.

³ Department of Health (2012) Minutes: review of the regulation of cosmetic interventions, available at: <http://transparency.dh.gov.uk/2012/09/07/rcci-3august2012/> item 3.

⁴ *Ibid.*

⁵ Goodwin APL, Marin IC, Shotton H *et al.* (2010) *On the face of It: a review of the organisational structures surrounding the practice of cosmetic surgery* National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

⁶ *Ibid.*, at page 4.

surgery).⁷ In only four per cent of replying clinics were those assessments routinely performed by a clinical psychologist. The authors discovered ‘an alarming lack of equipment available in theatre, in recovery facilities... and in out-of-hours surgical cover.’⁸ They concluded that it was urgent that “Cosmetic surgical practice should be subject to the same level of regulation as any other branch of surgery.”⁹

7. In contrast to the dominance of evidence-based medicine in other medical sectors, with aesthetic procedures there is only anecdotal evidence in many cases of adverse incidents, particularly with non-surgical cosmetic techniques such as dermal fillers.¹⁰ Patients may be embarrassed to report adverse outcomes of such procedures to their GPs, or they may not know where to complain if the procedure is not performed on the NHS. The NCEPOD report did find, however, that of the 32 per cent of surgical providers that sent in a response, 96 per cent indicated that patient outcomes were monitored.

The response of government and the medical profession

8. The General Medical Council does not receive a large number of complaints about cosmetic procedures: only 93 complaints over a ten-year period, compared to a total of approximately 17,000 complaints for all doctors over the same period.¹¹ However, given the absence of systematic audit and the role of non-medically qualified providers of products such as dermal fillers, it is unclear whether this is a genuine sign that there are few adverse outcomes. In January 2013, the Royal College of Surgeons issued guidelines stating that only qualified medical doctors with post-graduate surgical training should carry out invasive procedures such as breast surgery or liposuction, while ‘Botox and filler parties’ held in homes should be banned. The College stipulated that those who perform these non-surgical procedures must do so on medical premises and be properly qualified.
9. The PIP (Poly Implant Prothèse) breast implant crisis, involving multiple adverse clinical outcomes from non-medical grade silicone used in implants, triggered a major Department of Health review, due to report in March 2013. There was no mandate to force private firms to provide redress, so that the burden of restorative operations fell on the NHS. In

⁷ European Committee for Standardization (2011) *European Standard prEN16372 (Draft) Aesthetic surgery services*, available at: http://www.siai.se/files/pren_16372_41_e_stf.pdf.

⁸ Goodwin APL, Marin IC, Shotton H *et al.* (2010) *On the face of It: a review of the organisational structures surrounding the practice of cosmetic surgery* (London: NCEPOD), at page 5.

⁹ *Ibid.*, at page 8.

¹⁰ Department of Health (2012) Minutes: review of the regulation of cosmetic interventions October 2012 meeting, available at: <http://transparency.dh.gov.uk/2012/11/07/rcci-19oct2012/>, item 4.

¹¹ Department of Health (2012) Minutes: review of the regulation of cosmetic interventions December 2012 meeting, available at: <http://transparency.dh.gov.uk/2013/01/15/rcci-21dec2012/>, item 3.

general there is little regulation of aesthetic procedures from the Care Quality Commission and no system in place (outside the civil courts) to compensate patients who are harmed. Likewise, there is no national evidence base tracking implants or procedures.

10. Ethics committees of the medical professional bodies in the UK, US, France, New Zealand and Australia have taken a cautious view on genital cosmetic surgical procedures when there is no medical indication, e.g. in most cases of labiaplasty,¹² hymenoplasty¹³ and vaginal 'tightening' after childbirth.¹⁴ The British Association of Aesthetic Plastic Surgeons has joined with feminist organisations in calling on the government to ban cosmetic surgery advertising, as is done in France, because "the adverts recklessly trivialise surgical procedures that carry inherent risks".¹⁵ The signatories said: "The messaging and imagery commonly used in cosmetic surgery adverts contributes [sic] to undermining body confidence, which in turn drives demand."

