

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.

## **Mission and Public Affairs Council, Church of England**

### **Nuffield Council on Bioethics Consultation Response Cosmetic Procedures: Ethical Issues**

*The Mission & Public Affairs Council of the Church of England is the body responsible for overseeing research and comment on social and political issues on behalf of the Church. The Council comprises a representative group of bishops, clergy and lay people with interest and expertise in the relevant areas, and reports to the General Synod through the Archbishops' Council.*

*The Mission and Public Affairs Council presents a Christian ethos, drawing on the witness of the Christian Scriptures and reflecting on Christian tradition and contemporary thought. Belief in God as Creator and Redeemer, in human beings' intrinsic value as creatures made in the Image of God and in the imperatives of love and justice, underpins the Council's approach. The Council believes that the ethical and social principles developed from this foundation have a value and relevance in society that can be acknowledged by those of other faiths or none.*

Our answers to the consultation questions reflect this ethos and specifically seek to apply four guiding principles in our examination of cosmetic procedures. These principles inform our approach to all bioethical discussions: affirmation of life, care of the vulnerable, building a caring and cohesive society and respecting individuals.

In the context of cosmetic procedures, this includes emphasising that human beings have a value and significance that goes well beyond physical appearance. It also includes exploring the potential impact that cosmetic procedures might have on vulnerable groups such as those living with disability or disfigurement as well as the potential impact on social equality. We believe that individual autonomy is best exercised within a framework that seeks the common good.

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

Attempts to make a clear delineation between cosmetic and other procedures such as reconstructive surgery are common even among medical professionals. The division between the American Society of Plastic Surgeons and the American Board of Cosmetic Surgery is a good example of this. Plastic surgery *'is defined as a surgical specialty dedicated to reconstruction of facial and body defects due to birth disorders, trauma, burns, and disease. Plastic surgery is intended to correct dysfunctional areas of the body and is reconstructive in nature'*. Conversely, *'the procedures, techniques, and principles of cosmetic surgery are entirely focused on enhancing a patient's appearance. Improving aesthetic appeal, symmetry, and proportion are the key goals'* (<http://www.americanboardcosmeticsurgery.org/patient-resources/cosmetic-surgery-vs-plastic-surgery/>). In the UK, the NHS makes a distinction between 'cosmetic or aesthetic' surgery *'used to change a person's appearance to achieve what they perceive to be a more desirable look'* and 'reconstructive plastic' surgery *'used to repair damaged tissue caused by surgery, illness, injury, or an abnormality present from birth'* (<http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx>). The distinctions drawn between these different types of surgery may be extended to cover non-surgical procedures with similar goals.

While there is a 'common sense' appeal to the definitions given above, the organisations listed also accept that there is some overlap between cosmetic and reconstructive procedures, with the NHS, for example, recognising that there can be '*major physical or psychological reasons*' which would qualify a patient for cosmetic treatment on the NHS.

Drawing a definite line between aesthetic and reconstructive procedures is extremely difficult, if not impossible, to achieve in a consistent manner. As psychological factors play an important role in both cosmetic and reconstructive procedures it is not appropriate simply to make a distinction based on the physical severity of the underlying condition. Psychological trauma associated with perceived physical appearance (even if it might appear unremarkable to others) or body dysmorphism disorder ought not to be dismissed as being trivial. At the same time, there is a clear difference between liposuction for someone who wants to look trim in swimwear and bariatric surgery for someone who is morbidly obese and whose life may be at risk.

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. As we move from these extremes towards the middle, it gets increasingly difficult to make a distinction between cosmetic and reconstructive procedures. We recommend, therefore, that while the terms 'aesthetic/cosmetic' and 'plastic/reconstructive' will continue to be used (and are useful to a degree in more obvious cases), there is no definite dividing line to be drawn between the two types of procedures and that each individual case ought to be assessed as belonging somewhere on the impairment-enhancement continuum with decisions for treatment and utilisation of resources made accordingly.

It is essential, therefore, that cosmetic procedures are understood to be medical, dental or surgical treatments with the same safeguards and standards applied as other procedures, being similarly regulated by the relevant professional bodies. In particular, health professionals ought only to administer treatment if they are assured that it is in the best interests of their prospective patients or clients, the required benchmark for all healthcare procedures.

**Question 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?**

An underlying common theme for both prospective recipients and providers of cosmetic procedures is a focus on appearance rather than on functionality. Towards the middle of the impairment-enhancement continuum, both appearance and functionality might be involved (such as in the removal of excess skin after successful bariatric surgery), but the main motivating factor in very many cases is a desire either to appear 'better' or to address perceived 'ugliness'. The importance of psychological factors allied with peer or public pressure ought not to be minimised in assessing an individual's perception of what constitutes physical beauty or ugliness and their corresponding ability to deal with these perceptions. Prominent ears, for example do not generally present any functional problems, but can be the cause of genuine misery, sometimes accompanied by bullying, for those whose features deviate even slightly from 'the norm'.

