BEAUTY DEMANDS

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Introduction

About the Beauty Demands Network

Over the last two years, the Beauty Demands Network has brought together cultural theorists, historians, lawyers, doctors, philosophers, sociologists, and psychologists with medical and nurse practitioners, artists, and journalists to consider the changing requirements of beauty. Key questions which the Network explored were:

- Whether current beauty norms and worries about body image are significantly different from past concerns;

- Whether the increasing normalisation of what were once considered extreme practices, such as cosmetic surgery, is effectively pressuring more women to undergo such procedures;

- Whether routine beauty practices are becoming ever-more demanding;

- Whether technology is driving demand or merely responding to demands; and

- Whether, and if so how, regulators and practitioners should respond to these changes.

In order to produce recommendations presented in this briefing document, the Network discussed, both in person and virtually, these, and other, beauty questions.

Details of individuals who contributed to the Network, and the views they offered are available on the Beauty Demands website and blog (available at: http://beautydemands.blogspot.co.uk/).

The project, which was funded by the Arts and Humanities Research Council (AHRC) under its 'Policy Highlight Scheme', was led by a core project team:

- **Professor Heather Widdows**, Philosophy, University of Birmingham (Principal Investigator)
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- **Nuffield Council on Bioethics** (Partner)

The project team would like to thank all of those who have contributed to the work of the Beauty Demands Network so far. The Network is ongoing and welcomes new members with relevant research interests, or who simply have an interest in beauty-related topics. For details on how to join the Network, visit the Beauty Demands website (see: http://www.birmingham.ac.uk/generic/beauty/index.aspx).

About this briefing paper

This briefing paper draws on the collective insights of members of the Beauty Demands Network with respect to a broad range of beauty practices: from daily routine practices such as the application of make-up or the removal of body hair; to occasional and extreme practices, such as cosmetic surgery. This paper also draws on members' abstract concerns about the nature of the self and choice, in addition to practical considerations about psychological interventions, and the role of regulation and governance. As such, it is a collective response which is intended to be broadly representative of the main issues which emerged; individual members or partners of the Network may not endorse all of this paper's recommendations.

Although many important points emerged from discussions at each of the Network's four workshops (see: www.birmingham.ac.uk/generic/beauty/events/index.aspx), as well as in the research of the academics and practitioners who contributed to the Network, many of these debates were only tangentially policy relevant. This briefing paper, designed to influence policy, focuses only on the most practical and policy relevant aspects of these debates. We encourage those interested in beauty to consider not just these policy issues but also the complex debates about beauty norms and ideals addressed by the wider Network.

This paper is divided into three parts. The first part explores ethical concerns; the second part highlights psychological issues; and the third considers governance, regulatory, and legal issues. Each section includes recommendations for policy-makers and those responsible for delivering beauty practices.

Summary of recommendations

The Beauty Demands Network has identified the following areas of concern where action can be taken.

We need:

- To recognise that 'normal' is a value judgment and not a neutral or descriptive term;

- To improve understandings and representations of 'normal bodies';

- To recognise that consent might be compromised by pressures to conform;

- To recognise the potential for vulnerability in the beauty context;

- To develop effective interventions that promote positive body images in school curricula at all ages;

- To develop media literacy in school curricula and for the wider public;

- To promote diversity of models and mannequin sizes and shapes;

- To standardise training and qualifications required to administer so-called non-invasive procedures and cosmetic surgery;

- To set minimum standards for products and premises;

- To ensure that informed consent is sought personally by the practitioner carrying out the procedure, for all so-called non-invasive procedures as well as surgical procedures;

- To separate roles of salespersons and advertisers from practitioners performing procedures;

- To consider changing practice and policy with regard to advertisements to reduce risk of unrealistic expectations; and

- To put in place processes for better data collection, monitoring, and reporting measures.

Ethical issues

The three most significant policy-relevant ethical and conceptual issues that emerged from the workshops, and the Network's discussion of beauty practices, were those of normalness, choice and consent, and vulnerability.

Normalness

The terminology of 'being normal' emerged as common and important for those engaging in third party beauty practices (including both surgical and non-surgical practices). The use, interpretation and perception of what is 'normal' was identified as a key ethical concern.

The term 'normal' is currently used in ways that may appear to be neutral or objective, but are, in fact, underpinned by value judgments. For example, beauty practices may be justified as necessary for a person to feel normal, implying that the intervention is essential, not trivial or undertaken for reasons of vanity. This use is particularly prevalent in health care contexts when the funding of surgery by the NHS has to be justified on grounds of physical or psychological need. While, increasingly, other terms are being used (for example, those connected to self-improvement), the role of what is considered to be normal continues to hold weight.