Body image and the sexualisation of popular culture

11. This last point raises chicken-and-egg questions about whether cosmetic procedures merely meet existing demand from patients, or whether they help to create that demand in the first place. The decision to undertake aesthetic procedures and the criteria for their success might be thought personal and subjective. Yet objective social forces such as 'celebrity culture', the widespread use of 'airbrushing' in magazines, regular stories in the press about famous people's operations, the popularity of TV 'makeover programmes' and the 'mainstreaming' of pornography have all contributed to the rise in popularity of cosmetic procedures.¹⁶
12. In the past, surgery was generally performed to remove diseased tissue and to restore the body to normal functioning.¹⁷ In a positive sense, cosmetic surgery could be seen as moving beyond this merely

¹² 'Trimming' the labia minora.

¹³ Surgical restoration of the hymen to simulate virginity.

¹⁴ Royal College of Obstetricians and Gynaecologists (2009) *Hymenoplasty and labial surgery: RCOG Statement No. 6*, available at: <http://www.rcog.org.uk/files/rcog-corp/Statement6Hymenoplasty.pdf>; American College of Obstetricians and Gynecologists (2007) *Vaginal 'rejuvenation' and cosmetic vaginal procedures: ACOG Committee Opinion No. 378*, available at: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Vaginal_Rejuvenation_and_Cosmetic_Vaginal_Procedures; CNGOF (2008) (2008) Brèves du Collège: editorial **16**, available at http://www.cngof.asso.fr/D_TELE/brevés16.pdf (French language); Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2008) *Vaginal 'rejuvenation' and cosmetic vaginal procedures: College Statement C-Gyn 24*, available at: http://www.ranzcog.edu.au/component/docman/doc_view/932-c-gyn-24-vaginal-rejuvenation-and-cosmetic-vaginal-procedures.html?Itemid=341.

¹⁵ The Guardian (14 March 2012) *Cosmetic surgery ads should be banned*, available at: <http://www.guardian.co.uk/lifeandstyle/2012/mar/14/cosmetic-surgery-advertising-ban>.

¹⁶ Walter N (2011) *Living dolls: the return of sexism* (London: Virago).

¹⁷ Dickenson D (2009) *Body shopping: converting body parts to profit* (Oxford: Oneworld).

restorative function and as enhancing personal identity.¹⁸ The French writer Hervé Juvin claims that the ease with which we can now manipulate our bodies gives rise to a new form of egalitarianism, because everyone has a body, and everyone is equally free to alter that body as they please.¹⁹ The majority of women undergoing even something as radical as genital plastic surgery report overall satisfaction and subjective enhancement of sexual function and body image, although the evidence is subjective and there is little data available on subsequent experiences in childbirth.²⁰

13. In a more negative view, the 'normalisation' of cosmetic procedures can be viewed not as enhancing freedom and personal identity but as loading new pressure on women and girls (who constitute over 90 per cent of aesthetic surgery recipients despite a recent rise in male patients²¹) to conform to increasingly stringent and abnormal expectations of what the female body should look like. Labial surgery actually 'restores' the form not of the adult but of the prepubescent female body.²² A clinical study of well women requesting elective labial reduction surgery at a central London teaching hospital revealed that prior to surgery all of them already had labia within the normal range for adult women.²³
14. Young women and girls may be particularly vulnerable to peer pressures and self-doubts about body image. Two NSPCC reports have highlighted the increasing use of pornography and 'sexting' (sexualised text messages) among teenagers, with photos and YouTube videos of their girlfriends being used as a currency among young men. One girl said that the prevalence of pornography sent the message, "Your body should be like hers for him".²⁴ A statistically significant difference emerged in the number of girls and boys whose partners had put pressure on them by saying negative things about their appearance.²⁵

¹⁸ Kuczynski A (2006) *Beauty junkies* (New York: Doubleday). Genital piercing, which unlike labiaplasty is not permanent, has been found in some studies to enhance participants' self-assessed sense of their own sexuality: Nelius T, Armstrong MI, Rinard K *et al.* (2011) Genital piercings: diagnostic and therapeutic implications for urologists *Urology* **78(5)**: 998-1007.

