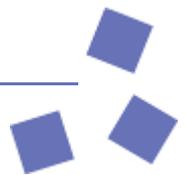


Regulation of Cosmetic Interventions

Research among the General Public and Practitioners



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1 Management Summary

1.1 Introduction

This research was commissioned to inform the review of the regulations covering surgical and non-surgical cosmetic interventions and whether they provide adequate protection for those undergoing them. Its aim was to provide up to date and in-depth information about the public's attitude to regulation in this area, including that of patients/clients.

In a combination of workshops with the general public, depth interviews with patients/consumers who have undergone or have actively considered a cosmetic intervention, and paired depths with teenagers, a range of issues were explored to address the research objectives. These were the:

- Regulations applying to surgical vs non-surgical cosmetic interventions
- Risks of surgical and non-surgical procedures, and the safeguards required
- Safety and quality standards offered in the private sector; qualifications, training, the experience of practitioners, membership of professional bodies
- Information that is/should be accessible to patients/customers
- Influence of advertising/media coverage, its impact on self-image, and opinions on the regulation of advertising
- Funding of post-operative medical care and the responsibilities of the NHS in correcting adverse events
- Need for psychological assessment/counselling prior to any cosmetic intervention
- Establishment of registries of cosmetic implants.

In addition, a series of depth interviews were conducted with practitioners with the focus of the discussion on the regulation of non-surgical cosmetic interventions and injectable procedures in particular.

1.2 Key findings

Despite their very different perspectives, there was a high level of agreement in the views of members of the public (including patients and those considering an

intervention) and those of practitioners in terms of the regulation of the industry for cosmetic interventions.

1.2.1 Influences on the market for cosmetic interventions

This research suggests that a wide range of influences, including media coverage of celebrities and their cosmetic interventions, reality TV programmes and the wider broadcasting of cosmetic procedures, alongside the increasing availability of and access to cosmetic interventions, are coming together to create a climate in which having a cosmetic procedure is increasingly regarded as normal and the associated risks are often underestimated. These factors also result in changing aspirations and ideals regarding body image, with some evidence that this results in greater salience for cosmetic intervention among the young.

While advertising is seen as widespread and therefore as adding to the impression of everydayness, individual advertisements seem to make little impact in terms of choice of supplier. However, mainstream advertising and marketing propositions such as discounting by third party operators, have clearly commoditised some non-surgical procedures. While there is no appetite for a wholesale ban on advertising, the hazards of time-limited offers are widely recognised and there is greater support for a ban/control of these. It is felt that more should be done to ensure the reliability of advertising in this area, to give the public a basis on which to filter potential suppliers and to protect the unwary prospective patient.

In making decisions about whether to proceed with an intervention and who to do this with, one's peer group and in particular, those within it who have already had such an intervention, are key sources of information about, and referrals to, practitioners. Indeed, their influence may override all other considerations. For those looking for information and guidance, there is no single 'go to' place for impartial information about interventions, practitioners, risks, questions to ask/things to look for; instead, those seeking to find out more are often driven to commercial sites by search engines. This often means that the practitioners are telling prospective patients what they want them to know and the patient is left unaware of the questions that he/she should ask and the answers that they should seek.

It was widely recognised that in the current climate for cosmetic interventions, certain groups of people may be vulnerable to messages of an easily accessible solution to dissatisfaction with their appearance including young people, those at risk of getting into debt and those with psychological problems. However, because many people are not fully informed when they undergo procedures and do not currently have the means to ensure that they can inform themselves, it would seem that a high proportion of those having interventions are at risk.

1.2.2 Perceptions of risk and the need for regulation

Even without being informed about current levels of regulation within the cosmetic intervention industry, over half of the public sample felt that it should be more tightly regulated, along with nearly all practitioners. While surgical interventions were seen as riskier, safeguards were assumed to be in place, and it was suspected that non-surgical interventions were where greater safeguards were needed. Among non-surgical interventions, it was anticipated that the greatest risk and need for enhanced protection was among the more invasive and potentially damaging procedures of injectables and chemical peels. Once members of the public had been shown information about the current state of regulation, there was an overwhelming call for greater regulation based on real concerns about the lack of safeguards across many interventions. Both surgical and non-surgical interventions were felt to need sufficient regulation to ensure patient safety, although it was recognised that the level and nature of the safeguards required would differ.

1.2.3 Safety and quality standards for practitioners

There was an expectation by the public that practitioners offering cosmetic interventions are trained and experienced in that intervention and currently, much is taken on trust that this is the case. At present, the prospective patient has no base of knowledge on which to judge the calibre of the practitioner; titles, qualifications/letters after the name, membership of professional bodies are all unfamiliar and lack meaning. Proxy indicators of quality and safety such as the type and appearance of the premises, the practice address and the behaviour of staff are then often used to guide decision making.

Medical professionals believed that only clinicians have the core training to respond appropriately to any adverse effects, including when administering many non-surgical

interventions. There were also consistent concerns expressed by practitioners that much of the training currently available for non-surgical procedures, particularly for injectables, is not of sufficient quality or depth.

There seems to be no professional body overseeing standards and ensuring consistent levels of competence in non-surgical procedures across practitioners.

1.2.4 Safety and quality standards for devices and settings

The following substances and devices were consistently felt to be inadequately regulated; injectables, in particular dermal fillers, chemical peels and certain equipment used in surgical procedures such as liposuction which is not currently regulated as a medical device. The public welcomed the idea of setting up a National Register of implants although support was not unanimous among practitioners.

There was also a call for the regulation of settings in which interventions are conducted in order to protect patients; reliance on inspections by local authorities for some outlets and Health and Safety at Work legislation were not felt to be sufficient.

1.2.5 Safety and quality standards around the process of undergoing a cosmetic intervention

The public would welcome some standardisation of process, information provision and consent that ensures that the patient is in a position to make an informed choice regarding whether to proceed with an intervention. There was broad support for a two-stage consent process for surgical procedures and in general, a well managed one-stage consent procedure was considered appropriate for non-surgical interventions. It was also felt that there could usefully be greater standardisation of follow-up and aftercare for different interventions.

Identification of the need for psychological assessment and counselling was felt to require more training of practitioners but it was not considered that these should be mandatory.

1.2.6 Responsibility for post-operative care

There was unanimous rejection of the NHS bearing responsibility for providing care for procedures conducted privately that have gone wrong. While some members of the

public and all practitioners recognised that it might be necessary to turn to the NHS in the event of serious health issues following an intervention, they insisted that the first port of call should be the practitioner/provider company. In the event that they cannot deal or do not wish to deal with the problem, then they should be liable for the cost to the NHS.

The research has indicated that there may be situations where it may be less clear how to proceed, for example where patients do not wish to return to the practitioner because they have lost confidence or where patients are discouraged from going to the NHS by practitioners who wish to 'deal with problems' themselves. It was felt that contingencies need to be in place to resolve such situations.

At present, patients do not know where to turn in the event of a complaint about their procedure and its outcome and an authority that can support, arbitrate and seek redress was called for. An ABTA style of scheme with an accompanying 'kite mark' was universally seen as having merit, both as a point of recourse and as a potential shorthand for the public to identify good providers.

1.2.7 Expectations of a regulatory body

The regulation of the cosmetic intervention industry by one or more regulatory bodies was widely anticipated before it was raised. While practitioners sometimes speculated whether their own regulatory bodies should do more in this area, others (public and the odd practitioner) looked to a single body working across all cosmetic interventions and practitioners. It was believed that this body could address several currently unmet needs:

- Overarching regulation that applies consistent requirements across practitioners and settings and ensures compliance with the designated standards
- Setting training and CPD standards that ensure competence, including in the event of a problem
- A source of information about both procedures and practitioners
- A point of recourse for patients.

1.3 Conclusions

The overriding conclusion from this research is that consideration should be given to regulation in a number of areas with others dealt with through guidance and improved training. If, in considering where responsibility for regulation should lie, the decision is taken to look to existing regulatory bodies rather than a new regulator, it will be important that there is joined up working to provide comprehensive coverage and comparable standards across the industry. Specifically, we conclude that consideration could be given to changes in a number of areas.

Beginning with the environment in which members of the public are influenced to think of cosmetic procedures as an accepted part of everyday life and to underestimate the risks involved, consideration could be given to providing a more balanced and accurate picture of the procedures, expected outcomes, risks and costs. This might involve:

- The laying down of guidelines for what is acceptable in the advertising of cosmetic interventions, in particular, to ensure that misleading executions and targeting which prey upon the vulnerable are prevented
- A strategy to address the pressures placed upon the prospective patient by time limited offers
- The facilitation of an overarching source/website to provide information on procedures and guidance for the prospective patient. The site should be subject to search engine optimisation to ensure that such a website features prominently when interested individuals seek out information.
- Consideration of whether some form of counter balance is needed to stem the increasing normalisation of cosmetic interventions, and to better educate the general public about the potential risks involved.

With respect to ensuring safety and quality standards for practitioners, consideration should be given to:

- Which roles, level of specialist training and experience define eligibility to administer different interventions and how the performance of practitioners is monitored

- How training can be improved to ensure that practitioners have adequate hands-on experience, understand the potential problems and how to deal with them, and to ensure they undergo CPD
- The role that professional bodies should play in this
- Providing a basis from which the prospective patient can make informed choices regarding where to go for a cosmetic intervention. Again, an overarching source/website may be the 'go to' place to find out about the training, experience and track record of practitioners.

The dismay that was expressed in response to the lack of regulation or appropriate regulation with respect to certain devices, substances and settings, suggests there is a need to consider whether:

- Devices and materials used in cosmetic procedures should be regulated as in any other medical sector
- Dermal fillers should become a prescription item and chemical peels should be subject to more stringent regulation
- Equipment used for cosmetic interventions should be subject to specific, rather than generalised regulation
- Regulation should be in line with other areas of medicine, not reliant upon the Health and Safety at Work Act.

Regarding safety and quality standards around the process of undergoing a cosmetic intervention, consideration could be given to the:

- Development of guidance on processes to ensure practitioners provide patients with the information to make an informed choice
- Signposting to, and promotion of, the independent source of information/website so that prospective patients can be empowered to know what to expect and the questions to ask

- Provision of the option of independent counselling and referral routes to patients by practitioners.

In order to address the perceived shortcomings in arrangements for post-operative care by some practitioners, the research suggests there is a need to consider:

- Processes to ensure that patient expectations are properly managed with respect to the outcome from the intervention, responsibility for post-operative care and how to seek redress in the event of a complaint
- Means of ensuring that practitioners/provider companies have in place the necessary insurances and indemnities to enable them to provide the care required or reimburse the NHS for doing so
- The possible merit of an ABTA style of insurance scheme and accompanying 'kite mark'
- Whether protocols need to be put in place to help patients who are discouraged from going to the NHS by practitioners who wish to 'deal with problems' themselves or who do not wish to return to the same practitioner.

2 Background and Research Method

2.1 Background

Given the growth in the cosmetic intervention sector, the intent of recent healthcare reform to put patients at the heart of care, and the questions raised by the PIP breast implant scandal, the Secretary of State has charged Professor Sir Bruce Keogh, NHS Medical Director, to review the regulations covering cosmetic interventions, both surgical and non-surgical, and advise on whether they provide adequate protection for the patient/customer. The review is due to report in March 2013 and will be wide ranging, examining the regulation covering:

- the products used in cosmetic interventions, including medical devices such as breast implants
- the professionals delivering the intervention, from cosmetic surgeons through to beauty therapists
- the organisations providing the cosmetic interventions
- insurance and indemnity and
- information, advertising and consent

The increase in the number of cosmetic interventions suggests that public acceptability of this sector is growing, however, there is no current attitudinal data on how the public in England expect this area to be regulated.

In order to fully consider these issues and discharge the Review's responsibilities in providing advice to the Secretary of State, a need for research was identified to comprehend how much the public understands about the current regulation of cosmetic interventions, what they should expect from a provider, and where they go to access information when they are considering paying for such an intervention.

2.2 Research objectives

The main focus of this research is the general public and the overarching aim is to gain an understanding of its awareness and perceptions of the regulations that apply to cosmetic interventions.

The specific objectives are to determine attitudes towards, and perceptions of, the:

- Regulations applying to surgical vs non-surgical cosmetic interventions
- Risks of surgical and non-surgical procedures, and the safeguards required
- Safety and quality standards offered in the private sector; qualifications, training, the experience of practitioners, membership of professional bodies
- Information that is/should be accessible to patients/customers
- Influence of advertising/media coverage, its impact on self-image, and opinions on the regulation of advertising
- Funding of post-operative medical care and the responsibilities of the NHS in correcting adverse events
- Need for psychological assessment/counselling prior to any cosmetic intervention
- Establishment of registries of cosmetic implants.

Research is also required among practitioners and particularly those offering cosmetic injectables. The secondary objective is to gain their views on the regulations that apply to cosmetic interventions.

For the purposes of the review and this research, the interventions that are of particular interest are as follows:

Surgical interventions	Non-surgical interventions
Face/neck lift	Injectable cosmetic treatments – ‘Botox’ (Botulinum toxin type A)
Other face/neck surgery	Dermal fillers
Breast augmentation or reduction	Chemical peel
Liposuction/sculpture	Dermabrasion
Tummy tuck	Laser hair removal, laser skin pigmentation correction, vein treatment
Cosmetic dental surgery, e.g. teeth whitening, veneers, implants	
Laser eye surgery	
Other surgery: lower abdomen, ears, genitalia etc.	

2.3 Research method

The research was based on a qualitative approach to allow perceptions, attitudes and behaviour with regard to cosmetic interventions to be fully explored. Given the likelihood that members of the public would not have considered the issues before, both time and appropriate stimulus were needed to enable them to do so. A mix of methods was used comprising workshops, paired depth and individual depth interviews, and telephone interviews. More detail is provided in 2.3.1 and 2.3.2.