Attention should be paid to what is meant by 'normal' in these circumstances: whether, for example, it refers to healthy physical functioning, or appearance that comes within a broad spectrum of social acceptability, or achieving what is seen in magazines and films, or simply another word for what is regarded as desirable in a particular social or cultural context. Similarly, conceptions of what is normal may be heavily influenced and limited by personal experience. For example, conceptions of normal breasts are influenced by breasts which are normally seen in the public domain, and these tend to be enhanced breasts. Likewise, there may be little understanding of the variety in healthy labia, and this may be true even for medical students provided with stylised textbook representations. Particularly worrying is when the term 'normal' is used as if it were a descriptive term and as a threshold criterion for treatment, even though there appears to be little consensus on how to measure or define a standard of what is normal.

Where practitioners or regulators use the idea of normalness to indicate what is ethical or unethical, this can be deeply problematic. For example, some argue that surgery is ethically acceptable in order to achieve a normal appearance, but not in order to improve or enhance appearance. However, this raises issues of discrimination for those who fall outside this norm: as what is normal becomes narrower and ever-harder to attain, gradually more people may fall outside this category, raising issues of justice and discrimination. Further, as the technological possibilities for changing appearance develop and become more readily accessible, the danger arises that there will be more

pressure to use them, and that it may even be seen as unethical *not* to try to look 'normal'.

Recommendation 1

'Normal' should be recognised as a value judgment and not a neutral or descriptive term. Accordingly, this term should be used with care in all policy and practice contexts.

Recommendation 2

Further work should be undertaken in order to improve understandings and representations of normalness and what is normal (for example, publication of more literature and visual material featuring a wide range of breasts and / or other body parts in teaching and medical settings).

Choice and consent

The second important ethical concept that emerges in the beauty debate is choice, and its associations with consent for procedures carried out by a third party. The terms 'choice' and 'consent' imply that an individual is making their *own* decision to have a cosmetic procedure, free from any external pressures. However, this may be far from the case, given social pressures to conform to particular beauty norms.

Moreover, demands differ across demographics, and some groups, such as adolescents, are under particular pressure to conform. As beauty products and procedures are increasingly regarded as routine, it is likely that the risks involved are perceived to be minimal, or indeed ignored altogether. These pressures can make it harder for individuals accurately to assess risks and benefits, and make a genuinely free choice about what is right for them.

Recommendation 3

Practitioners involved in beauty practices must be made aware of the limits of individuals' ability to consent, in light of pressures to conform to beauty norms.

Recommendation 4

Consider how pressure to conform to narrow and demanding beauty norms can be challenged by different actors and across sectors.

Vulnerability

When people are vulnerable, their capacity to consent can be undermined. The situation in which people may find themselves can make them vulnerable, even if they

might not normally be considered, or consider themselves, as such. When it comes to determining who is vulnerable in beauty contexts, it is likely that this does not map onto standard medical assumptions. For example, as the psychological discussion below shows, those who have low self-esteem and low body satisfaction are likely to be more vulnerable (less resilient) to pressure to modify their bodies. Low body satisfaction occurs throughout the lifespan and is often connected to, and triggered by, stress factors and life changes (such as divorce, unemployment, or bereavement).

Recommendation 5

Practitioners should be trained to recognise the potential for a person to be vulnerable in beauty contexts, and to understand that vulnerability may well be found in those who would not usually be considered vulnerable.

Psychological issues

The three most significant psychological issues that emerged from the workshops and the network discussion were those of low body image, the challenge of visual culture, and the link between cosmetic surgery and self-esteem.

Low body image across life-span

From as young as three-to-five years' old, girls are aware of stereotypes surrounding body size: for example, by showing a preference for thinner individuals and more negative attitudes towards fatter ones. Research suggests that, from age six, up to 50% of girls begin to experience dissatisfaction with their own shape. Acceptance of this 'thin ideal' is a risk factor for later problems: for example, problem eating is more common in nine-year-olds who were dissatisfied with their bodies at younger ages. Dissatisfaction with body size increases during adolescence, particularly for girls, more than 70% of whom say that they would prefer to be thinner. Adolescent body dissatisfaction is associated with negative physical and mental health, including eating disorders, low self-esteem, and depression. Once adulthood is reached, women tend to retain similar levels of dissatisfaction with their bodies throughout their lives, and levels of dissatisfaction are much higher for women than for men. Perhaps most concerning, rates of body dissatisfaction seem to have increased markedly over the last few decades.