¹⁹ Juvin H (2005) *L'avènement du corps* (Paris: Gallimard).

²⁰ Goodman MP (2011) Female genital cosmetic and plastic surgery: a review *Journal of Sexual Medicine* **8(6)**: 1813-25.

²¹ Based on American Society for Aesthetic Plastic Surgery estimates for US patients.

²² Royal College of Obstetricians and Gynaecologists (2009) *Hymenoplasty and labial surgery: RCOG Statement No. 6*, available at: <http://www.rcog.org.uk/files/rcog-corp/Statement6Hymenoplasty.pdf>.

²³ Crouch NS, Deans R Michala L, *et al.* (2011) Clinical characteristics of well women seeking labial reduction surgery: a prospective study *British Journal of Obstetrics and Gynaecology* **118(12)**: 1507-10.

²⁴ Ringrosse J, Gill R, Livingstone S and Harvey L (2012) *A qualitative study of children, young people and 'sexting'* (London: NSPCC), at page 40.

²⁵ Barter C, McCarry M, Berridge D and Evans K (2009) *Partner exploitation and violence in teenage intimate relationships* (London: NSPCC), at page 57.

Ethnicity, disability and cosmetic procedures

15. The issue of ethnicity and cosmetic surgery is complex. The American Association of Plastic Surgeons reported that in one year, between 2006 and 2007, aesthetic surgery for minority ethnic groups grew at almost twice the overall population rate.²⁶ Is this development an indication of 'racial self-hatred', as critics allege, or simply another extension of the way aesthetic surgery has become 'normal'?
16. On the one hand, some commentators see such procedures as eyelid surgery to create a more 'Caucasian' eye among East Asians as a new form of eugenics, "an alternative and acceptable medical method of 'cleansing' and 'purifying' racial/ethnic phenotypes (as opposed to previous efforts at targeting the genotype)".²⁷ It would not necessarily be irrational 'self-hatred' for minority ethnic patients to seek cosmetic surgery, when discriminatory stereotypes based on phenotype still have a powerful social effect. Negative stigma attached to Afrocentric facial features affects the length of prison sentence handed down to a convicted criminal offender, according to a Florida study.²⁸ Even though black and white offenders got roughly the same length of sentence, within the black group those with more 'Negroid' features received harsher sentences.
17. Persistent social stigma has also been attacked in studies criticising facial cosmetic surgery for people with Down syndrome²⁹. Society urgently needs to recognise so-called 'abnormal' facial features as part of the individual's identity, argues James Partridge of the UK charity Changing Faces.³⁰
18. On the other hand, although a recent UK study found lower acceptance of aesthetic surgery among Afro-Caribbean and South Asian women than among whites, the attitudinal determinants of willingness to undergo cosmetic surgery were not so much ethnic self-identification as body

²⁶ Wimalawansa S, McKnight A and Bullocks JM (2009) Socioeconomic trends of ethnic cosmetic surgery: trends and potential impact the African American, Asian American, Latin American, and Middle Eastern communities have on cosmetic surgery *Seminars in Plastic Surgery* **23(3)**: 159-62.

²⁷ Banales VM (2005) 'The face value of dreams': gender, race, class, and the politics of cosmetic surgery, in *Beyond the frame: women of color and visual representation* Tadiar NXM and Davis AY (Editors) (London: Palgrave Macmillan), pp131-52, at page 138.

²⁸ Blair IV, Judd CM and Chapleau KM (2004) The influence of Afrocentric facial features in criminal sentencing *Psychological Science* **15(10)**: 674-9.

²⁹ Katz S, and Kravetz S (1989) Facial plastic surgery for people with Down syndrome: research findings and their professional and social implications *American Journal of Mental Retardation* **94(2)**: 101-10; Frank AW (2004) Emily's scars: surgical shapings *Hastings Center Report* **34(2)**: 18-29.