2.3.1 Research sample: Public

The sample structure was designed to take account of the population groups that are contributing to the growth of the cosmetic intervention industry based on available statistics and earlier research. This shows that patients and prospective patients are more likely to be female and aged 25-55 years. While cosmetic interventions occur across socio-demographic groups, evidence from the PIP scandal indicates that the more vulnerable patients are C2D who are seeking the cheapest surgery they can find. An increase in activity has also been noted among men aged 35+ years, male and female high achievers aged 45-55 years who want to look younger in the workplace, singles, full-time workers and mothers and daughters seeking pre-wedding procedures. There is also evidence of a growing interest in cosmetic procedures among teenagers and young adults, notably females. The brief required the sample to include the general public as well as those people who have had or have considered having cosmetic interventions, both surgical and non-surgical. In terms of specific interventions, less priority was to be given to laser eye surgery and cosmetic dental surgery.

The approach and sample used in the research are summarised in the table on the next page. Further detail is provided in the recruitment questionnaire provided in the Appendices.

The research began with an extended workshop with members of the core female audience in order to scope out the issues to be discussed and pilot the stimulus materials. The discussion content was then developed for use in the other sessions with the public.

Method	Length	Sample																
Extended workshop	3.5 hours	Women aged 25-55, ABC1C2, half to have considered some form of cosmetic intervention																
8 workshops	2 hours	<p>8 workshops; 6 with women and 2 with men structured by socio-economic group (SEG) and age</p> <p>All the workshops included people who had considered some form of cosmetic intervention; those with the men also include some who had had such an intervention.</p> <table border="1"> <thead> <tr> <th></th> <th>Female ABC1</th> <th>Female C2D</th> <th>Male (ABC1C2)</th> </tr> </thead> <tbody> <tr> <td>18-25</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>25-40</td> <td>1</td> <td>1</td> <td>1 (<40)</td> </tr> <tr> <td>40-55</td> <td>1</td> <td>1</td> <td>1 (40+)</td> </tr> </tbody> </table>		Female ABC1	Female C2D	Male (ABC1C2)	18-25	1	1		25-40	1	1	1 (<40)	40-55	1	1	1 (40+)
	Female ABC1	Female C2D	Male (ABC1C2)															
18-25	1	1																
25-40	1	1	1 (<40)															
40-55	1	1	1 (40+)															
8 follow-up telephone interviews with selected participants from workshops with women aged 25-55 (2 from each of 4 workshops)	30 mins	<table border="1"> <thead> <tr> <th></th> <th>Female ABC1</th> <th>Female C2D</th> </tr> </thead> <tbody> <tr> <td>25-40</td> <td>2</td> <td>2</td> </tr> <tr> <td>40-55</td> <td>2</td> <td>2</td> </tr> </tbody> </table>		Female ABC1	Female C2D	25-40	2	2	40-55	2	2							
	Female ABC1	Female C2D																
25-40	2	2																
40-55	2	2																
4 paired depth interviews with teenage girls (friendship pairs)	1 hour	<table border="1"> <thead> <tr> <th></th> <th>Female ABC1</th> <th>Female C2D</th> </tr> </thead> <tbody> <tr> <td>14-15</td> <td>1</td> <td>1</td> </tr> <tr> <td>16-17</td> <td>1</td> <td>1</td> </tr> </tbody> </table>		Female ABC1	Female C2D	14-15	1	1	16-17	1	1							
	Female ABC1	Female C2D																
14-15	1	1																
16-17	1	1																
24 depth interviews with women (20) and men (4) who have had or considered a surgical or non-surgical intervention	1.5 hours	Details of the achieved sample are given in the Appendices (11.1).																

All workshops had 8 participants and across the different audiences, people from minority ethnic groups were included. Those who were strongly opposed to cosmetic interventions were excluded.

2.3.2 Research sample: Practitioners

Depth interviews lasting 1.5 hours were conducted with ten practitioners providing non-surgical cosmetic interventions privately; some of whom also offered surgical procedures. The sample comprised the following; two plastic surgeons, one General Practitioner, two nurses, two dentists and three beauty therapists. They practised in a range of settings; clinics, dental surgeries, consulting rooms in Harley Street or their own home, beauty salons, and patients' homes. All administered injectable procedures except the beauty therapists (one of these assisted in them).

2.4 Outline of the discussion content

Discussion guides were developed for each audience; these are provided in the Appendices along with the materials used to stimulate discussion on specific points.

In order to give some sense of the flow of the discussion guide used with the primary audience, the public, an outline of this is set out below.

Initial perceptions of regulation

- Capture of immediate impression of whether the level of regulation operating in the cosmetic procedure industry is about right or should be changed. This questionnaire was completed again at the end of the discussion to identify any changes in views.

Awareness and perceptions of cosmetic interventions

- Grouping of the various surgical and non-surgical interventions in ways that 'make sense' to the participants by sorting and laying out cards (based on pre-existing knowledge and assumptions)
- Perceived benefits of / motivations for having these interventions
- Individual ratings of each procedure according to perceived risk (again repeated at the end)
- Regrouping of the interventions according to level of risk and exploration of how risk relates to levels of protection needed for those undergoing these procedures
- Presentation of information about the procedures and in the light of this, any changes required to the 'risk map' of procedures are made (this map is then referred to during the discussion when discussing different aspects of safeguards and regulation).

'The Patient Journey': Finding out about cosmetic interventions

- Sources of information used/ anticipated
- Response to examples of advertising used in the industry and specific features such as

free consultation, treatment packages etc.

- Perceived benefits and disadvantages of advertising in this area, risks associated with advertising and other information
- Exploration of controls / regulation including a ban on advertising.

Decision making about going ahead with an intervention

- What they might look for in deciding on a provider/ whether to go ahead
- Information that would be sought including the importance of risks, safety, present and future cost
- Expectations of choice of practitioner – including skills and training
- Response to range of titles that might be encountered including Aesthetic Practitioner and Cosmetic Practitioner
- Perceived importance of various information about the practitioner in making an informed choice e.g. about their specialism, experience, membership of professional bodies etc. and how to find this out
- Presentation of information about training and qualifications of different practitioners and exploration of response to this
- Responsibility and means of providing information about practitioners including response to the Treatments You Can Trust website.

Quality and safety

- Presentation of information about safety and quality assurance for devices and organisations for different procedures and discussion of the perceived adequacy of this.

Consent

- Expected process to ensure patients can give informed consent including discussion of two stages of consent
- Perceived need for psychological assessment and counselling.

Follow-up to a cosmetic procedure

- Expectations of follow-up and after care
- Responsibility if more after care than expected is needed or something goes wrong and role of the NHS in this
- Desired insurance arrangements for the practitioner/organisation, attitudes to an ABTA-like scheme for the industry
- Awareness and perceptions of the PIP debate
- Response to the idea of a national register for implants.

Priorities for change and any changes in views

- Repetition of questionnaires on perceived risk and regulation.

2.5 Research timing and locations

The fieldwork for the research took place between 8 and 29 October 2012. It was conducted in urban locations across England and specifically in:

- Central London
- Waltham Abbey (London/ Essex borders)
- St. Albans
- Bristol
- Leeds
- Newcastle upon Tyne
- Wilmslow, Cheshire
- Manchester
- Birmingham
- Nottingham

2.6 Structure of the report

The key findings of the research are brought together with a series of conclusions in the Management Summary (section 1). The main body of the report is made up of the detail of the research findings. This begins with the broader context for regulation; the influence of advertising and media coverage (3), other influences on choice (4) and the perceived motivation for cosmetic interventions (5). The following four sections deal with perceptions of risk and the need for regulation in general (6) and then attitudes towards specific areas in which regulation and quality standards may be needed; these are, practitioners (7), devices and settings (8) and the process of undergoing a cosmetic intervention (9). The views of practitioners on the marketplace and the need for regulation are detailed in section 10. The appendices contain all the materials used in conducting the research.

Quotations extracted from transcripts have been included to illustrate specific points. Where these are taken from depth interviews with individuals, we can be more specific

about whether the participant has had or has considered having a cosmetic intervention. Where the quotation is from a workshop participant, we are only able to attribute it to the workshop rather than the individual. In order to give a fuller picture of some of the participants, their backgrounds and views, we have also inserted five case studies at various points in the report.

A final word - the findings reported here are qualitative in nature and, as such, should be treated as broadly indicative of the views and opinions of members of the public who have had a cosmetic intervention or would not reject the idea of having one. The practitioner sample is particularly small and it may be that those who agreed to take part did so because they were particularly concerned about the lack of regulation in the industry. Care should therefore be taken when generalising to the wider population of members of the public, or of practitioners.

3 The Influence of Advertising and Media Coverage of the Cosmetic Intervention Industry

3.1 Introduction

In this section we report on the influence of both advertising for cosmetic interventions and the wide ranging media coverage of cosmetic interventions upon the participants in this research.

3.2 Media coverage

All parts of the sample were aware of the extensive media coverage of cosmetic interventions, and this coverage appears to be highly influential, with the result that the whole industry has gained both currency and topicality; it is no longer a 'taboo' subject, particularly for women. In particular, awareness of television coverage of cosmetic interventions was widespread, with much reference to programmes such as 'The Only Way Is Essex' ('TOWIE'), and 'Sex in the City', and more dedicated programmes such as '10 Years Younger', 'Embarrassing Bodies' and 'Extreme Makeover'. Additionally, some participants watched more 'medical' programmes showing procedures taking place, which also add to increasing familiarity with the procedures depicted.

Coverage of the cosmetic intervention industry via editorial in women's magazines was also widely referred to, where procedures had been seen portrayed from many perspectives – 'how to', real life stories, celebrities etc. Indeed, hearing about celebrities having cosmetic interventions, and the portrayal of this as everyday behaviour, is itself highly influential in conveying a world where having procedures is seen as the norm. Whilst the experiences of some, such as Lesley Ash and Katie Price, were cited as cautionary tales, others were seen as success stories. It was particularly clear that both television programmes such as 'TOWIE' and interest in celebrity culture were playing a role in both making cosmetic procedures topical and building levels of awareness and knowledge.

In addition, media in this broader sense also appears to be influencing attitudes and ideals of body image, with increasing aspiration to be 'perfect' evident, including among the young.

“But on the other side, there’s the whole body image thing and with everything coming out in the media and celebrities doing this and if you’re maybe average, or think that you’re average or below average, you might seek to do those things where if it wasn’t so ... in your face like comparing yourself with things like you need to go and correct yourself with surgery. ...

... You start evaluating your whole body, don’t you?” (Female, 25-40, C2D, Bristol)

“The majority of celebrities are having these kinds of things done and they all look fantastic. If you see someone for example, who’s had a tummy tuck, who’s got a really amazing figure and a flat stomach and you’re sat there and you’re really not happy with yourself and you see x amount of celebrities that have all had this procedure done, that all look amazing, something is going to click where you think, ‘I’m just going to spend the money and I’m just going to have it done’.” (Female, C1, Pre-Family, Had Surgical Int, West London)

“Because I think people want to look their best and media portrays ‘perfect’ looking people or they portray a certain image and then because it’s what you see all the time, it almost feels like if you don’t look like that, then it’s wrong.” (Female, B, Pre-Family, Considered surgical Int, West London)

“I think you see it in magazines, celebrities are like, walking advertisements.” (Female, 18-25, C2D, Manchester).

3.3 Advertising

For the most part, advertising was not top of mind as a source of information that participants would turn to in order to find a practitioner, nor had it been directly used in this way by patients; rather, as detailed above, the effect and influence is one of ongoing familiarisation with the industry. Advertising for cosmetic procedures was felt to be increasingly widespread, especially for laser eye surgery, teeth whitening and breast enlargement, and its progression from the small ads at the back of magazines to a wide range of other media had very much been noticed. Some of the teenagers commented that they would place more trust in practitioners advertising in a ‘reputable magazine like Cosmopolitan’.

Executions appearing in mainstream media were frequently referred to and had clearly not only raised awareness, but had also commoditised the procedures themselves, making them seem more ‘everyday’ items. In particular, the public were generally very aware of TV advertising for laser eye surgery, which had resulted in it being seen widely as an everyday item, with executions described that show people ‘breezing in and out, having it done and smiling’, which, by definition, is felt to imply that it must not therefore be a particularly risky intervention. As a further example, in the workshop conducted in London, current radio advertising for breast enlargement was sufficiently familiar that it

could be quoted verbatim by most participants, and they were also very aware of the large volume of advertising on the Underground for the cosmetic intervention sector. Advertising for cosmetic interventions had also been seen widely in spas, gyms and salons visited for beauty treatments.

“I think laser eye surgery to me does seem a bit less risky just because of the adverts on television, and whether that is stupid or not, but the fact that they advertise it, it just seems really normal.” (Female, 25-40, ABC1, London)

“They are a bit more accessible, aren’t they, you see a lot more adverts for that sort of thing... laser hair removal and stuff you can see on the side of a bus.” (Female, 18-25, C2D, Manchester)

“It’s everywhere. It’s all over the place. It’s like, you go on Facebook and all.” (Female, 18-25, C2D, Manchester)

More broadly, members of the public were aware of the small ads at the back of newspapers and magazines, of cosmetic procedures being advertised on the internet, for example, as pop-ups on social media and on YouTube, and of cosmetic procedures being offered by third party discount providers. Some had taken advantage of such offers including teeth whitening for Christmas presents and pre-wedding treatments. However, there were also examples of participants taking up an offer only to arrive at the venue and deciding not to go ahead because the premises or impression of the practitioner did not inspire confidence, or of beginning the process but then backing out, also due to lack of confidence in the practitioner. The view was put forward in some discussions that such discounted offers were from providers who were desperate for business and therefore likely to offer a sub-standard service.

Case study 1

- Female, late 20s
- She thinks that having procedures has become quite normal now and has herself had two different types of chemical peel, microdermabrasion, laser hair removal and teeth whitening in preparation for her wedding. She suffers breakouts especially when stressed, so was particularly worried about her skin.
- She firstly visited a Harley Street clinic to ask about laser skin rejuvenation but didn’t go ahead because the treatment being suggested was £800 for 6 treatments. She felt under pressure at the consultation, and thought *“they pick out your insecurities as a tactic for making you purchase stuff...it was supposed to be a free consultation but they definitely do pressure you into having stuff.”* She described how she nearly handed over her credit card at the consultation when they asked for a down payment of £400 and was very relieved afterwards that she had not done so as she is unsure she would have been able to get her money back. The person conducting the consultation had been wearing a white coat but she felt that it was ‘all a bit of a front’ and that she hadn’t been given enough information about how it works or how long it would last for. She had also been ‘made to’ purchase some skin

products to use before the first treatment – “*she was very pushy and very persuasive into buying the products.*” The clinic dismissed her suggestion for laser hair removal (she assumed this was because it was a cheaper procedure) but they did suggest a chemical peel which is where this idea came from.