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. When providers advertise their procedures as means of clients acting to address self-esteem issues or to present themselves in a manner that pleases them, the truth is likely to be much more complex.

Regardless of the balance between intrapersonal and societal factors, many people undergo cosmetic procedures because they are unhappy with their appearance. Providers might argue that in these cases they are helping to alleviate unhappiness, but largely ignore the fact that the existence of their services can be a contributory factor in helping to create the conditions for such unhappiness to arise. (At the same time, the ability of surgeons to 'normalise' unusual distinguishing facial features can be a genuine counter to distress).

Another continuum could usefully be employed in this context: discontent and distress. Prospective clients could be enabled, through a series of structured questions, to identify the degree to which their desire for a procedure arises from a sense of discontent as distinct from an experience of distress. To some extent, this might also help clients and providers to determine whether a desire for treatment is focused primarily on intrapersonal or societal factors. 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. In order to undergird the fact that cosmetic procedures are medical interventions rather than beauty treatments, providers ought to have an obligation to offer counselling to prospective clients prior to the commencement of any treatment. (Cf. <http://www.telegraph.co.uk/women/womens-life/10071794/Cosmetic-surgery-What-compels-women-to-go-under-the-knife.html>).

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 (see answer to Question 5).

**Question 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 arguable to what extent people '*use their clothes, hairstyle, and make up to beautify themselves*'; 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. Positively, this might be because they want to project visually something of their personalities. Negatively, it might be because they wish to hide insecurity or to project a false image in order to gain acceptance or other social goals. In many cases, people are fairly relaxed about their physical appearance, doing enough to 'get by', although it is the case that for some, physical appearance is the cause either of significant pride or anxiety (or both).

Even where clothing, hairstyle and makeup are used deliberately either for social purposes or to address personal anxieties or aspirations, there is a difference between the temporary nature of these interventions and the permanent or semi-permanent effects of most cosmetic procedures (notwithstanding that some procedures do not produce the permanent effects desired and have to be repeated). There is also a distinction to be made between the extrinsic nature of cosmetics and the intrinsic nature of cosmetic procedures: acting intrinsically on the body is different from adding extrinsically to it with corresponding psychological and ethical distinctions to be drawn.

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

If, as we have suggested in our answer to Question 2, desire for undergoing cosmetic procedures arises from a degree of discontent or distress (intrapersonal or societal) caused by perceptions of physical ‘normality’ or beauty, it is important to identify both those drivers that help to determine normality and beauty and those drivers that are likely to increase distress for those who perceive themselves to be ‘abnormal’ or less ‘good-looking’ that they wish to be/once were.

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. An unintentional by-product of promoting healthy lifestyles has been a narrowing of perceptions of what constitutes a healthy body and, in particular, what a healthy body ought to look like. Helpful public health messages with regard to exercise and diet are often unhelpfully incorporated into advertisements, programmes and merchandise promoting an unrealistic body-image including unsustainable quality of muscle and skin tone as well as body shape and size. Oft repeated messages of ‘real beauty’ are, frankly, overshadowed by mass-media visual representations of ‘beauty’ which are replicated constantly on social media.

As images of beauty become increasingly stereotypical (even if there is more than one stereotype), the range of what might be considered ‘normal’ also narrows. Again, many people might not be greatly influenced by this, but significant numbers of people are. While the pursuit of beauty might affect a relatively small percentage of the population, almost everyone wishes to be thought of as being ‘normal’. The normalisation of a narrow range of bodily and facial images is likely to prove to be a greater factor in increasing numbers of individuals seeking cosmetic procedures than the pursuit of beauty alone.

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.

In addition to visual images being readily available through film, television and online, perhaps the factor with the greatest potential to increase individual discontent and distress with regard to physical appearance is the array of social media that very many people engage in. Not only cyber-bullying, but 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.

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

The fact that the numbers of cosmetic procedures undertaken increases year on year, suggests that some procedures, at least, are becoming routine. 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, for example, 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.