There are a number of interventions that can improve self-esteem and address negative aspects of peer influence, particularly in adolescence. These include interventions that help adolescents to focus on more positive constructions of the self, rather than comparing themselves to others. Programmes aimed at raising self-compassion, a construct which encompasses self-kindness and mindfulness, have also been shown to reduce self-criticism and body dissatisfaction in adult women, and could usefully be applied to adolescents.

> **Recommendation 6**
>
> Evaluate and, if effective, roll out and embed interventions that promote positive body image in school curricula at all ages.

Influence of visual culture

The sociocultural message that 'thin is good' helps to explain the high and increasing prevalence of body dissatisfaction. Starting in childhood, toys and the media are influential factors which reinforce this message, and the influence of the media, especially social media, remains powerful throughout adolescence and into adulthood. There is extensive evidence that higher levels of exposure to pictures of 'idealised' bodies, such as those used for fashion and beauty adverts, are associated with lower

levels of body satisfaction and higher internalisation of the thin ideal. One explanation for this is our tendency to evaluate ourselves relative to others, and then feel bad when the comparisons are unfavourable. These comparisons are especially likely in those who have strongly absorbed cultural beauty ideals, and so may be exacerbated by the proliferation of 'perfect' images, particularly of celebrities, across all forms of media.

Increased interest in celebrities is related both to higher body dissatisfaction, and to more positive attitudes towards, and use of, cosmetic surgery. The explosion of social media and the almost constant access to idealised images has exacerbated such pressure, and postings on Facebook and Instagram are carefully chosen and often digitally manipulated. The interactive and personal nature of social media, along with the emphasis on peers, makes it especially problematic for adolescent girls for whom comparisons with attractive peers can be more detrimental than comparisons with models. At least 80% of 12-17-year-olds use social networking, and studies are beginning to show that higher social media use is connected with higher body concerns, which in turn are associated with disordered eating, depressed mood, and low sexual functioning.

It is not easy to address the challenges of visual culture. Early research suggested that drawing attention to digital alteration of images can reduce the negative effect, but the majority of studies find that even when people know that images have been airbrushed, they are still affected by those images. However, increased media literacy may help to counter the pressures of media culture.

> **Recommendation 7**
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> Media literacy in school curricula should be subject to evaluation and, if effective, rolled out and embedded.

Diversity of size of models and mannequins

The use of thin mannequins in displays, and of thin models in catwalk shows and print advertising, heightens negative comparisons. The fashion and beauty industry have justified their current practice by stating that "thin sells". However, this is not borne out by the evidence: it is not true that *only* thin sells. Research shows that when average sized models are used in adverts, this has a lesser effect on body dissatisfaction compared with ultra-thin models but the adverts are just as effective in selling products. Some countries have tried to regulate the presentation of overly thin ideals and increase the diversity of models' body shapes and sizes. The target is to change and extend the ideas and images associated with normality.

> **Recommendation 8**

Retailers should be encouraged to increase the diversity of mannequin size and shape. Similarly, modelling agencies and media should be encouraged to employ models with a variety of body shapes.

Cosmetic surgery and self-esteem

Body dissatisfaction is one of the driving forces for cosmetic surgery, and surgery may be seen as a 'quick fix', often with respect to a specific feature. For some people, surgery does seem to improve body image. However, the effects on broader aspects of well-being, such as self-esteem or mental health, are less clear-cut. Findings have shown a mixture of improvement; no change; and even worsening of these aspects after surgery. Multiple factors are associated with poor psychological outcomes following cosmetic surgery. The expectations of the patient, and the extent to which these are realistic, are particularly important. Expectations are heightened by adverts that suggest that procedures will not just change your appearance but also make you feel good. More generally, internalisation of the beauty ideals to which we are constantly exposed leads to more positive attitudes towards cosmetic surgery, and an increased likelihood of requesting it.

Recommendation 9

Trained mental health professionals should discuss motivations and expectations of invasive cosmetic interventions with all potential patients, and they should be encouraged to consider alternatives.

Governance, regulatory and legal issues

The primary regulatory and legal issues which emerged from the workshops and the Network discussions were those of piecemeal regulation; safety of practices; safety of premises and products; risks from unqualified practitioners; regulation of images; cross border procedures; and, throughout, a lack of robust and accurate data upon which to make policy decisions.