- Her next step was to look into chemical peels on the internet as she had not heard of them before and concluded that they might help with her skin problems. She sought out discounts in magazines and from third party discount providers; “*I thought, well I’m sure I can definitely get it cheaper than at that place and I just thought well how different can it be really?*”
- She found an offer for a facial that included a peel in ‘Look’ magazine and went ahead with this. She then noticed an offer for a set of three salicylic acid peels in the window of a ‘professional’ looking clinic that she walked past - “*I chose clinics that looked quite professional. I was able to judge by walking past and both of them were not too big, they were quite nice and small, a bit intimate but they looked, they were very new, modern and looked quite professional.*” This was enough to reassure her – she did not feel it necessary to look into the qualifications of the person carrying out the peel because it was not an ‘extreme’ procedure.
- She has also taken up other discounted offers on laser hair removal and teeth whitening but was more wary of using these for skin procedures/interventions on her face. She was somewhat put off by the unorthodox setting in which the teeth whitening took place – “*Just a woman in a kind of, almost like a flat, it did seem a bit dodgy. She had one of those dental chairs. Because everyone was going for this deal, she was probably doing about 15 a day but it did make you a bit wary because it didn’t seem like a proper place.*” While it made her think that she should be more careful, the price was persuasive.

In addition, some had received targeted advertising, particularly by text, but also by e-mail, examples of which are described at 5.3. These included opportunities and competitions to win procedures, and there were other examples given of cosmetic procedures being offered as prizes; for example, one participant had won a chemical peel in a raffle at the clinic where she had had dermal fillers and had returned for the procedure, only to back out part-way through because she found it so distressing.

“It wasn’t a full chemical peel but I hated it, I hated it. I can’t imagine it was a chemical peel because I know they’re very very expensive and I won it. But yeah, it was horrible, and I hated it and I made the woman take the stuff off really quick because I couldn’t stand it.” (Female, C1, Older family, Had Non-surgical Int., Leeds)

3.4 Issues with advertisements for the cosmetic intervention industry

In addition to their spontaneous comments, participants were shown a range of examples of advertising, mainly press ads but some offers from third party discount providers also, and asked to comment on them generally. They were also asked for their views on specific features of advertisements in the sector; free consultation, financial incentives such as 0% finance packages, packages which offer discounts for

also having other procedures, lifetime aftercare guarantees and time limited deals. Examples of these features were also available in the advertising examples shown.

The public highlighted a range of issues with advertising in the sector that they felt should be addressed. While they might themselves feel that they were not taken in by certain claims, they recognised that advertising for cosmetic interventions could play on vulnerable audiences, as could the use of unrealistic/altered/photoshopped imagery, including for **before and after images**, particularly with regard to portraying unrealistic outcomes. There were also felt to be issues regarding the way the industry uses **testimonials**, with doubts as to whether examples that had been seen were genuine. The promise of services such as a '**lifetime aftercare guarantee**' were felt by most to be neither credible nor deliverable, and that they should not therefore be offered. By contrast, the young women (18-25, C2D) in one workshop took such offers at face value, and felt they would be influenced by being offered lifetime aftercare for surgical procedures. In particular, the use of **time limited offers** was felt to be inappropriate for the cosmetic intervention industry, and to encourage poor choices, and it was felt by the majority that this should be prevented, especially for surgical procedures.

"The likes of [name of third party discount provider] suggesting you only have 6 hours to get it, throws your wealth of information that you'd want to gather before you make a decision, out of the window, doesn't it?" (Male, 40-55, ABC1C2, Waltham Abbey)

"I would never use [name of third party discount provider] for cosmetic procedures because I think they sell you fake things because it's not, this isn't regulated well enough either." (Female, C1, Post-family, Considered Non-surgical Int., Nottingham)

While advertising a **free consultation** was expected by most, and seen as a benefit in offering the opportunity to go along and find out more, pressurised selling in this area, either by a hard sell follow-up at/after a consultation, or by offering financial incentives to have cosmetic procedures, was felt to be inappropriate. Not surprisingly, there was consensus that the prospective patient should not be pressurised into making a decision without being given the opportunity for due reflection. Moreover, it was clear from some patients that the consultation can be the point at which the decision to proceed is made or sold.

"I felt really pressurised by them, I got calls for weeks after, £500 deposit, and I was like, 'I'm deciding, I'm not sure'. I used to get panicky and think 'I don't want to answer the phone'." (Female, 18-25, ABC1, St Albans)

“So if they advertise a free consultation you’d hope that they are a professional company, they’re not just after your money, there’s going to be someone there that medically understands what you’re looking for, is familiar with the procedures and can give you all the information you’re going to ask for and is not just going to pressurise you.” (Female, 18-25, ABC1, St Albans)

“I thought, ‘I’ll go and have a look’ - it was a free consultation, that was the thing ... so now they’re hounding me by email! And then they say things like, ‘we do finance, we do this ...’ and it’s like, ‘hold on, I want the procedure, not the finance’ and I just wanted to see really, see how far I would take it.” (Female, C1, Pre-family, Considered Non-surgical Int., West London)

Moreover, while it was expected that an initial call will be fielded by either a receptionist or a sales person rather than the clinician, it was anticipated that it will be the clinician who conducts the consultation. There were, however, examples given in the study where consultations were conducted by what was clearly the sales team, especially for laser eye surgery.

Offering **financial packages** such as instalment payment plans was felt, on the one hand, to improve access to procedures by making them affordable when otherwise they would not be; as such, they were welcomed by those for whom finances were tight. On the other hand, it was felt that the prospective patient may well be tipped into taking the offer of finance up without reflection if a discount is offered for a narrow time window. By helping to overcome the financial barrier, the decision to proceed with a cosmetic procedure is made easier and lighter and the full implications might not have been carefully thought through. In addition, it was recognised that providing financial packages could result in the user gaining unwanted debt, and some participants questioned what would happen if the user is then dissatisfied with the outcome of the procedure yet still has to pay for it. For some, as with third party discount providers, the offer of financial packages/discounts was seen as an indication of lower quality.

“It might be a way of helping ... I might think, ‘well actually, if I can pay it off... if I go and say, ‘right I want a tummy tuck’, that might be something that would... tip me over.” (Female, 40-55, ABC1, St Albans)

“I do think though that, because when I was looking into having my nose done, they was offering like a payment scheme, it wasn’t a credit card, so that I could spread it out over a certain time period and that appealed to me because you don’t just have four grand or however much it is, to hand.” (Female, 18-25, ABC1, St Albans)

“I think for me and also a lot of other people would just go for the package because it’s easier to get what you want quickly.” (Female, C1, Pre-family, Considered Non-Surgical Int., West London)

“A friend of mine has had a boob job and she’s paid on finance and it doesn’t sit right with me, that she was doing that. And also, if you listen to her care compared to mine, it’s a little bit scary. She paid on finance and she got sent out the same day, after she’d had the operation. Her scars to me, I would not be happy with them, they feel a bit like a botched job. And she found them in the back of a magazine - ‘I can get a boob job on finance’ and I was just like ... ‘yeah, to me, it just has alarm bells’.” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

Package deals that bundle together procedures were consistently felt to be morally wrong, especially for surgical procedures, and to encourage potentially inappropriate use. Some of the patients included in this study had had additional procedures e.g. Botox ‘thrown in’ as part of their dermal filler treatment. However, packaged deals were felt to have a place at the least risky end of non-surgical procedures, for example, some had encountered ‘his and hers’ teeth whitening offers and felt there was nothing wrong with this.

3.5 Attitudes towards a ban on advertising and its regulation

When asked directly, the balance of opinion was that the advertising of cosmetic procedures should not be banned. This was partly because participants felt that genuine providers should have a chance to advertise their services and meet the obvious demand that exists, and partly because it was felt that it might result in the industry becoming even less transparent, or being pushed into the ‘back street’. Banning media advertising was also felt to be pointless in the face of the easy access to unfiltered information about procedures via the internet.

Some did support a ban because of the role advertising played in proactively promoting the idea of cosmetic interventions and in order to protect vulnerable audiences, including the young and those with low self confidence.

“I don’t think that it should be advertised, I think that the NHS or the doctor’s surgery isn’t advertised. I think that when people need something, they will go and seek it out and find it. I think the cosmetic surgeries should be treated exactly the same because it’s not something that you want people to have but it’s something that’s there as a possibility”. (Female, B, Pre-family, Considered Surgical Int., West London)

There was a widespread assumption that the wide range of advertising is either monitored or has been checked for accuracy before being placed in the media and that although the images used may well have been altered, the information provided can be assumed to be factually accurate. Upon realisation that there is currently no vetting

procedure in place, some participants felt vindicated in their support for a ban. Conversely, rather than a ban, some felt that a system should be put in place to ensure that clear guidelines are set down for the advertising of cosmetic interventions and advertisements are monitored to check that they meet these standards .

In addition, there was a call for the provision of some kind of ‘route map’ that enables the prospective patient to be able to judge what is good and what is not in the industry. Currently there was felt to be no basis upon which to filter advertisers or make a judgement as to who could be trusted, for example, there was no way to evaluate the qualifications of the prospective practitioner, their membership of professional bodies, or their level of competence in the procedure being advertised. These issues are discussed in more detail later in this report. One of the advertisements shown to prompt discussion had a CQC registration number on it – when noticed, one participant hazarded a guess that this may denote ‘Certification of Qualified Cosmeticians’ and this was seen as a useful indicator of quality.

“But that’s where a nice little leaflet from the government or whoever would be nice. Because you could look out for certain accreditations and, I mean, I don’t know which ones are the right ones and which ones are made up.” (Female, C1, Older family, Had Surgical Int., Leeds)

Others similarly called for some form of quality stamp/kite mark (which they compared to the membership symbols used to select tradesmen, to ABTA/ATOL membership in the travel industry, or to charity registration numbers) that authenticates the source of the advertising, and acts as a first filter for the prospective user. It was also felt that providing such a framework could be part of the remit for a regulatory body in this area.

“I think they should regulate the people that are advertising ...I mean we do look in the papers, we do look in magazines, we do look on the internet, mainly on the internet, you know it’s the first thing we do – but equally, I would feel better if I know that the company I’m looking at have been fully – you know, that whoever’s let them advertise are fully happy with them, they’ve been regulated and whatever.” (Female, C1, Older Family, Had Non-surgical Int., Leeds)

“Maybe start from the top with the kind of, the restrictions and stuff, and if you’ve got tighter restrictions, then the ones that meet those criteria should be able to advertise, and then you kind of expect to see some kind of medical guild or, do you know what I mean, some kind of mark on them or something.” (Female, 18-25, C2D, Manchester)

4 Other Sources of Information and Influences on Choice

4.1 Introduction

In this section we report on other sources of information about cosmetic interventions highlighted by participants, and on the broader issue of the other key influences that are working alongside advertising and media coverage to change attitudes towards the industry.

4.2 The influence of peers

Peer group was often the first source of information and advice mentioned. Word of mouth was important in engendering awareness and consideration of procedures, and as a source of referral; the first thought in many cases was to ask around and see if anyone you/your friends know has had the procedure and how they evaluate the practitioner who carried it out.

“My best friend went to [name of cosmetic interventions provider] as well and she actually got a boob job and she was really happy with it so that has made me think, ‘oh, now I want it done’, because I’m still not happy. I still do want, I don’t want massive boobs but I do want bigger boobs and knowing that hers look so good and they don’t look really fake, she has tiny little scars, and it’s made me have trust in [name of cosmetic interventions provider] that they could do mine like hers.” (Female, 18-25, ABC1, St Albans)

“My friend’s doctor was really nice and he explained everything to her, all the risks and stuff like that and being realistic with her about what he could do. I went to see him instead of the other guy who’d done my friend’s, just because I thought her boobs were too big and they looked quite fake.” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

Participants increasingly knew a growing circle of people who had had a procedure carried out. This added to the growing salience of cosmetic interventions, bringing the industry into their immediate circle and making it something that ‘we’ do, as well as providing a source for word of mouth reporting of experience and referrals to practitioners. The result is therefore increasing familiarisation with cosmetic procedures as they become part of everyday life rather than something that is happening at a distance.

The Asian women participating in the research reported that cosmetic interventions tended not to be discussed so openly, and in particular were not mentioned to their

parents, who they felt would actively disapprove and discourage; one to one word of mouth recommendation by peers was the key source of referral and the way they found out more.

“If a lot more people are doing it, it kind of makes you think, ‘well, nothing’s happened to them, so I’ll give it a go’.” (Female, 18-25, C2D, Manchester)

“The wrinkles, I’m fed up with them, just age really I think. And I have a lot of friends who have had it [‘Botox’] done as well and so I thought, ‘oh well, everyone is getting it done these days’.” (Female, C1, Older family, Had Non-surgical Int., Leeds)

“I thought maybe it’s [breast enlargement] not that bad and is not seen as that bad, not as taboo these days. The more people have it done, the more comfortable you feel about enquiring about it. I spoke to a few people and they were really pleased with it.” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

4.3 Other key sources of information

After consulting peers, the first thought as a starting point for finding out more was not surprisingly, **Google and the internet**. However, those searching for information about procedures had tended to end up on practitioner sites rather than on a broader informative site and there appeared to be no ‘go to’ site from which those looking could find independent information and assess the pros and cons of the cosmetic interventions they are considering. Some had specifically tried to find an unbiased and authoritative site that outlined clearly the risks as well as the benefits but had not managed to do so. A few thought they might look on the NHS website or try and get information from NHS Direct, but on reflection, were unsure whether they would find what they needed there.

However, some participants had taken the information provided on practitioner sites at face value, seeing them as a reliable source. This naturally varied from site to site; other sites had been found to be no more than encouragement to contact the practitioner.