³⁰ Partridge J (1990) *Changing faces: the challenge of facial disfigurement* (London: Penguin).

image and self-esteem.³¹ One US study suggests that minority ethnic cosmetic surgery patients do not necessarily want to look more 'white', but, if anything, more like the ideal for their own ethnic group.³² These findings suggest that the issues about choice and consent for minority ethnic groups would be no different than for majority ethnic populations, although they are still difficult issues, to which we will now turn.

Consent, choice and patient autonomy

19. Aesthetic procedures are frequently presented as enhancing women's autonomy and as a positive reflection of society's newfound openness about body appearance and sexuality, even as a triumph of feminism. "The assumption is that this is a free choice by women who are in all other ways equal to men."³³
20. In this view, it would be patronising and paternalistic to question the choice by adult women to undergo cosmetic procedures such as breast augmentation. While non-medically-indicated procedures on minors could be seen as limiting the future autonomy of the young person, there would be no legal or ethical grounds for questioning an adult's decision to undergo aesthetic procedures.³⁴ In the context of liberal political theory, which valorises individual choice, even decisions that seem not to reflect the individual's best interests must still be accepted. However, there have been incisive recent studies in political theory questioning whether that proposition is necessarily valid, particularly in cases of women who voluntarily risk harming themselves for the sake of beauty norms.³⁵
21. The source of this emphasis on autonomy and choice is usually thought to be Kant, with his conception of individuals as autonomous members of the 'kingdom of ends'. But while autonomy has attained the status of *primus inter pares* among the widely accepted 'four principles' of medical

³¹ Swami V, Campana AN and Coles R (2012) Acceptance of cosmetic surgery among British female university students: are there ethnic differences? *European Psychologist* **17(1)**: 55-62.

³² Wimalawansa S, McKnight A and Bullocks JM (2009) Socioeconomic trends of ethnic cosmetic surgery: trends and potential impact the African American, Asian American, Latin American, and Middle Eastern communities have on cosmetic surgery *Seminars in Plastic Surgery* **23(3)**: 159-62.

³³ Walter N (2011) *Living dolls: the return of sexism* (London: Virago), chapter 6.

³⁴ However, the Female Genital Mutilation Act 2003, which makes it a criminal offence to excise, infibulate or mutilate any part of the female genitalia for non-medical reasons, includes women under the same category as girls (see definitions, section 6 of the act, and note 39 below). Although there have been no prosecutions to date under the Act, this is a clear exception to the general rule that the choices of consenting competent adult patients must be accepted.

³⁵ See, for example, Chambers C (2007) *Sex, culture and justice: the limits of choice* (University Park: Pennsylvania State University Press); Hirschmann NJ (2003) *The subject of liberty: toward a feminist theory of freedom* (Princeton: Princeton University Press).

ethics,³⁶ Kant himself specifically states that it does not apply to treating one's body as an object. That would be to regard oneself not as a member of the kingdom of ends, but merely as a means – even if the person voluntarily consents to treat her own body in this fashion.³⁷ The question from the Kantian perspective is whether cosmetic procedures involve too much objectification of the body and thus actually threaten personal autonomy rather than enhancing it. In that case, the decision to undergo aesthetic procedures could not simply be taken as an expression of the patient's autonomy, deserving respect.

22. It is patently false to say that whatever I do, I have chosen to do. It is equally problematic, as well as circular, to maintain that all my choices deserve respect simply because they are my choices. But from a slippery slope perspective, it would be difficult to spell out which sorts of choices to undergo cosmetic procedures deserve respect, if not all do.
23. From a legal rather than a philosophical perspective, it would also be mistaken to think that there are no problems about aesthetic procedures so long as an adult patient has given her consent. There are some bodily incursions to which the law does not allow us to consent. In the case of *R v. Brown*, involving a group of men who participated in sado-masochistic practices, the defendants were found guilty of assault occasioning actual bodily harm and unlawful wounding, even though everyone in the group had consented and no one suffered permanent injury.³⁸ Consent is not a defence to an assault causing grievous bodily harm, any more than it is a 'knock-down' ethical argument, one against which there is no possible response.
24. Could this reasoning from a case about male genital injury be applied to female genital surgery and other cosmetic surgical procedures? It might even be thought that because it is permanent, labiaplasty is more serious than the harms the men suffered, and that it should not be possible to consent to it. True, unlike the case of *R v. Brown*, labiaplasty involves a medical professional, but there are also some procedures which medical professionals are not allowed to perform even if the patient consents, such as euthanasia (in any jurisdiction where it is illegal).
25. In a widely cited paper, Kelly and Foster have stringently examined the ethical and legal limitations of consent to labial surgery.³⁹ They note that while some other countries (such as the USA and Canada) hold that no offence is committed by any doctor who performs genital surgery on a woman over eighteen, the UK Act specifically treats women and girls