Piecemeal regulation

Currently, cosmetic surgery and non-surgical (commonly referred to as 'non-invasive') procedures are regulated in English law in a piecemeal manner. For example, the Supply of Goods and Services Act 1982 requires practitioners to exercise reasonable care and skill when providing cosmetic services in a commercial environment, and there may be both criminal and civil penalties where patients suffer harm as a result of poor quality care, or where valid consent has not been obtained. Health professionals must also be registered with their statutory regulatory body (the General Medical Council, the General Dental Council, and the Nursing and Midwifery Council, for example). However, despite these multiple regulatory regimes, there are some significant gaps with respect to how premises and practitioners are regulated:

- Private clinics providing cosmetic surgery must be inspected by the Care Quality Commission (CQC), but the 2013 'Keogh review' noted that the absence of agreed standards for cosmetic surgery meant that the CQC did not have clear criteria by which to judge clinics.

- Many premises providing non-surgical procedures such as botulinum toxin injections or dermal fillers are not routinely subject to inspection, as the public might assume, although the use of sunbeds is specifically regulated by the Sunbeds (Regulation) Act 2010, and some local authorities regulate laser treatments.

- There are no statutory requirements that surgeons must have specialist qualifications in particular procedures before providing cosmetic surgery.

- There are no statutory requirements with respect to the qualifications held by those offering non-surgical procedures (see below under qualifications and training).

- Patients who have cosmetic procedures privately have no access to the Parliamentary and Health Services Ombudsman, and so have only the option of taking (potentially costly) legal action to seek redress if things go wrong.

The Keogh review in 2013 recommended that the CQC "should work with professional organisations to produce inspection guidelines for cosmetic surgery providers", and that training for those providing non-surgical procedures should include an

understanding of the importance of operating from safe premises. An initiative emerging from within the medical profession is the development of pooled insurance schemes for practitioners, where practitioners are required to meet set standards in order to obtain insurance cover.

Suggestions for statutory regulatory change include extending the remit of the Parliamentary and Health Service Ombudsman to cover the whole of the private healthcare sector, including cosmetic procedures. Alternatively, a dedicated statutory regulator could be established, along the lines of the Human Fertilisation and Embryology Authority, with a remit to regulate and license the performance of cosmetic procedures, ensure regular review, and provide information to the public through codes of practice and other guidance. It could be involved in licensing not only premises but also practitioners, as well as monitoring consent processes, education, training, and the collection of data.

Qualifications and training

Cosmetic surgery is carried out primarily in private practice, and the qualifications and training of those who carry out procedures vary. There are a number of specialist professional associations which aim to promote high standards in cosmetic practice, including the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) and the British Association of Aesthetic Plastic Surgeons (BAAPS). However, surgeons are not required to belong to one of these associations, and membership does not demonstrate that a surgeon is qualified to perform a particular procedure. The GMC has a list of specialist plastic surgeons who are eligible to work as NHS consultants in plastic and reconstructive surgery, but there is no equivalent specialism of 'cosmetic surgery'. In response to the recommendations of the Keogh review, the Royal College of Surgeons has established a Cosmetic Surgery Interspecialty Committee (CSIC) with a remit to develop a system of certification, so that patients and hospitals can search for a surgeon who is certified to perform a specified procedure. The GMC is also considering a system of 'credentialling' to recognise areas of medical expertise.

Non-surgical procedures are often carried out by non-health professionals, such as beauty therapists, and there are no statutory requirements with respect to necessary qualifications and training. Similarly, where procedures are carried out by health professionals such as dentists or nurses, there are no requirements that they are specialists in the procedures offered (although they have professional duties, under their regulatory regimes, to operate within the limits of their competence). In January 2016, Health Education England (HEE) published detailed training requirements for practitioners offering non-surgical procedures, and a voluntary register is to be established by a new Joint Council for Cosmetic Practitioners.

> **Recommendation 10**
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> The work by HEE and CSIC should be built on in order to standardise training and qualifications and ensure that practitioners offering particular procedures are properly qualified to do so: for example, through registers of qualified practitioners, recognised training, insurance, and kite marking.

Product safety

The safety of products used in cosmetic treatments, from implantable medical devices to chemicals such as hair dye (which may damage the scalp, destroy hair, and cause major pain when sensitivity tests are not undertaken, or when products are used incorrectly) is also a matter of concern. The Poly Implant Prothèse ('PIP') breast implant scandal (in which implants were fraudulently made from industrial level silicone, raising significant health concerns) highlighted the inadequacy of the current regulation of implantable devices under the EU Medical Devices Directive. The EU is currently considering proposals for a new regulation to replace the Directive and to ensure greater consistency of application across the EU. Materials such as dermal fillers that are used as part of a 'professional service' are not currently covered either by the Medical Devices Directive or the EU General Product Safety Directive, and hence their content is entirely unregulated. In contrast, botulinum toxin is restricted as 'prescription only'.