“I think they cover exactly what they need ... I’ve looked on the website... [name of cosmetic interventions provider] covered everything that I needed to read up on if I was considering having anything done, and if there wasn’t anything... all I need to do was just ask, and you get your free consultation anyway.” (Female, 40-55, C2D, Newcastle)

“I literally just put into Google ‘places in Manchester which do laser hair removal’. It brought loads of places and I went on the top 10 places and then read reviews and all that... no-one I know has had it done so I didn’t have anyone to say

‘where did you go?’, ‘what price did you pay?’ I just did my own research really.” (Female, B, Pre-family, Had Non-surgical Int, Wilmslow)

Beyond this, prospective patients had looked at a range of web based information, such as blogs, forums and testimonials written by those having/providing procedures, chat rooms where people were talking about whether they were satisfied with the procedure, YouTube interviews/clips about having procedures. These often included patients posting their own before and after photos, or images of how they looked following the procedure. Throughout this search process, it was noted that some names came up time and time again, and this was interpreted and used by some as a basis for identifying who is ‘reputable’ in that location.

“My friend recently had a nose job and she literally for months before, she was on all different forums. People posted pictures of their nose before and after, who their surgeon was and she’s put her pictures up on a daily basis of what it looked like when she took her cast off, and she just found that really reassuring that she’d seen loads of pictures from the same surgeon that she knew she was booked with.” (Female, 18-25, ABC1, St Albans)

“I just typed it into Google and then worked through whatever came up; you’re trying to go for the names of companies that are a bit more reputable. If you hear about the names in passing, certain names ring bells to you, some names you never hear of, so you work out which ones are reputable.” (Female, B, Pre-family, Considered Surgical Int., West London)

Some thought that if they were considering a surgical procedure, they would try and find out if the surgeon had any malpractice/legal suits against them or pending. However, one patient had tried to find this information and had found it difficult.

In general, the easy access to a large volume of information about practitioners on the internet is deceptive; participants generally thought they knew what information to look for, which questions to ask but realised during the course of the discussion, as they became better informed, that in fact they had not known what to ask, or what information to look for.

In addition to the role already discussed in building awareness and salience of cosmetic interventions, some of the **celebrity and TV influences** discussed earlier were also influencing choice in a more specific way, by acting as a starting point for referral suggestions and through their perceived endorsement of particular organisations or practitioners.

“You’ll see on certain Sky channels, people from ‘The Only Way Is Essex’ that use that clinic and you see the girl who’s just had hers done, who’s on television in this reality show, advertising it...I think I’ve seen it and it’s been one of the girls from ‘The Only Way Is Essex’ and she’s standing there going, ‘I used the [name of cosmetic interventions provider] to have my breasts re-done, I’ve never been happier ...’, that kind of advert.” (Female, C1, Pre-family, Considered Non-Surgical Int, West London)

“The guy she went with had done nose jobs for Mark Wright and the guys on ‘TOWIE’ so she was like, ‘he must be really good then’...she felt a bit more safer.” (Female, 18-25, ABC1, St Albans)

Only rarely did prospective patients consider consulting a **membership organisation**/site but then tended not to know what the relevant body would be.

As stimulus to prompt discussion of regulation versus a more self regulatory approach, participants were shown the home page of the **Treatments You Can Trust** website. Whilst some felt it was at least better than nothing, for most it raised more questions than it answered. Their questions were around the basis upon which the practitioners who are recommended on the site are approved/included, and the implications if approval is dependent on payment. There was felt to be a conflict between paid subscription and government backing, with the latter felt to imply that it is impartial and inclusive. More broadly, if the site does not cover all practitioners, it was thought to have limited value, leaving the prospective patient unsure both as to the basis for inclusion and as to what to deduce about practitioners who are not on the site. None had discovered and used the TYCT site in their own online investigations of procedures and practitioners.

Some had/thought they would consult a **health professional**, with their GP the first port of call. This seemed particularly likely if considering a surgical intervention, although this may in part have been due to initially finding out whether they would be able to have the procedure under the NHS. However, some had gone to their GP as their first source of information and advice, for example, one had asked their GP for a private referral for a nose ‘reorientation’, another for their views on laser hair removal.

4.4 The influence and effect of access to cosmetic interventions

Across the participants in this research, the widespread and growing presence of the cosmetic intervention industry had been noticed and was raised spontaneously. Procedures were felt to be available everywhere, resulting in the industry being

perceived as increasingly accessible for all, a change from the past when it was seen as limited to the rich and famous. The cosmetic intervention industry had been noticed on the high street, in shopping centres and across a wide range of outlet types, from clinics, to spas and salons. There was also widespread awareness that it can be found in the home; 'Botox' parties were particularly top of mind, but local GPs who offer injectables to individual patients in their home were also mentioned, as were mobile practitioners offering procedures at lower cost in home.

Moreover, respondents were aware that some procedures could be bought by the public on the internet; for example, one respondent had bought herself a teeth whitening kit for 99p in this way. In some discussions, including a workshop with young women aged 18-25, they were very aware of DIY kits for 'Botox' available on the internet, and put forward the view that they should be banned.

"I don't think you should be able to do any of them yourself. I don't think you should be able to buy a laser hair removal machine..."

... You can buy 'Botox' off eBay and just have a go. Not like I would but...

... You could buy anything, couldn't you, and you wouldn't know. Like, you could be injecting anything into your skin, or a diluted version, or anything that could cause you some damage." (Female, 18-25, C2D, Manchester)

To summarise, the combined effect of the widespread advertising and media coverage of cosmetic interventions, celebrity culture, growing word of mouth and increasing visibility of providers/outlets offering access, was an ongoing process of normalisation of the cosmetic intervention industry. Procedures were seen as more popular, more everyday; it was felt to be ever more 'the norm' to have a procedure carried out, and they appear to be increasingly front of mind as a solution to a body feature than is disliked or seen as less than perfect.

Moreover, the increasing availability and presence of cosmetic interventions resulted in the procedures being seen as less risky – 'if they are so widely available, they must therefore not be risky' was a widely held and influential attitude. For all of these reasons, at least some procedures were already familiar, and this too reduced the sense of risk and need for caution.

"I think by having all these ads for things like laser eye surgery and teeth whitening, it's almost normalised it and I think ... you almost feel that eye surgery is less risky because you're always seeing ads everywhere. It's true, the more

ads you see because you just think lots of people are getting it done and you just assume that it's less risky but has the risk gone down actually?" (Female, 25-40, ABC1, London)

"I don't think there's like a taboo about - maybe there would have been 20 to 30 years ago because a lot of people don't care do they, if you say, 'Oh my god, like you look great'. 'Oh yeah, I've had like a breast reduction.' People don't try and hide it." (Female, 40-55, ABC1, St Albans)

"There's definitely more and more of it than there used to be and it almost makes you feel like it's the norm now to go and have your tummy tuck or get your stretch marks sorted out. It's like it's expected that you'll have it done because there is so much advertising." (Female, C1, Older family, Had Surgical Int., Leeds)

Interestingly, it appeared that there is currently little counterpoint to the increasing normalisation of and familiarisation with the cosmetic intervention industry.

5 Perceived Motivation for Cosmetic Interventions and Vulnerability

5.1 Introduction

In this section we provide some background to the attitudes towards and motivations for having procedures and discuss the issue of those who may be vulnerable to making poor choices with regard to cosmetic interventions. It should be noted that this study is not intended as an in-depth examination of the motivations for having a cosmetic procedure, rather, this topic is included as background to the views explored in detail regarding regulation of the industry. The findings from this small sample of the general public should not be viewed as generalisable across the population but indicative of the attitudes and outlook of some of those who might be interested in having a cosmetic procedure at some point.

5.2 Attitudes and motivations for having cosmetic procedures

Those who had had procedures, consistently talked about increasing self esteem, confidence and wanting to feel better about some aspect of themselves as the core reason for having any procedure and for some, achieving a transformation in their physical appearance. Whilst some expressed the view that this had indeed been life enhancing, others spoke of the pressures associated with the need to conform to an ideal, such as wanting to be 'perfect' or to stay 'young'.

Many described their motivations for having a procedure in terms of doing something for and about themselves and for some, procedures had been carried out to address long standing dissonance with themselves, such as a feature that had bothered them since childhood.

"I've talked about my nose so much over the years but I don't just want to dive in and have it done...as I've got older, more insecurities are creeping in and I can see me arguing less about the medical and more about the aesthetic." (Female, B, Young family, Considered Surgical Int., Wilmslow)

For others, the procedures undertaken had been a way of dealing with a changing body, for example, as a result of ageing, dieting, hair growth etc that they viewed as undesirable, or, as with laser eye surgery for instance, that they felt was impacting upon the quality of their life. Procedures might also have been triggered by life/lifestage changes that have caused a desire to re-appraise or make changes to themselves.

Interestingly, ‘restoring’ their body to how it was pre-pregnancy was mentioned fairly frequently, particularly in the context of considering breast surgery.

However, for some the aims were simpler, with non-surgical cosmetic interventions seen as a treat, ‘doing something for myself, to make myself look and therefore feel better’.

For others, the aims of cosmetic procedures appeared more outwardly directed, about their perceptions of how others see them and judge them on their appearance. In part this was a reflection of changing cultural norms, aspiring to an ideal of beauty or ‘perfection’ that they believed to be widely valued. Others had more specific reasons such as resisting ageing, wanting to stay young, to be seen by others as still youthful, looking as young as they felt etc., or they had a more specific goal in mind, for example, a wedding, or helping to get a new job. Additionally, they felt they had the possibility of achieving their aim through cosmetic intervention – the attitude that ‘if you can change something to improve how you look and feel, why wouldn’t you?’ was mentioned on several occasions

“I think that when you get to my age, and you see everything going south and you want to do what you can.” (Female, C1, Older family, Had Surgical Int., Leeds)

“I think it’s just the fact that they can and I think over the years, women have a battle with their bodies, as they change, different ages, they do, they struggle with trying to accept it over different years and the fact that you can, it’s like ‘wow, so what, it’s a bit of money, let’s just change ourselves.’” (Female, C1, Pre-family, Considered Non-surgical Int., West London)

Moreover, the likelihood of feeling this way and taking action may be increased when others in their circle are following that path; as mentioned above, peer groups were highly influential in motivating people to consider/have cosmetic procedures.

“Obviously in this area, in Essex, it’s used a lot. It’s just a way of life as well. We’re used to it. If one girl has had one thing done, they want to get it done as well because it looks good.” (Male, C2, Pre-family, Considered Int., Waltham Abbey)

“I think I had them done because I’ve got friends that have had them and they look good with them but I’d lost some weight and I looked very drawn, and so I looked into it and I had the dermal fillers done.” (Female, C1, Older family, Had Non-surgical Int., Leeds)

“My friends were all having things done and I could see changes and I could see themselves changing, their lives changing, their jobs changing and I associated

that with the way they looked, which may or may not be right and I think it started off with their appearance, then their confidence grew, then they changed their careers suddenly and things were a lot nicer for them and I don't know, maybe I just went, 'maybe it's because of that'. That's where it started.” (Female, C1, Pre-family, Considered Non-surgical Int., West London)

Despite the growing prevalence and discussion of cosmetic procedures, whilst some had clearly talked openly to family and friends about their cosmetic interventions, for others it had remained their secret, for example, one participant had been having 'Botox' for several years before, much to her disappointment, her husband noticed.

5.3 Vulnerable audiences

In the aftermath of the PIP scandal there were concerns that some women were making poor choices regarding both breast enlargement in particular and cosmetic interventions in general, including those swayed by lower cost interventions. In addition, there has been some evidence of a growing interest in cosmetic procedures among teenagers and young women. Both of these potentially vulnerable audiences were represented in this study.

Some of the young people participating already had the idea that they might have a cosmetic procedure at some point, and they acknowledged that the influence of a 'want it now' culture meant that this was something they would ideally do sooner rather than later. Specifically, some of the teenagers already had in mind that this was something they might find out more about in the future, and all felt that there were girls of their age who would like to change something about their body if they could. Moreover, like others, their focus was on the immediate effect rather than any consideration of long term maintenance, or future costs for repeating or re-doing procedures.

*“Things that you don't really need but you just feel you want to have them.”
(Female, 16-17, ABC1, Manchester)*

*“I wouldn't actually mind having surgery because if people... really don't like a feature, it'll bring them down. I would gladly have a nose job pretty much.”
(Female, 14-15, C2D, St Albans)*

“The other day actually, we were in our classroom and my friend was like, 'oh yeah, I'm going to get a breast enlargement when I'm older'. And we were like, we kind of just got onto the subject of it like, 'oh yeah, I want a nose job' and stuff like that. I don't know, it just kind of pops up, mostly...”

... Or you'll be like, 'oh yeah, I wish I could get liposuction' or 'you should get liposuction'. It's mostly joking around, but some people I think are definitely considering it...

... Yeah, probably some people like genuinely wish they could have it now, especially probably the boobs and the liposuction.” (Female, 14-15, ABC1, London)

“I want to get those lip things done... it makes your lips go a bit bigger but it’s more like perfect lips. They are like Chloe from ‘TOWIE’ but I don’t want them as big, I just want them done a bit so they are a bit up.” (Female, 16-17, C2D, Waltham Abbey)

Some of the teenagers/younger women from ‘blue collar’ families were blasé, referring to cosmetic procedures as ‘something you might get’, a commodity to be acquired. One 16 year old felt that everybody should be entitled to one cosmetic intervention on the NHS. Certain procedures, in particular, breast enlargement, were particularly top of mind, whereas others were seen as more for older women. Unusually compared to the sample as a whole, some had a starting point of thinking there was probably too much regulation in this area, again reflecting the perception of cosmetic interventions as an everyday commodity.