At first glance it might appear that the more routine cosmetic procedures become, the more they are carried out for intrapersonal rather than social reasons since the results are often more positively perceived by recipients than by others. This, however, masks the possibility that recipients perceive themselves differently from 'observers' and believe that they now look younger, healthier or more attractive than others believe them to be. As this realisation sinks in, it is not uncommon for one cosmetic procedure to follow another in pursuit of achieving third party approval and complement. If this is the case (even sometimes), then individuals are at risk of becoming enslaved not only to societal norms with regard to physical appearance, but also to achieving active approval of others in their fight to ward off the effects of age, illness or lifestyle, a fight that they are inevitable bound to lose. The more routine cosmetic procedures become, there is a risk that individuals will adapt less well to the processes of ageing or to the effects that life will have on their bodies; it might be possible to alter some of the signs of ageing, but that might well make the remaining signs all the more disagreeable.

Similarly, 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. To return to examples from dentistry, straight teeth are now the norm and the use of dental braces in adolescence is routine. The focus has now moved not only to whiteness but also to uniformity with the 'even' smile of the celebrity the desired goal. Consequently, white fillings are given to those who can afford them while crowns are utilised for cosmetic purposes as routinely as they are for health purposes, again for those who can afford the treatment. There is little doubt that gum enhancement will become another area for cosmetic intervention once the celebrity smile becomes the norm. Not only will this increase pressure on people to spend increasing amounts of money to 'be normal', but the goalposts will constantly shift. While it might be argued that such has always been the case with regard to the rich and famous, it creates new pressures on a much wider group of people if cosmetic procedures become routine.

**Question 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?**

In addition to the comments made above, there are particular concerns with regard to race and disability.

The idea that light skin is more attractive is found in many cultures, often with discriminatory implications for those with naturally darker skin. Skin-lightening products are not only potentially dangerous, but their acceptance and use might well contribute to racist attitudes. The suggestion that any colour or tone of skin is more normal or beautiful than another is antithetical to human rights and dignity. Similarly, facial and other body features vary not only from person to person, but also between ethnic groups; to suggest that one set of features is either normative or more beautiful than another is equally repugnant. Given the predominance of Caucasian celebrities within the UK and in the international media and film industries, there is a real danger that normality and beauty could be increasingly modelled on 'white' features.

With regard to disability, 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. While surgery or other procedures that address physical impairments are welcome, anything that might encourage a narrowing of 'normality' is likely to have a detrimental effect on societal attitudes to those who live with such impairments. This, in turn, is likely to increase intrapersonal pressures on a group of people, many of whom are already vulnerable to such pressures.

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

As stated in the answer to Questions 1 and 2, we believe that reasons for having cosmetic procedures are complex, but that 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. It is the prerogative of every individual to apply for cosmetic procedures, but it is the responsibility of health professionals to determine whether or not a specific procedure is in the best interests of a prospective client; the same test as for any medical, dental or surgical procedure. Every prospective client ought to be interviewed by a relevant health professional with a view to enabling them to identify the reasons and motivations for their application. It is essential that medical and dental professionals apply the same standards for cosmetic procedures as for any other procedure and that they adhere fully to GMC and GDC guidelines.

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

It is essential 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.

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

In order to ensure the integrity of cosmetic procedures and those who authorise them or carry them out, 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.

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

It is essential that patients or clients are given full information on the nature of their procedures, evidence with regard to outcomes of these procedures, alternatives to the procedures under consideration and the risks involved. It is also important that they are offered counselling enabling them to identify their reasons for applying for cosmetic procedures.

**Question 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?**

All patients must be competent to give full, informed consent under the Mental Capacity Act. Treatment ought only to be given if medical professionals are assured that it is in the best interests of their prospective patients or clients.

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

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.

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

All cosmetic procedures, surgical and otherwise ought to be treated in the same way as other medical or dental treatments and ought only to be provided by trained health professionals after authorisation by medical or dental professionals, in keeping with professional bodies' regulations and guidelines.

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

The responsibilities are identical to those of all private healthcare providers and ought to be subject to regulation under the relevant professional body.

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

We believe that the current regulatory measures are too lax and that all procedures ought to be treated as medical, dental or surgical intervention and ought to be regulated by the relevant professional body. Only qualified and registered healthcare professionals ought to administer cosmetic procedures.

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

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. This is so, even though there are societal pressures with regard to the appearance of certain parts of the body that do not usually apply to other parts. In spite of prevailing attitudes, some people, for example, might view a procedure on their eyelids as significantly as others might view a procedure on their breasts. The 'best interests' test ought to be applied equally in all cases.

**Question 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?**

The Act is in keeping with treating cosmetic surgery in the same way as other surgical interventions: it ought only to be performed if it is in the best interests of the patient; that is, it is necessary for the prospective patient’s physical or mental health. It is for the relevant surgeon to determine, in consultation with the prospective patient, whether or not distress or discontent at physical appearance constitutes adequate grounds for intervention on the grounds of mental health.

**Question 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?**

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 and fully discussed prior to any procedure taking place.