> **Recommendation 11**
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> Urgent regulatory action needs to be taken in order to ensure that any product used as part of a cosmetic procedure is safe and fit for purpose.

Valid consent

Valid consent, based on a sufficient understanding by prospective patients of what is involved, is required for all cosmetic surgery. However, there is good evidence that consent procedures often fall short of good practice. The Keogh review recommended that consent processes should be strengthened: for example, by ensuring that consent is always sought by the operating surgeon in person, and not by staff with non-medical roles (such as salespersons). A multi-stage consent process is also needed to ensure that patients are not rushed into decisions. Non-surgical procedures, such as the injection of botulinum toxin and dermal fillers, also carry risks including infection, scarring, bruising, and permanent disfigurement. Rigorous consent processes for these procedures are equally important.

> **Recommendation 12**
>
> High standards in informed consent procedures for both surgical and non-surgical cosmetic procedures should be enforced. As a minimum, consent should be

sought personally by the practitioner who will be carrying out the procedure. Prior to decisions being made, a 'cooling off period' should be observed.

Recommendation 13

The roles of salespersons and advertisers must be kept separate from those performing procedures.

Adverts and images

A further area in which practice could be improved is with regard to advertising and the re-touching of digital imagery. For example, France has more extensive restrictions on advertising, and its Kouchner Law (2002) banned publicity of surgery in order to encourage cosmetic surgery to be seen as a medical act, rather than as a simple commercial transaction. Likewise, some publications might choose only to use 'non-re-touched images' or to acknowledge in some way that images are digitally altered (although simply noting that images are altered may be counter-productive).

Recommendation 14

The extent to which regulation of advertisements and imagery is likely to have a positive impact should be explored (for example, with respect to more realistic expectations of surgery).

Cross-border issues

Similar regulatory and safety concerns arise, and are exacerbated, when it comes to cross-border procedures (for example, making informed decisions in an unfamiliar health system with different regulations and a potential lack of information may increase vulnerability). There is currently proposed reform of EU regulation of medical devices but there is no compulsory regulation of cosmetic treatment providers and no way of ensuring consistency in standards of quality and of safety. Currently harmonisation of EU quality and safety standards of such treatment providers is unlikely given the absence of such requirements in relation to professional training of cosmetic practitioners across the EU. However, advice on cross-border treatment could be made available to prospective patients, and non-UK bodies could apply to attain kite marks or be added to an approved list, or similar.

Recommendation 15

Further exploration needs to be undertaken regarding the ways in which people who travel abroad for cosmetic surgery might be better informed and / or protected.

> **Recommendation 16**
>
> Prospects of collecting detailed data on cross-border procedures must be subject to further exploration.

Lack of evidence

The lack of accurate evidence is stark across both surgical and non-surgical procedures. There is little data on successful and unsuccessful procedures: this undermines decisions about regulation and governance. There is thus a need for evidence on the number of procedures carried out, by whom, and where. In addition, registries of products used must be established and maintained. Even without significant additional regulation, more data could be collected and synthesised, for example through systematic reporting of poor outcomes by GPs and A&E staff.

> **Recommendation 17**
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> Urgent data are needed on the number and type of surgical and non-surgical procedures carried out, by whom and on whom, as well as on the premises where they are carried out, and on any adverse effects.

> **Recommendation 18**
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> Registries and reporting mechanisms should be established as soon as possible: these could be temporary while more stable regulatory structures are developed, such as an umbrella body.

Conclusion

The Beauty Demands Network has sought to begin to address the challenges of the changing requirements of beauty. This briefing document is a small contribution to thinking about what needs to be done and thought about in policy terms. The recommendations speak to this moment in time and we anticipate that thinking about beauty norms and the ethical and policy responses to them may well change, and change fast. If individuals are to be protected and policy is to be proportionate, more effective data, more research, and more discussion between interested parties is required. To engage in this ongoing work, join the Beauty Demands Network, visit the Beauty Demands webpage (www.birmingham.ac.uk/generic/beauty/index.aspx), and contribute to the Beauty Demands Blog (http://beautydemands.blogspot.co.uk/).

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