Case Study 2

- Female, 16 years old, at college
- Expresses the view that ‘everybody wants to look like a celebrity when you’re younger’ and is influenced by TOWIE ‘because they always look perfect’. Also points to the media and how it ‘makes them think they aren’t perfect, well not perfect, but makes them think they aren’t really that pretty compared to them people that have it done’. She suggests that you won’t feel perfect inside unless you are (more) perfect physically.
- Proposes that everyone should be allowed at least one cosmetic intervention on the NHS, and maybe a second one for a cheap price.
- She would like a breast enlargement, a nose job ‘because my nose is fat’, and to get ‘the lip thing done’. When she reads through the descriptions of procedures, she also likes the sound of a chemical peel and microdermabrasion. She thinks that if she didn’t like the nose job ‘they could just do it again’.
- She has seen teeth whitening for £99 in a tanning and nail shop locally and thinks she might have that for her Christmas present.
- Receives e-mails every month from a website (is unsure of the name) telling her about cosmetic interventions that she can have when she is 18 – ‘I just delete it because I know I’m going to get it every month. It’s like when you turn 18, you can have like all of these done and it’s saying like, ‘go to this website and get it done’. I think it’s a bit dodgy.’ She is also persistently offered teeth whitening by text.
- Her friend gets texts on a similar basis and e-mails about cosmetic procedures.
- Before getting any of the surgical procedures done, she thinks she would ask the practitioner for details of people that have had the same procedure and Facebook them to find out how it went.
- She does not think there should be more regulation – she is of the view that ‘it’s your body and you can do what you want with it’.

The influence of the media and celebrity culture was again clear, both in terms of raising awareness and general aspirations regarding appearance but also where cosmetic procedures were reportedly seen as a way of achieving ambitions, for example, wanting to have a breast enlargement in order to try and become a model.

“I can’t wait till I’m rich enough to get my teeth done, really. I can’t wait. It’s one I’m definitely doing.” (Female, 18-25, C2D, Manchester)

“That is all what we’ve seen in the media. There’s a lot about it on television, we read a lot about it in magazines. Like laser eye surgery, there’s a lot of adverts you always see, along with teeth whitening, you see a lot advertised just around Manchester.” (Female, 16-17, ABC1, Manchester)

“And you hear about celebrities because you’ll be like, ‘oh wow, they look amazing’ and someone would be like ‘but they’ve had this and this done’, like really!... It makes you more encouraged to do it because they look so nice most of the time.” (Female, 14-15, C2D, St Albans)

“A lot of people want to do modelling as well, like what’s her name, Beth, she got a boob job to do modelling.” (Female, 16-17, ABC1, Manchester)

“You always hear it, like most of the celebrities you’ll look at them and think, ‘oh yeah, she’s had her boobs done, she’s had this done’ because it’s just kind of what you think of when you look at them... if a celebrity has it and that is when we would be talking about it probably, like thinking whether they have had like liposuction done or breast reduction or whatever.” (Female, 14-15, ABC1, London)

“Like on the programme [‘TOWIE’], they make it sound because they’ve all had their breasts done, well not all of them, but most of them, but they make it sound like it was the best thing they ever did and stuff like that and so people are like, ‘oh, I want to try it’, or ‘I want to do it’.” (Female, 14-15, ABC1, London)

Being surrounded by images of ‘perfection’ clearly played a part in shaping their expectations; whilst they admitted that the images they saw were edited and ‘photoshopped’, they nevertheless aspired to them in their own body image ideals. In addition, as would be expected for this age group, peer group norms were highly influential, such as knowing friends/girls within the same social circle who are having breast enlargements as an 18th birthday present. In addition, some had encountered the cosmetic intervention industry indirectly via their peer group; for example, friends’ mums conducting both ‘Botox’ and chemical peels and one teenager’s mum who wanted to have a tummy tuck. As discussed earlier, together these influences result in the idea of cosmetic interventions becoming normalised at a young age, and, for some young women, in a commoditised approach towards their own bodies.

“My friend’s mum, she is into beauty and she does mini-chemical peels on people.” (Female, 16-17, ABC1, Manchester)

“I think the bad point is that because it’s always so in your face that it sort of becomes the norm and you just think, ‘well like, if everyone else is getting it done, then I might as well go and try and get it done as well’.” (Female, 16-17, ABC1, Manchester)

“Quite a lot of people say, ‘oh I wish my teeth were whiter, I wish my teeth were straighter’ and there’s like, ‘when I’m 18 I’m going to go and get my teeth whitened as a birthday present’ or something like that, because a lot of celebrities’ teeth are really white...

... And like perfect...

... So they want to have it done.” (Female, 14-15, ABC1, London)

“I think it’s like us [that are the influence] a lot of the time because if you see like your friend has got bigger boobs than you or she’s got a flatter tummy than you or something, you’re like, ‘oh my God, I wish I was like that’...

... Yeah, and so you want to be like her.” (Female, 14-15, ABC1, London)

In addition, there were relatively young women having ‘anti ageing’ treatments, with questions raised by others as to the appropriateness of this.

“I think there’s a fine line, isn’t there? I’ve got a friend who’s early 30s and she’s been like having Botox and I’m like, ‘does she really know, she’s 30 and her forehead is like’...

... My daughter’s been talking about it as well, she’s 26.” (Female, Workshop 4, St Albans)

“I know this girl, she’s only 23 and she’s already had Botox.” (Female, C1, Older Family, Had Non-Surgical Int., Waltham Abbey)

For some of the teenagers and young women, the industry is actively reaching into their lives; as well as seeing cosmetic procedures advertised, the young women in this study had clearly been targeted, encountering the industry on their phones, on social media, and in their e-mail inbox. For example, one 16 year old received regular texts letting her know that she could have procedures when she was 18, another regular e-mails. One young woman (18-25) had asked for more information on a website and had then been hounded.

“One thing I found quite disappointing is that the person who contacted me was just a sales person who was just trying to hit the target, and I was a bit, like, ‘you’ve not actually asked me anything. I could be 12 years old and you’re just trying to sell something to me’, so I was really off put by that...he didn’t have any kind of consultative approach. He were just like, ‘do you want to buy it? Buy it

now, and just come in and get it done' and I was like, 'whoa, hang on a minute'." (Female, 18-25, C2D, Manchester)

The industry is also encountered on the high street, in nail bars and salons visited for beauty treatments; for example, one teenage girl went to a beauty therapist for her eyebrows and was regaled with information about how the salon was going to start offering 'Botox'.

By comparison, at the other end of the spectrum, there were some patients who were clearly vulnerable as they faced ageing, often when combined with other factors that were changing their lifestyle, such as divorce, or other major life changes. However, there were also those with more fundamental psychological issues who saw cosmetic procedures/making physical changes as the answer to other problems, and who are therefore always likely to be disappointed, and to be open to being sold multiple procedures. In this situation, it seems that prospective patients simply do not hear the potential risks.

"She just wanted her eyes to look like they were bigger, like they used to be. Do eyes sag a bit? I suppose they do. But what's quite sad about it is she lost her partner in April, he died suddenly of a heart attack while running, so I think she'd been through quite a lot and then all of a sudden she had it." (Female, C1, Older family, Had Non-surgical Int., Waltham Abbey)

A different aspect of potential vulnerability comes from the financial implications of the significant sums that can be involved in having interventions. Some spoke of taking out loans or instalment plans to make interventions affordable. For those who are more financially challenged there is therefore the risk of getting into debt, either in the short term, or longer term, due to not realising the longer term financial implications of the procedures being considered. Additionally, it was clear that some were making decisions based upon cost that might lead to greater exposure to risk.

It was clear that the combined effect of the normalisation and currency of cosmetic interventions places a wide audience at potential risk; whilst there is increasing interest in and awareness of the possibility of having a cosmetic procedure, as detailed later in this report, members of the public do not necessarily know what they are looking for, or the specific benefits that can/cannot be provided, they do not know the risks involved, and are unable to judge the quality of what they are being offered. On this basis, any prospective patient could theoretically be in a potentially risky situation.

6 Perceptions of the Risks of Cosmetic Interventions and the Need for Regulation

6.1 Introduction

In this section we report on the perceived risks of surgical and non-surgical procedures, the factors influencing such perceptions and how they were affected by the provision of information about the procedures. We also give an overview of attitudes towards the need for regulation in the cosmetic intervention industry and whether attitudes changed after participants were provided with information about the current state of regulation and safeguarding and had the opportunity to deliberate on this.

6.2 Levels of perceived risk

Participants in the research did discriminate between surgical and non-surgical procedures in terms of the perceived risks involved, with surgical procedures seen, as would be expected, as the higher risk due to the potential complications associated with having a general anaesthetic, the level of invasion ('someone cutting you', 'going under the knife'), and the fact that the effects are permanent and seen as irreversible. Surgical procedures such as breast enlargement/reduction, face/neck lifts, nose surgery, liposuction and tummy tucks were therefore seen as the most 'serious', the area where it is most important to research the procedure before committing to it. There was also more focus upon the individual practitioner who will be carrying out the surgery, their track record, and their competence/skill level, or in some cases, on the clinic/hospital where the surgery will take place.

"It is the risk to your life, so each of these surgeries is quite invasive, you're under general anaesthetic and therefore any complications could arise." (Female, B, Pre-family, Considered Surgical Int., West London)

However, because it is surgery, there is an assumption that there will be regulation and safeguards in place to protect the prospective patient, and that in terms of the requirements upon those conducting the surgery that the prospective patient may be better protected.

"I thought the surgical ones, this might just me being twisted, I've put them as less risky because for me, they'd be done in a sterile environment, in a hospital, with back-up and like people were saying, you get like recovery time and you'll get a proper anaesthetist...you have a proper team." (Female, 40-55, ABC1, St Albans)

Non-surgical procedures were typically divided into two groups according to the level of perceived risk; riskier/more invasive non-surgical procedures (injectables, chemical peels, laser skin resurfacing, dental implants) and what were seen as more 'high street' non-surgical procedures: teeth whitening, dental veneers, microdermabrasion, laser hair removal. Microdermabrasion was not always known as a procedure initially but, once informed as to what was involved, it was consistently seen as a low risk procedure, closer to exfoliation and a beauty treatment than to a more serious cosmetic intervention. For the lower risk non-surgical group, it was often felt that little can go wrong, that these are widely available, that they are courses of treatment that build up slowly or are carried out in small steps. These were felt to be procedures that you can just go and have done, where there is no need to conduct extensive research beforehand.

Interestingly, laser eye surgery was often felt to sit alone and to be difficult to assess in terms of the risks involved; on the one hand, it is called surgery and affects the eyes, so the implications of something going wrong were felt to be potentially extremely serious if your sight could be compromised or lost. This was at odds, however, with the widespread prevalence and advertising of laser eye surgery, and the impression that it neither takes very long nor requires admission. There was therefore a mismatch between what is implied by the procedure and its ready availability that left participants unsure how to judge the degree of risk involved. Moreover, some of those who had had laser eye surgery pointed out that although they would have liked to have met the individual who was carrying out the procedure, they were never in a position to do so as they did not conduct the initial consultation.

It was the 'higher risk' non-surgical interventions that caused the greatest debate and where perceptions of the risks involved varied considerably. For this group of procedures, of which injectables and chemical peels were most top of mind, it was felt that the risks involved may be greater; firstly, because they are more invasive and therefore a more serious procedure, and secondly, because they are not surgery and there may therefore be less safeguarding and regulation in place. As with laser eye surgery, it was felt difficult to balance the perceived risks with the message sent by the widespread availability of these procedures; participants were aware that these procedures are growing in popularity, are available in a wide range of settings, including non-clinical settings, and from a wide range of practitioner types. As discussed earlier,

this implies that the risks involved must not be great. Indeed, the salon or high street setting caused some to place all non-surgical procedures together at the lower risk end of the spectrum.

This perception of easy accessibility was weighed up against the fact that injectables are going into the body (and may therefore be classed as invasive) and chemical peels are going on to the face, which increased the perceived risk involved. Moreover, participants felt that there is no obvious specialist in injectables and chemical peels (unlike say, for dental procedures), and that this makes it harder to judge the level or type of qualification required to carry out the procedure safely.

“There is still a risk they could go wrong or that you might not react well to them, but obviously lots of people do have them done but it’s not as risky, I suppose.” (Female, 25-40, ABC1, London)

“I think people are better protected for the more invasive treatments, but these ones (‘Botox’ etc) I think, just because anybody can do them, I mean I don’t know how it works in terms of licences, but I know that you can just go into a salon and get it done. I don’t know what training those people have had, if any, who polices it.” (Female, 25-40, ABC1, London)

“(Chemical peel, dermal fillers) In and out job, in and out one day but more than just a little bit of something, I think, isn’t it?” (Female, 25-40, C2D, Bristol)

“I think ‘Botox’ would be in the middle as well because people go out in the day just to get that. My friend gets it all the time on her lunch break.” (Female, 18-25, C2D, Manchester)

“You wouldn’t really call them surgery, they are like procedures rather than like surgery, like if someone was going in for a nose job or teeth whitening, it’s kind of different realms, isn’t it?” (Female, 25-40, ABC1, London)

“I think the fillers are (risky), I’ve seen too many programmes about fillers going wrong, because once they’re in, you can’t take them out, they don’t go anywhere, they just stay in your face, so if they do it wrong...” (Female, 40-55, ABC1, St Albans)

“I think basically if anything is going into your body, whether it’s someone cutting you open or putting some substance in your body, that’s invasive to me. If I am just, say, using some sort of chemical on my skin I wouldn’t say that’s invasive but if I’m injecting it then...” (Female, 18-25, ABC1, St Albans)

When informed about these procedures, they were felt to be more risky than had been anticipated – the idea of putting acid on to the face with a chemical peel, how ‘Botox’ acts by paralysing muscles, the fact that dermal fillers can be permanent – all of these increased perceptions of how risky these procedures are.

Initially, dental implants were often assumed to be a relatively low risk procedure, comparable to teeth whitening, but when informed as to what was involved, this too was seen as involving far greater risk than had been originally understood.

Overall, the risks of cosmetic interventions were greater than was anticipated; across all members of the public, patients and those considering a cosmetic intervention participating in this study, once given information about cosmetic procedures, they were globally seen as more risky than had previously been thought. It would appear therefore, that the public is consistently underestimating what is involved in having a cosmetic intervention.

In particular, the risks were felt to be greater than anticipated for injectables, chemical peels and dental implants. Among surgical procedures, the risks were greater than thought for liposuction, which was generally thought to be a more minor procedure, and tummy tucks, which was also a much more involved and invasive procedure than had generally been imagined.

Certain procedures were less familiar - dermal fillers (although they are assumed to be like 'Botox'), microdermabrasion, laser skin resurfacing and, to a lesser extent, chemical peels, and it was therefore felt initially to be difficult to know what the risks might be.