³⁶ Beauchamp T, and Childress, J (2009) *Principles of biomedical ethics*, 6th Edition (New York: Oxford University Press).

³⁷ Marzano-Parisoli, M (2002) *Penser le corps* (Paris: Presses Universitaires de France).

³⁸ *R. v. Brown* [1993] 2 All ER 75.

³⁹ Kelly B, and Foster C (2012) Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *International Journal of Obstetrics and Gynaecology* **119(4)**: 389-92.

alike in regarding the performance of genital surgery on any female as a criminal act unless it is necessary for her physical or mental health.⁴⁰ In light of the lack of evidence about long-term adverse outcomes, they also draw attention to the risk “that women who are already anxious or insecure about their genital appearance or sexual function may be further traumatised by undergoing what is an unproven surgical procedure.”⁴¹

26. The function of consent in medical law is to protect the doctor against a criminal charge of assault or a civil action for battery, if a valid consent has been obtained. Again, given the lack of a proper evidence base for much cosmetic surgery (see paragraphs 6, 7 and 10), particularly for new or rarely performed procedures, it might be questioned whether a patient’s consent can actually be sufficiently informed to afford this protection. The Department of Health review has expressed particular scepticism about whether the patient can be sufficiently informed to give consent when the individual obtaining the consent is not the surgeon who will be performing the operation, but rather a sales person.
27. In the cases of *Simms v Simms* and *A v A and another*, the concept of patient’s best interests was held to extend beyond proven treatment into the experimental realm.⁴² However, this case involved two very sick teenagers in the advanced stages of Creutzfeldt Jakob disease, for whom no conventional treatment was available. The court held that in light of the possibility that some benefit might accrue, it would be wrong to disallow treatment because the treatment was unproven through the usual mechanism of clinical trials.
28. In the case of aesthetic surgery, however, no life-saving benefit is involved, while there are risks from anaesthesia and possible side effects.⁴³ In this sense, the ethical issues in cosmetic surgery are akin to those in other elective surgeries such as face or hand transplants, which do not prolong life and may indeed shorten it (although cosmetic surgery, unlike transplants, does not entail lifelong immunosuppressants).⁴⁴ It has been argued that there is a double

⁴⁰ Sections 1(2a), 1(3a) and 1(5).

⁴¹ Kelly B, and Foster C (2012) Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *International Journal of Obstetrics and Gynaecology* **119(4)**: 389-92, at page 390, citing Liao LM and Creighton SM (2007) Requests for cosmetic genitoplasty: how should healthcare providers respond? *BMJ* **334(7603)**: 1090-2.

⁴² [2003] 2 WLR 1465, [2003] 1 All ER 669, [2003] 1 FCR 361.

⁴³ In female genital surgery, these could include infection, altered sensation, painful intercourse, adhesions and scarring, along with possible difficulties in childbirth. An exception can be made for medically indicated genital surgery, e.g. an operation to reverse or repair female genital mutilation or genital prolapse (see: Royal College of Obstetricians and Gynaecologists (2009) *Hymenoplasty and labial surgery*. RCOG Statement No. 6, available at: <http://www.rcog.org.uk/files/rcog-corp/Statement6Hymenoplasty.pdf>).