6.3 Factors influencing perceptions of risk

A wide range of factors were identified that influenced the perceived level of risk of a cosmetic procedure:

- Whether the procedure is permanent or temporary, whether it is reversible or not
- How likely it was felt to be that something could go wrong, and what would happen if something did go wrong

"If any of them (surgery) went wrong, you'd look terrible and there might be a lot of other risks, like you could die and ... that is the sort of thing where you'd need to have at least a week off work." (Female, 25-40, ABC1, London)

"With the laser eye surgery you can go blind, that's pretty major. Hair removal, the worst you're going to have is a little scar." (Male, 40-55, ABC1C2, Waltham Abbey)

- How 'serious' or major, how invasive, or how painful the procedure was perceived to be

"To me, that's terrifying. I think I'd really worry about doing something like that (breast reduction/surgery), whereas the others, I'd look into them and think, 'do I want it or not' rather than, 'is it safe?'" (Female, 18-25, C2D, Manchester)

- Whether the participants had heard about things going wrong, either by word of mouth, or via the media, including hearing of them going wrong for celebrities
- How widespread or popular the procedures appear to be
- Whether they are advertised widely
- How readily accessible the procedures seem to be
- How quick and easy they appeared to be to conduct, including the recovery time that might be needed

"They're known as lunchtime thingies, you literally can get them done in 30 minutes." (Female, 18-25, ABC1, St Albans)

"I don't think the laser eye is that risky to be honest. Just because I know people who have had it done literally in a day and that's it." (Female, 25-40, ABC1, London)

"These are more serious ones [surgical], you would have to look into them a bit and you'd be off work with them whereas these [non-surgical], you can do some of these in your lunch hour. People offer these things to be done within 24 hours." (Female, C1, Pre-Family, Had Surgical Int., Manchester)

- Where the procedures are being carried out; a high street setting can convey a lack of risk

"I can just go upstairs (at the hairdressers) and get some microdermabrasion – it seems such an easy thing to do." (Female, C1, Pre-Family, Had Surgical Int., Manchester)

- Who or what type of practitioner is carrying out the procedure; if a beauty therapist can carry it out, it was assumed that it cannot be risky
- The cost of the procedure; for some, low cost was equated with low risk (because there cannot be much involved), while for others, a higher cost is assumed to denote quality and therefore lower risk. Participants highlighted the

wide variation of costs in the sector and how it was difficult to know whether you were comparing 'like with like'.

6.4 The influence of perceptions of risk on attitudes to cosmetic interventions

While participants were able to articulate their views about their perceptions of risk as applied to the different interventions, it appeared that the influence exerted by such perceptions was in part related to their individual personalities and how cautious or 'gung-ho' they felt about the idea of having a cosmetic intervention. Moreover, there was a trade-off between the perceived risk of cosmetic interventions and the normalisation discussed earlier in this report, which served to mitigate perceptions of risk. Finally, personal experience, knowing someone who has had a particular procedure carried out successfully, can be an overriding influence and outweigh any other considerations in evaluating the risks involved.

"If you know somebody that has had it done and you think that looks really good and so I might consider it for myself." (Male, 18-40, ABC1C2, Birmingham)

"I think you can note down how risky anything is, if you want it done you're going to have it done, you don't take any notice of that." (Female, 25-40, C2D, Bristol)

A further potential issue regarding perceptions of risk that should be highlighted is the role of the many scare stories that circulate regarding cosmetic interventions. Many such stories were related during the course of this study, examples of which include people

- having fillers injected in hotel rooms who then died
- buying fillers/ 'Botox' on the internet and self injecting
- buying kits for home lip fillers that were actually filled with plastics and injecting them into their lips
- with their faces 'frozen' from too much 'Botox'
- and a plethora of 'safari' cosmetic intervention stories.

The danger is that these tales have semi-mythical status and they did not therefore always translate to a felt risk, or appear to feel close enough to inform behaviour. The PIP scandal would however seem to be an exception to this; whilst horror stories

abound about it, there was also a perception that this was a widespread problem that was reported extensively in the media and in which the NHS was involved. It was therefore placed in a different league, and had been taken on board as an instance where something went seriously wrong and people were put at risk, rather than being an example of a one-off rogue practitioner or gullible individual. However, despite this, breast enlargement was described on several occasions as a fashion and how, in having such a procedure, one was merely following a trend. Awareness of PIP did not therefore seem to have acted as a counterpoint to this.

Indeed, more broadly, cosmetic interventions were described as trends or fashions to be followed.

“I think ‘Botox’ is very of the minute. Laser eye surgery, although it’s been around, it’s much cheaper now to obtain. Teeth whitening, I mean a few years ago that was quite rare. And I think those things are trending.” (Female, 25-40, ABC1, London)

“It’s like a trend ain’t it, like we all follow a trend don’t we, so like the fashion? To me, some of these are like fashion... I mean half of my friends have got a boob job so I’m the only one that ain’t. But then I think, once I have a boob job you never know, I might like have, ears and liposuction, I’ll carry on.” (Female, 25-40, C2D, Bristol)

The other influence of the scare stories regarding cosmetic procedures was to generate a perception that this can be a ‘slippery slope’, that once you start changing your body, it becomes easier to make further changes, and you could easily become ‘addicted’ to ongoing improvements, with celebrity examples such as Katie Price and Michael Jackson readily provided. There were also some examples of this desire among the patients included in this study, a couple of whom had undergone several procedures and seemed to be seeking ongoing improvement. Again, it was felt to be important that processes are in place to identify and offer some help to these individuals.

“Also, you see people that have had procedures and they just keep going, don’t they? They have them over and over again ‘till they look like a freak show.” (Female, 40-55, ABC1, St Albans)

“It was like you’re just never happy with what you’ve got, if you start on it, it can be like a slippery slope... And then when people get addicted to it is when they just start looking awful.” (Female, 18-25, ABC1, St Albans)

6.5 Overview of attitudes towards the need for regulation

The starting point for about half of the participants in the research was that the cosmetic intervention industry should be more tightly regulated. Of the remainder, not surprisingly, many did not feel that they were sufficiently well informed to know whether or not the current level of regulation was adequate.

However, at the end of the interviews/workshops, and following deliberation, the overwhelming opinion was that the industry should be more tightly regulated. Moreover, when some of the women were followed up after the workshops (once they had had time to reflect a little more on the information that had been shared), they tended to feel even more strongly that tighter regulation was required in order to ensure adequate patient protection. The opinion was expressed that the cosmetic intervention industry should be brought more closely in line with other medical procedures.

In particular, injectables were raised as the key area of concern; it was consistently believed that these should all be prescription items and regulated accordingly.

“You do still hear a lot of stories about it going wrong, which probably leads to you needing maybe tighter restrictions on it.” (Female, 18-25, C2D, Manchester)

“I don’t suppose they can offer a guarantee but you’d like to think that they’d all been regulated somehow.” (Female, C1, Older Family, Had Non-surgical Int., Leeds)

“I just think they should all be regulated but depending on the level of danger, I suppose.” (Female, C1, Post-family, Considered Non-surgical Int., Nottingham)

Perceived shortfalls in the current situation were consistently felt to be a matter for regulation, rather than voluntary self-regulation, because participants believed that they need to be universally applied to ensure that all patients are equally protected. This was felt to be necessary because it was felt that the public do not always have the knowledge to know what they should be looking for. Participants also believed there should be adequate protection and regulation in place for all procedures; many assumed that this is already the case, and there was considerable shock expressed at the lack of regulation in some areas, as detailed later in this report. However, there was also an assumption that the degree of regulation and extent of control in place will vary between surgical and non-surgical procedures, and between non-surgical procedures, to reflect the differing nature of the procedures and risk levels involved.

“I think everyone that’s practising should have a degree of regulation to begin with. Obviously the more invasive that we feel it is, the stronger the regulation should be.” (Male, 40-55, ABC1C2, Waltham Abbey)

“I would say those ones would be more unregulated as well because more people can do it. Like you can just go into a salon and get that done whereas I would imagine there’s more regulation (for surgical procedures).” (Female, 25-40, ABC1, London)

“I think if you can potentially die from a procedure going wrong, then there should be really high regulations for those particular ones.” (Female, 18-25, C2D, Manchester)

“Well a high level protection especially for the intrusive ones. I mean things like teeth whitening, it’s not, I mean it can go bad but it’s not going to go horribly wrong.” (Female, 25-40, C2D, Bristol)

“I think it requires different levels of regulation because if you’re going to regulate things such as teeth whitening at the same level as face and neck lifts then you know it just costs a lot of money and time for the government so yes, different levels would be appropriate.” (Female, 18-25, ABC1, St Albans)

Participants also emphasised that they expected the whole industry to be adequately regulated because all procedures carry some element of risk.

“I think something like teeth whitening should be regulated because it seems like such a minor thing that maybe people would over-use it because they’d just have this assumption that it’s nothing really and have their teeth whitened maybe more often than you should and that would result in some detrimental effects ... so I think even the really minor ones should be regulated to a certain extent.” (Female, 18-25, ABC1, St Albans)

“I think the regulation should be the same for any kind of cosmetic procedure. Because alright, ‘Botox’ isn’t the same scale as tummy tucks but that is still someone’s body, they are still handing over good money and putting trust in someone to do something to their body. It’s like if you went and had a normal operation, you wouldn’t expect any less guidelines if you was having an operation on your toe, to if you was having an operation on your face, you’d expect the same level of care.” (Female, C1, Pre-Family, Had Surgical Int., West London)

Many respondents commented spontaneously at the end of the discussions that they felt they had learned so much from participation and that this information should be disseminated more widely among the general public. Overall, they felt that they would now approach the industry with greater caution, seeking information and asking questions that would never have occurred to them previously.

7 Attitudes towards Regulation and Quality Standards for Practitioners

7.1 Introduction

In this section we report on attitudes towards regulation and quality standards specifically with respect to practitioners, covering qualifications and training, membership of professional bodies, titles and other indicators of standards.

7.2 Qualifications and training

The training and qualifications of practitioners were widely seen as the foundation from which patient safety stems. They represent the mechanism by which their skill set is put in place and maintained, and the way competence is ensured, including in the event of something going wrong. Not surprisingly perhaps, it was consistently felt that it should be a priority to ensure that every practitioner carrying out cosmetic interventions is fully qualified to do so.

In reality, prospective patients had not asked practitioners about their training, when they qualified, which qualifications they held etc, or to demonstrate competence, nor had they looked at the qualifications held. It was felt to be difficult to ask someone whether/to what extent they are qualified, and participants suspected that they would not know how to interpret the answer anyway. Rather, the level of qualification and training was taken on trust, and the ability of a practitioner to be able to carry out a particular cosmetic intervention was assessed at the global level of the type of practitioner they were (i.e. a doctor, a nurse, a beauty therapist etc). It was felt that beyond this, the prospective patient does not have the necessary knowledge to judge whether that practitioner is competent to carry out that procedure. As a consequence, it would very much be welcomed if this information was readily available without having to ask the individual concerned.

“Would you ask someone for qualifications if you went to a salon for one of these? I don’t think I would. In your local salon I don’t think that is a question you’d ask for these procedures... you wouldn’t go into your dentist and say, ‘are you qualified?’, you’d just assume.” (Female, 25-40, ABC1, London)

“I think wherever they go, for a consultation, you should be given a list... you should be given it by law, I think... the name of who’s doing it and what their accreditation means and what that actually means, and maybe a number or a

website where you can check that they're on there.” (Female, C1, Older Family, Had Surgical Int., Leeds)

“The only thing that means anything is ‘Doctor’. If it’s ‘Doctor’, then they’ve got to be okay, haven’t they? That’s how I see it.” (Female, C1, Post-family, Considered Non-Surgical Int., Nottingham)

“Titles - I really don't have a clue. I'm thinking yeah, I look at titles and I go with recommendation, but how do I know if that person's qualified? You very rarely see certificates anywhere. I wouldn't ask for it, I'd be embarrassed to ask that question because I'd think they were thinking, 'don't come here then, obviously you can see that I've worked'.” (Female, C1, Pre-family, Considered Non-Surgical Int., West London)

Generally, a level of competence based on relevant training and qualifications was assumed to be in place for medical professionals. For surgical procedures, the expectation was that these are carried out by a qualified surgeon who is specialist in the area.

“I think I would assume that a surgeon is highly trained and if they said they were a surgeon, I don't know how much research I would then do into what he was qualified in, because I'd be like, 'he's like a surgeon, he's up here on my list, he's not a cosmetic practitioner with a made-up title, he's a surgeon'.” (Female, 40-55, ABC1, St Albans)

Upon deliberation, it was felt that cosmetic surgery should be on the specialist register as it was assumed that those conducting surgical cosmetic procedures are specialist in the area. Indeed, there was genuine shock that surgical cosmetic procedures can be carried out by non-specialists; the consensus across this study was that this should not be allowed, that those conducting surgical cosmetic procedures should be specialists in cosmetic surgery and have adequate experience in that procedure. When informed what BAAPS membership denotes, it was felt that the criteria for membership encapsulate the surgical expertise sought.

“I want to know how long they've been doing it, I want to know if they've got any kind of specialism. You get a cosmetic surgeon but they might have done two tummy tucks and 3000 nose jobs, well I don't want a nose job.” (Female, C1, Pre-Family, Had Surgical Int., West London)

It was also felt to be vital that surgical skills are kept up to date and there should therefore be a requirement for ongoing training/CPD. Moreover, formal assessment of competence should be in place; it was not felt to be adequate for this to be self-assessed. Prospective patients wanted to be able to assess the track record of the

surgeon, to be able to find out how often they have carried out that particular procedure, their success rate, whether they have had any patients where it has gone wrong, etc.

However, it was non-surgical procedures where it was felt that ensuring adequate training and qualification was a potential issue, with some awareness that the level of qualification and training may vary considerably between practitioners. It was sometimes assumed that a practitioner will be qualified to conduct procedures at a lower risk level than those they might usually conduct (e.g. that a doctor or nurse is qualified to carry out non-surgical procedures), which may not necessarily be the case.

There was considerable surprise about dentists offering injectables among those not previously aware of this, and mixed views on them doing so. For some, they are an unexpected source and this is outside their area of specialism and expertise; they would not therefore choose or trust a dentist to carry out a non-surgical procedure of this kind. However, others felt that dentists do have the medical foundation from which to add appropriate specific training, and that as long as that extra training has been undertaken, they are a potentially credible source.