⁴⁴ Dickenson D, and Widdershoven G (2001) Ethical issues in limb transplants *Bioethics* **15(2)**: 110-24; Huxtable R and Woodley J (2005) Gaining face or losing face? Framing the debate on face transplants *Bioethics* **19(5-6)**: 505-22; Agich G and Siemionov M

standard in medical ethics insofar as living organ donation is treated sceptically, on the basis of medical paternalism, whereas there are few limits on cosmetic surgery, which is considered solely in the light of patient autonomy.⁴⁵

29. In organ donation, however, there are no commercial interests, whereas the cosmetic surgery sector is dominated by profit-making clinics. It might be argued that it is the industry's inventiveness in creating new procedures and the demand for them that is driving the 'normalisation' of aesthetic procedures, rather than demand originating in the first instance from patients. This is consistent with other areas of the commercialisation of biotechnology, for example, private umbilical cord blood banking or direct-to-consumer genetic testing services, in which the biotechnology industry has created new ways to stimulate demand for products of which no one could have dreamt 20 years ago.⁴⁶
30. In this highly commercial context, it is sometimes alleged that women undergoing cosmetic procedures are being exploited. While such an interpretation would not fit the classic Marxist definition of exploitation, which focuses on the disparity in surplus value between what a worker is paid for his labour and the profit made by the employer, the concept of exploitation is a valuable antidote to the dominance of choice in most medical ethics.⁴⁷ Alternative definitions of exploitation, concentrating on dignity or degradation,⁴⁸ would actually be more consistent with the original Kantian interpretation of the patient's relationship to her body than a simplistic autonomy approach.

The duties of a doctor and the goals of medicine

31. While there is a presumption of competence in adult patients, giving them the negative right to *refuse* even life-saving treatment,⁴⁹ there is no *positive* right to request a treatment which contravenes the clinical judgment of medical professionals.⁵⁰ Even if patients do want aesthetic

(2005) Until they have faces: the ethics of facial allograft transplantation *Journal of Medical Ethics* **31(12)**: 450-4; Royal College of Surgeons Working Party (2006) *Facial transplantation*, 2nd Edition (London: Royal College of Surgeons); Freeman M, and Jaaoude PA (2007) Justifying surgery's last frontier: the ethics of face transplants *Journal of Medical Ethics* **33(2)**: 76-81.

⁴⁵ Testa G, Carlisle E, Simmerling M and Angelos P (2012) Living donation and cosmetic surgery: a double standard in medical ethics? *Journal of Clinical Ethics* **23(2)**: 110-7.

⁴⁶ Dickenson D (2013) *Me medicine vs. we medicine: reclaiming biotechnology for the common good* (New York: Columbia University Press).

⁴⁷ Dickenson D (2013) Exploitation and choice in the global egg trade: emotive terminology or necessary critique? in *Regulating contestable commodities in the global body market: altruism's limits*, Goodwin M (Editor) (New York: Cambridge University Press).

⁴⁸ Sample R (2003) *Exploitation: What It Is and Why It's Wrong* (Lanham, MD: Rowman and Littlefield).

⁴⁹ Re C [1994] 1 All ER 819.

⁵⁰ This principle has been upheld in a number of resource allocation cases (e.g. *R. v. Secretary of State for Social Services, ex parte Hincks* [1979] 123 Sol Jo 436). Outside the rationing context, in the case of *Pearce v United Bristol Healthcare Trust* (1999) 48

surgery, there is no obligation on doctors to provide it against their best clinical judgment, and indeed in the case of cosmetic labiaplasty it is illegal to do so (although there have been no prosecutions so far under the 2003 Act).