“Apparently dentists and doctors are the best people to go to for ‘Botox’ is what I’ve heard...”

... Dentists yes, because they’re good with injections...

... They know exactly where your muscles are.” (Female, 18-25, ABC1, St Albans)

There were, however, widespread concerns regarding non-medical professionals administering injectables, and this was an area felt to be completely outside the expertise of those qualified in other areas such as hairdressers; there was consensus that this should definitely not be allowed. For some, beauty therapists too should not be allowed to administer anything but the lowest risk procedures or anything invasive, and all felt there should be processes that ensure that beauty therapists have the in-depth knowledge to practise in this area. Some would expect procedures such as injectables and chemical peels offered by a beauty salon to be administered by a specialist medical professional brought into the salon for that purpose, and some were aware that this does happen currently.

“If they [beauty therapists] do [injectables], then they need regulating. If they move to the next step they need to take the various exams and qualify, get

regulated, get insured, then they can do business. But until they've done any of those things, then they shouldn't be allowed out of the front door.” (Male, 40-55, ABC1C2, Waltham Abbey)

“You'd probably want somebody who understood the body a bit more to be doing something like that ['Botox'], as opposed to a beautician. I'd want someone who, if it went wrong, knew what to do or the effects it might have, as opposed to a therapist.” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

“It's not really their job. Their job is to do beauty therapy on somebody's face or body like... because they don't have 'doctor' in their title or anything so you don't think they should be allowed to do it, if they don't have the training or qualifications or anything.” (Female, 14-15, ABC1, London)

7.3 Membership of professional bodies

In theory, it was recognised that membership of the relevant professional bodies for practitioners of cosmetic procedures should provide some of the guidance needed in choosing a practitioner because they were assumed to:

- Set standards for members that guarantee competence
- Act as a 'stamp of approval' when choosing a practitioner
- Provide a database of information about members that enables the prospective patient to make an informed choice
- Provide a point of recourse in the event of dissatisfaction or a problem.

However in practice, there was almost no awareness of what the relevant membership bodies in this area are and, even on the very few occasions when participants had vaguely heard of an organisation, they had no idea of its role or responsibilities. In addition, it was felt that there were a plethora of 'bodies' in this area, making it more difficult to know who was responsible for which areas/which type of practitioner.

More generally, participants were unsure what such a body might do with respect to monitoring members' professional practice nor what teeth they might have, to impose sanctions for example. It was generally known that doctors can be 'struck off', so there was a sense that there are sanctions that exist for malpractice, at least for some practitioners.

Importantly, the public did not know how the approval/sanction of a membership organisation/practitioner might be recognised by the prospective patient and used to

facilitate choice of provider. The membership organisations are not therefore currently fulfilling the theoretical role desired; if they are not known, and there is no known way to recognise membership, they cannot be used as a guide to standards.

There was also some doubt as to the extent to which membership organisations serve the interests of the public compared to those of their members. Participants pointed out that a membership organisation is not useful as a guide if they are there primarily to benefit the profession, if the criteria for membership are self selected rather than useful in setting standards, if they only cover those professionals who have chosen to pay the membership fees, or if they give a false sense of unbiased endorsement that is not based on objective criteria.

“What these [membership organisations] would make me think is, what do people have to do to become a member of it? So is it something that they apply to be in and buy into or is it something that they’ve got to have a certain level of qualification to be a member of? And how do they check on that person? When someone’s qualified, does someone from one of these boards go and check that this person’s qualified to their level or how does it work?” (Female, 40-55, ABC1, St Albans)

Across the study, there was therefore a suggestion that there should be a single regulatory body offering one port of call, providing simplification and inclusiveness. For the public, this would mean one title/organisation to know, one place that covers and has authority over the industry as a whole, and certainty as to where to go if needed. It was suggested that this body would then become the ‘go to’, trusted source for any query, issue or information need regarding the cosmetic intervention industry, the place from which to find or check on a practitioner, to get advice, and the place to go for recourse if needed. It was envisaged that membership would be compulsory for those wishing to practise in the area (for example, along the lines of the GMC) and would be conditional on demonstration of adequate and specific training. It was also suggested that there should be a monitoring role, with CPD requirements and competence of practitioners monitored on an ongoing basis. There was acknowledgement that the requirements will need to be adapted to cover the range of cosmetic interventions, with suggestions that there could be some kind of graded structure to accommodate different levels of risk, or for surgical versus other procedures.

“I think potentially like, not an extra qualification but maybe they would have to come and observe you and monitor you and make sure you’re meeting certain criteria before you’re allowed to be on that body...”

... So you know that everybody that's part of BAAPS or whatever it's called has been observed for a year and they're ticking every box and all their patients within those 12 months have been happy etc., now you're allowed onto that body, or something like that...

...I think auditing, like periodic auditing, just because you met the criteria when you joined five years ago doesn't mean you're still good so maybe periodically just checking." (Female, 18-25, ABC1, St Albans)

It was envisaged that a central body of this kind could fill the gap for a hub for information and assistance, including providing a central database of information about practitioners, and a guide to 'approved' practitioners that could be used to find a practitioner that could be trusted. Such a body might also allow members to use some symbol of accreditation (the 'kitemark' referred to in 3.5) in promoting themselves to help reassure prospective patients.

"You should have this sort of governing body that you can go to and say, 'look, I've had this surgery and this and that which has gone wrong'." (Female, 40-55, C2D, Newcastle)

"If you are accredited to that standard of that kite mark or whatever it might be, then you must have come up to a certain standard in order to be able to do that, so you can't be anyone who is just going to start giving people 'Botox', you'd have to be someone that's got all those relevant things in place." (Female, 25-40, ABC1, London)

"So there should be one place to go to, provided by the government with everything on there, so you should be able to search the registers to find the practitioner, you should have all the information about the thing and you should have all the risks." (Female, C1, Pre-Family, Had Surgical Int., West London)

7.4 Titles and other indicators of standards

Participants were asked how they would interpret titles such as Cosmetic/Aesthetic Doctor and Cosmetic Practitioner. In general, they said they would assume that a practitioner with the title of Cosmetic/Aesthetic Doctor was an expert in the field, although it should be noted that Aesthetic was by no means a familiar term for all, and there was confusion between this and Anaesthetist. The title of Cosmetic Practitioner resulted in cynicism among the more savvy but clearly had potential to confuse the impressionable as to the level of specialist expertise conveyed. In terms of level, it was assumed by some, though not all, that a Cosmetic Practitioner was an equivalent to a Beauty Therapist who had specialised in the field. However overall, it was felt that these titles had little meaning, and that if they are to be used, this should be made more explicit including what level of specialist qualification lies behind them.

“I mean I could set up a little shed and put that cosmetic practitioner on the top and start injecting people with dermal fillers and stuff and it would be perfectly legal, which is a bit worrying.” (Female, 18-25, ABC1, St Albans)

The initials after a practitioner’s name were not felt to be useful as a guide to levels of qualification and competence as it was felt that the general public do not know what they mean, and find both the titles and the initials too complicated to remember. Some assumed that they denote a level of training and qualification but did not know the specifics of the particular letters that may be relevant in this area. There was a low level of recognition that FCRS denotes a surgeon.

“Unless you know what the letters stand for, it really doesn’t make an awful lot of difference and half the time I suppose you pay to be part of an organisation to get the letters to add to your name so I don’t know really that that’s that important, unless they must be regulated to get into the club where they get the names from.” (Female, C1, Older family, Had Surgical Int., Leeds)

But knowing that the practitioner also worked for the NHS was felt to be important, as it guarantees both the authenticity of the practitioner and that they have received the level of training required. It was also felt to indicate that the practitioner is currently working in that field and is therefore up to date.

“I’d probably feel a bit more trusting. Even though they’re working outside the NHS you would know they had been vetted, you would know that they’d gone through the system so I think that would probably feel better.” (Female, C1, Older family, Considered Surgical and Non-surgical Int., Waltham Abbey)

“He works for the local hospital so it’s quite reassuring that he doesn’t just do plastic surgery, he deals with day to day people, he’s a breast consultant so it’s a little bit of reassurance. I don’t know why that is but it just is, he does other stuff that he’s not paid loads for, he’s still in the NHS, I don’t know why.” (Female, C1, Pre -family, Had Surgical Int., Manchester)

While the training and competence of the individual practitioner were therefore considered to be the ultimate safeguard, participants felt unable to make a judgement as to whether this is in place or not. It was clear that they would like there to be an easily accessible system where they are able to check on the qualifications of the practitioner, their length of experience in that procedure, how often the procedure is conducted, with what results etc.

In the absence of this information, those considering cosmetic interventions and patients were using other factors as a shorthand for safety and quality standards. Thus, the organisation and its reputation, the appearance of the premises, including whether

they look clean and professional, the address (in particular, Harley Street) of the organisation/ practitioner, the appearance of the staff (e.g. wearing white coats) and a personal evaluation of the individual concerned (most notably, whether they have a professional and empathetic manner) were all used as proxy indicators of quality. The appearance of premises as a guide to quality was cited frequently and for non-surgical procedures, the busyness of the salon was seen as a positive sign. As mentioned in 4.3, celebrity endorsement or use was also very influential. In addition, it was often assumed that because the intervention was being carried out by private practitioners and patients were paying for it, a better standard of care and newer techniques and equipment would be available than in the NHS, at least as far as clinical settings are concerned.

“It’s a lovely place, you know you went in and they sat you in a little waiting room. There was tea, coffee, water and whatever, the receptionists were really nice and it looks lovely and clean.” (Female, C1, Older family, Had Non-surgical Int., Leeds)

“I think they are very clever with that, I mean if they call themselves ‘the Harley whatever’, you immediately associate that it must be a top surgeon who is there. If you call yourself ‘whatever medical centre’, you think, ‘oh well, they must be certified and accredited’.” (Female, 25-40, ABC1, London)

“The way the salon is set out and the professionalism of the people that are there, you know uniforms and stuff like that, you’re not saying, ‘oh, what BTEC have you got in beauty?’ You just trust that they are going to do a good job...so the nicer looking the salon looks, I guess the more faith you have in them, which is kind of wrong.” (Female, 25-40, ABC1, London)

“I just rang them up and asked them if they did it and went down for a consultation and I think there were nurses in nurses’ uniforms and the consultants were all quite smartly dressed. I know that shouldn’t really make a difference, but it felt like a hospital. So I just thought they maybe seemed to know what they were doing more.” (Female, C1, Older family, Had Surgical Int., Leeds)

“They’re so trained to sell.but the person I spoke to, he was just so lovely and so nice and I did feel like I could trust him – if I went through with it.” (Female, C1, Pre-family, Considered Non-surgical Int., West London)

“I’d like to know how long they’ve been doing the job for, if they could name-drop anybody that they’ve treated, I know not maybe ordinary people, but maybe they could say ‘I did a celebrity’ or ‘I did so and so.’ It would give me confidence because I’d try and associate what they looked like before and then afterwards”. (Female, D, Young family, Considered Surgical Int., Nottingham)

“We expect that the private providers are going to be better for some reason. The aftercare and the level of care before and after are probably going to be a little bit more involved because that’s what you get with private healthcare.” (Female, B, Pre-family, Considered Surgical Int., West London)

There is therefore a need for the general public to be able to assess who is qualified and competent, a clear way to decode standards that can be used to facilitate informed choice.

Case Study 3

- Female, 41, junior manager, has teenage children
- She has had laser eye surgery and 'Botox', as well as consultations for laser hair removal and teeth whitening and admits that she wants to combat the ageing process.
- She had seen laser eye surgery advertised on tv and also knew friends who had had it done and recommended it. She researched it on the internet, including going onto chat rooms where it was being discussed. After looking into some opticians, she decided in the end to go for a private eye hospital because she felt safer in a clinical environment. However, she had mainly seen sales rather than clinical personnel who had told her something about being part of an organisation '*with logos at the bottom that made it look as though it was all official*'. She did not ask about qualifications. She was satisfied with the procedure, outcome and follow up.
- She was motivated to try 'Botox' because she was fed up with her wrinkles but admitted that another influence on her decision was the fact that a lot of her friends had had the procedure – it therefore felt that '*everyone is getting it done these days*'.
- Although she read about it at her local beauty salon, again she decided to go to a private clinic for this treatment.
- She was very disappointed with the outcome – it took a week to make a difference and it was uneven so she went back and had more done. This caused her eyelids to be pushed down, making her look angry until it wore off.
- The clinic she went to then suggested that she should have dermal fillers. Despite her dissatisfaction, she is considering going back to the same clinic for more treatment with 'Botox' because the practitioner knows her, and she believes she is 'very experienced', although she knows nothing of her qualifications.

8 Attitudes towards Regulation and Quality Standards for Devices and Settings

8.1 Introduction

In this section we report on attitudes towards the adequacy of existing regulations for devices and settings.

8.2 Attitudes towards regulation of devices

Not surprisingly, participants did not feel in a position to assess the quality of devices or products used, relying instead on assessing the practitioner/organisation and then trusting that they are doing the right thing and using the right materials.

Once informed about current regulations, this was an area where there was genuine shock at the lack of safeguarding around certain cosmetic procedures and a consistent and urgent call for more regulation; it was assumed that the level of control is much higher than is in fact currently the case.

*“That is not specific, that is not tailored enough, that’s not medical at all.”
(Female, 25-40, ABC1, London)*

Across the audiences, key areas were consistently highlighted where the current regulations were felt to be inadequate. Firstly, it was felt to be unacceptable that **dermal fillers** are not necessarily regulated as medical devices, and are not regulated in the same way as 'Botox'. There was unanimity among participants that dermal fillers should be regulated as a prescription item and should have to meet the safety requirements that would involve.

“The dermal fillers, I would say, need more regulation, because I’d expect anything that’s being injected into my skin to be prescription only. I wouldn’t want to use anything that wasn’t.” (Female, 18-25, C2D, Manchester)

“They need to be trialled and documented and, well, they must be alright, it’s been going now for years, hasn’t it? People have it done all the time, but I don’t know why there’s no regulations for it and why it’s not got a quality care logo attached to it.” (Female, C1, Older Family, Had Surgical Int., Leeds)

“Dermal fillers, I think there needs to be more safety in that, they are not regulated at all. It is still going into your body.” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

Similarly, it was also thought to be unacceptable that **chemical peels** fall outside the regulations for cosmetic products/procedures, and there was consensus that they too should be subject to more stringent control.