32. We need to go beyond the question of patient choice and conclude by examining the duties of the doctor in relation to cosmetic surgery. As the German physician and professor of medical ethics Urban Wiesing has written: “It should not be asked whether a patient should have an aesthetic operation or not, but whether physicians should perform it.”⁵¹
33. A rather unexpected parallel from the debate on euthanasia may be useful. The medical ethicist Daniel Callahan has suggested a doctor’s possible response to a patient requesting termination of life might be, “Your right to die doesn’t imply my duty to kill”.⁵² Although aesthetic surgery is of course not as final as euthanasia, Callahan’s position is helpful in that it separates out the patient’s choice—whether or not it is fully free—from the question of the doctor’s own conscience.
34. Doctors are not mere technicians who perform whatever procedure patients request. In the traditional view, their primary duty is ‘first do no harm’. Given that cosmetic surgery, by definition, does not deliver medical benefits but involves medical risks such as anaesthesia, there are serious ethical questions to be debated about the duties of a doctor in this instance.
35. In the case of labiaplasty or hymen repair, despite the legal position, concerned gynaecologists may feel they can best perform their duties by ensuring that the procedure is done safely and hygienically under their supervision, if it is likely to be done anyway somewhere else, whether abroad or in the UK. They may even feel that the patient would be at risk if they did not offer their expertise, particularly in the case of hymen repair. This is a genuine dilemma for physicians, but it does raise possible uncomfortable parallels with doctors who have justified their participation in judicial executions on the grounds that they can ensure the execution is performed more humanely.⁵³ Using this example as the real-life equivalent of a thought experiment brings up profound ethical issues.

BMLR 118, a pregnant woman failed to persuade her obstetrician to carry out a Caesarean against his better clinical judgment, although the fetus was two weeks past dates and later died in utero. In *Re J (a minor)* [1991] 4 All ER 614, the court found that physicians were not obliged to resuscitate a severely brain-damaged child, contrary to his parents’ request, “unless to do so seems appropriate to the doctors caring for him given the prevailing clinical situation”.

⁵¹ Wiesing U (2011) Ethical aspects of aesthetic medicine, in *Aesthetic Medicine* Prendergast PM and Shiffman MA (Editors) (Berlin: Springer), pp7-11.

⁵² Callahan D (1989) Can we return death to disease? *Hastings Center Report* **19(1)**: 4-6.

⁵³ British Medical Association (2001) *The medical profession and human rights: handbook for a changing agenda* (London: Zed Books/BMA).

36. What do health care professionals feel that they are doing, in relation to the goals of medicine, when they perform aesthetic procedures? What licence does society want to give them in this respect? Is the decision to undergo cosmetic procedures simply a consumer choice, something to be regulated by consumer protection laws?⁵⁴ Or does the involvement of a doctor in specifically surgical procedures move them out of the realm of contract and consumer choice, requiring us to consider the rightful goals of medicine?
37. An attitudinal survey commissioned by the Department of Health for its inquiry found that patients cannot easily assess the risks associated with different aesthetic surgical procedures or the quality of services offered. They assume that because a service is available from a doctor, it must be regulated.⁵⁵ But as we have seen from the NCEPOD report, that is a very optimistic view indeed. If people do want reliable regulation of cosmetic procedures, as this survey suggests, it would actually be paternalistic to *deny* them that – even though medical paternalism is generally contrasted with the patients’ rights approach.
38. The fundamental trust between a patient and a physician is based on the assumption that the doctor will not only ‘first do no harm’ (the principle of non-maleficence) but will also have the patient’s best interest at heart (the principle of beneficence). If there is an incentive, financial or otherwise, for a doctor to perform a particular procedure, that trust may be threatened.⁵⁶
39. The acceptance of palliative care as a medical specialty shows that cure is not the only rightful goal of medicine. Even when cure is no longer possible, however, the palliative care physician clearly delivers medical benefits to the patient, such as pain relief. In the case of cosmetic procedures, where no such medical benefits generally apply but possible medical harms may be done, and where there is a widespread lack of evidence or objective outcome measures, it is very much up for discussion what the goals of medicine and the duties of a doctor ought to be.

⁵⁴ See, for example, Department of Health (2012) Minutes: review of the regulation of cosmetic interventions December 2012 meeting, available at: <http://transparency.dh.gov.uk/2013/01/15/rcci-21dec2012/>, item 7. Here the committee appears to accept the consumer model of ‘buyer beware’.

⁵⁵ *Ibid.*, item 6.

⁵⁶ Hinsch K (2009) Bad doc, greedy doc? Is it ethical for physicians to add cosmetic procedures to their core practice? Women’s Bioethics Project, available at: http://www.womensbioethics.org/index.php?p=Bad_Doc,_Greedy_Doc&s=335.