“I would want some more than the very loose regulation that is Health and Safety at Work or COSHH for something that’s designed to take off a layer of skin.” (Male, 40-55, ABC1C2, Waltham Abbey)

It was felt that the equipment used for **liposuction**, and indeed in any equivalent procedure, should definitely be regulated as a medical device, especially given the invasive nature of the procedure.

“Excuse me, how can liposuction not be classed as a medical purpose? They are invading your skin and going into your body. That is mad. If it is used in a cosmetic procedure, why wouldn’t it be, what else would it be used for then? I had no idea! It shocks me.” (Female, C1, Post-family, Considered Non-Surgical Int., Nottingham)

More broadly, participants considered there should be a tighter system than the current **CE marking** process and that the system in place should ensure review and monitoring, not just one-off approval.

It was also felt to be inadequate that any aspect should fall just under the Health and Safety at Work Act rather than regulation that is specific to cosmetic intervention/medicine. It was felt that the Act was not designed specifically for a serious medical situation which was the level of regulation that should be in place.

“When you go back to the risks of it, and you think how risky some of the things are, what does that mean, ‘Health and Safety at Work’?” (Female, 40-55, ABC1, St Albans)

“The chemical peel, the laser hair removal, dermal fillers, anything like that, the ones where it says they’ll be covered by the general Health and Safety at Work regulations. Seriously?” (Female, 25-40, ABC1, London)

“I can’t believe liposuction isn’t regulated further. If it’s like under the Health and Safety at Work Act, what does that mean? How strong is that?” (Female, 18-25, C2D, Manchester)

The lack of regulation increases the perception of the risks involved as it had been assumed that there was more patient safeguarding in place.

“Because initially, I thought it was on the lower end because I assumed that somebody was regulating it but when you hear there’s no regulation at all then you think, ‘well actually, maybe things need to be stepped up a little bit’. It’s not as risk free as we initially thought.” (Female, 18-25, ABC1, St Albans)

8.2.1 Response to a National Register for implants

It was felt by the majority to be a good idea to set up a **National Register** for implants. There was widespread awareness of the PIP scandal among the general public due to the extensive media coverage both at the time and since, and it was felt to be vital that any similar problem is prevented from happening again. Interestingly, it had influenced the views of some, resulting in a more cautious approach to the sector than would previously have been the case, although, as discussed earlier, the tide of interest in breast enlargement among young women did not seem to have been affected. The PIP scandal had also raised awareness that there may be different components used in cosmetic interventions, although this would seem to have not yet transferred to awareness that dermal fillers may be made of different substances.

“Definitely. That’s a really good idea, I’d definitely want someone to contact me if something had gone wrong with my breast implant. Yes, rather than it being some kind of panic over it, I’d prefer someone to ring me and say, ‘not too sure but could you come in?’” (Female, C1, Pre-Family, Had Surgical Int., Manchester)

The PIP scandal has also raised awareness that implants do not last forever; many participants were able to quote 10 years as the typical lifespan but there were also longer estimates of 15-25 years given, including an expectation of a 20 year life span by a patient who had had a breast enlargement. However, for most this did not seem to then filter through to an appreciation of the long term cost implications of having to have breast enlargement redone, which therefore need to be spelt out. This may not be that surprising, as even a patient in her 20’s who had clearly been fully informed regarding 10 year replacement, was postponing thinking about the costs involved two years later, and not thinking beyond the next replacement. Indeed, none of the patients with breast implants included in this study had plans for meeting the costs of replacement. However, if this is thought through, and young women do realise that they may therefore be facing, and having to find the funds for, five or six replacement operations, it may be a deterrent from considering breast enlargement at a young age. It is therefore important that prospective patients are made aware of this as a consideration; at present it appears not to be a factor in decision making in a procedure becoming increasingly popular and considered by young women.

“I’m definitely going to have to replace them. I guess by 10 years you would have got used to them as well so it’s not like you could just go back to not having

them. I was saying that I would set up a savings account for them and have to get prepared for that but I haven't started thinking about it yet. Probably when it gets closer to the time, I'll start panicking about what I'll do but I haven't thought about it just yet." (Female, C1, Pre-Family, Had Surgical Int., Manchester)

"I probably wouldn't, if I knew that, I mean, I've never considered a breast enlargement anyway, but if I knew that, I probably wouldn't bother, because it's a lot if it's only going to last for 10 years." (Female, 18-25, C2D, Manchester)

While supportive of the idea of a National Register, it also prompted questions about data protection and anonymity and the majority believed that women should have the right to opt out of being on the register if they wish. However, it was felt reasonable that there should be consequences for making such a choice, with suggestions that if patients elected not to be on the register, they should be advised of the risks and have to sign a 'disclaimer' that they will not expect to be covered in the future/will not call upon the NHS in the future if there are problems with their implants.

It was anticipated that the register would be held either by the NHS or by an overarching regulatory body if one were to be set up. Some suggested that it could also be used to monitor practitioners, for example, by checking whether there were any patterns in the recall of patients that related to specific practitioners.

Conversely, the balance of opinion was that there did not need to be a register for those having injectable interventions. Given that these are not permanent and are a 'regular' but short-term treatment, it was not felt to be worth setting up a register for a substance that would be gone in a few months time. However, it was felt that the processes should be put in place to ensure adequate record keeping by practitioners so that patients for injectables, and indeed for any other procedure, would be readily traceable should the need arise.

Case Study 4

- Female, 30, married, two young children
- Decided to have breast enlargement after having her children with the aim of regaining her pre-baby size and shape. Her motivations were to boost her confidence and to recapture how she used to feel about her body – she felt it was *'not her body any more'*.
- Had PIP implants inserted in 2011 by a major provider, having looked into other large providers as well (*'seemed like the top companies to use'*) via research on the internet but also recommendation from a friend who also had had a breast enlargement. The chosen provider gave a referral incentive – £250 to her friend and £100 to her.
- Having chosen this provider on the basis of the price and the process, she had not felt under pressure and thought they checked she wanted the procedure for the right reasons. She was reassured by the large company name, professional look and feel to their offices, the

professionalism of the people, and the surgeon whom she met a week beforehand. *“They go into a lot of detail on why you want it done and psychological factors and everything to make sure you should be doing it.”*

- The procedure went smoothly and she was satisfied with the process and outcome.
- When she heard about the problems with the PIP implants, she contacted the provider although she felt they should have contacted her. They said they would replace the implants if they ruptured and she was advised to have a scan (£300) to see if the implants were intact. She left it but is trying to have the scan done by the NHS. She had thought replacement would be free from the provider but now understands that it will cost £2500. Her GP did not know what to suggest but she assumes that she is okay based on what she has read/heard on the news. She now realises that although she had done some research, she had focused on the setting and the people, rather than the implants.
- She had understood that she had a 10 year guarantee for the implants which doesn't now seem to apply. *“I'm sure there was something like that, like a 10 year guarantee on the implants I had put in. I can't remember it all exactly, I've got a big file of all the paperwork I got sent home with and there was quite a lot and there was some sort of guarantee in it, so it did make you feel like if anything came along, you would be covered. I don't know how they've managed to worm their way out of it but I'm pretty sure these PIPs aren't included on it.”*
- She has no plans/savings to cover replacement and now feels let down by the provider – *“I felt a bit betrayed really because they're such a high up company and it seems to me like companies that had used these PIPs were doing it just to cut costs and I didn't ever expect a company like that to do something like that.”*
- Her experience has changed her outlook - *“it has made me realise that there are things that can happen afterwards and that can be a risk”.*

8.3 Attitudes towards the regulation of organisations

It was felt that the regulations governing organisations should ensure patient safety as appropriate to, and taking account of, the nature of the procedures being conducted. It was therefore assumed that surgical procedures would be carried out in a surgical setting that is regulated in the same way as any other surgical environment. For non-surgical procedures, the belief was that the rules and regulations should be in place to ensure that the necessary requirements for patient safety are met.

For both surgical and non-surgical procedures, as noted earlier, the organisation/premises can be used as an indicator of quality/point of reassurance, and some patients clearly felt that their safety was assured by having chosen a clinical setting for a non-surgical procedure. It is also assumed by some that there is some specialist monitoring of settings that takes place.

There was considerable surprise when participants were shown details of current regulation as they would have assumed more stringent regulation to be in place. In

general, as for devices, it was not felt to be adequate that settings are covered by the Health and Safety at Work Act alone, nor was Local Authority regulation found reassuring, as this was associated more with retail and food premises.

“There’s no single scheme for regulating clinics offering cosmetic procedures and it comes under the local authority licensing. In my mind, local authority licensing, I’m thinking more about shops and that sort of thing and not clinics... They’re not going to have people who understand what the equipment is, it needs to be above that. Staggered levels, it needs to go much more in depth.” (Female, 18-25, ABC1, St Albans)

The lack of regulation led some to conclude that the risks are, in fact, far greater than they had previously envisaged.

9 Attitudes towards Safeguarding the Process of Undergoing a Cosmetic Intervention

9.1 Introduction

In this section we report on attitudes to information provision and consent, and responsibility for follow-up and aftercare.

9.2 Information provision and informed consent

In terms of expectations of the consultation process, the ideal was felt to be some kind of standardisation of both information provision and procedure. This would comprise guidelines for the practitioner on the process that should be gone through, and a checklist for the prospective patient showing what should happen, the areas to be covered, and the information they should be given in the consultation.

The expectation was that the consultation process will incorporate thorough coverage of the potential risks involved as well as the benefits, the potential outcomes, and management of the experience, not just in terms of the process conducted but for example, in terms of pain and recovery times. In providing this information, the point was made that the practitioner should not assume that the patient is informed. In particular, it was felt that realistic management of expectations of the outcomes of the procedure, including how long it will last, should be part of the consultation for all cosmetic interventions, as should specific coverage of what would happen if something goes wrong.

Some also suggested that for surgical procedures, there should be some facility to access previous patients, in order to speak to them and find out their experience with that practitioner.

It was expected to be the norm that the practitioner would obtain written consent from the patient that they are happy for the procedure to go ahead. It was also suggested that there should be some kind of written declaration that the necessary process and information provision had been complied with by the practitioner.

Participants were asked their views on a **two stage consent process** and there was widespread support for this for surgical procedures, as these were recognised as

permanent, major, serious procedures that require a real opportunity for the patient to reflect before committing themselves. It was felt by most that a two week 'cooling off' period would be an adequate minimum period. It should also be noted that the two stage consent process was, on occasion, brought up spontaneously.

Two stage consent was also felt to be a good idea for surgical procedures because of the significant financial investment involved. It was recognised that this had implications for the complete consent process however, because if there is a 'cooling off' period, the prospective patient would not want front loaded charging that effectively commits them before the final point of consent.

"I think there should be a 'cooling off' period, just in case, because I could imagine that they go in somewhere and they tell you, 'it's brilliant, it's wonderful, we're going to make you look perfect, here's the before and after', you tick and... And I think probably people are just like, a bit overexcited and they may be a little bit intimidated into like signing something." (Female, 40-55, ABC1, St Albans)

"It gives you time to think about the procedure, what's involved, any side effects, before you actually go through with it and then think, 'Oh, I actually don't want to do that.' So it gives you time to think about it." (Female, D, Young family, Considered Surgical Int., Nottingham)

"I think that's important. I think you sign it to make sure you want to do it and then you just need to confirm that you definitely want to do it. I just think the more time you have to consider it, the more sure you'll be about it, so yes, I think that's good." (Female, 14-15, C2D, St Albans)

However, views were much more mixed regarding the idea of a two stage consent process for non-surgical procedures, with a consensus that this is unnecessary at the lower risk end of the spectrum. There was more debate regarding injectables and chemical peels but on balance, it was felt that a properly tailored one stage consent process is adequate. However, some had found the gap between their initial consultation and having the procedure carried out useful, and others had felt rushed by the immediacy with which treatment was progressed.

"I had the consultation initially and talked it through, obviously made an appointment for whenever but I had that 'cooling off' period if I wanted, you know. And I got some literature from there as well, so I felt that if I'd wanted to change my mind – I didn't feel pressurised in anyway at all." (Female, C1, Older family, Had Non-surgical Int., Leeds)

"Like the 'Botox', I don't think there was any chance for a cooling off period. It was literally, 'right, we'll book you in next Tuesday then' or 'do you want to come tomorrow?' I think she said, and I was like, 'Oh, I don't know!' Yeah, I think

certainly, for that type of thing, it definitely needs a 'cooling off' period.” (Female, C1, Older family, Had Surgical Int., Leeds)

Interestingly however, patients for injectables were not always in favour of two stage consent for these cosmetic procedures as they felt it would be less convenient and would delay access.

9.3 Assessment and counselling

In terms of the need for assessment and counselling, the broad consensus of opinion was that there was a need for clear guidance regarding good practice rather than this being a matter of regulation. It was felt to be important that those considering surgical procedures were offered counselling and that guidelines regarding patient safeguarding ensure that patients are fully informed and that their motivations are examined before they give their consent. However, it was felt that even for surgical procedures, there are likely to be many instances where full psychological assessment/formal counselling is unnecessary.

Moreover, the perception was that for the majority of non-surgical cosmetic procedures, full psychological assessment/counselling are unnecessary, and that they are definitely inappropriate at the low risk end of the spectrum e.g. counselling for teeth whitening.

For mid-risk treatments such as injectables and chemical peels, there was more debate (although it should be noted that users tended to be against the need for counselling) but the majority felt that the need was to ensure that those at risk are identified and offered appropriate help. A key influence upon opinions was the fact that these procedures are temporary in effect, which mitigates the perceived need for formal counselling – proper advice, however, was felt to be vital.

There was however recognition among participants that there are prospective patients who are vulnerable and that this can be for a wide range of reasons, such as having unrealistic expectations, hoping the procedure will be the answer to more fundamental problems, having mental health/psychological problems, being impressionable or gullible, or very young, and those 'addicted' to cosmetic change. It was felt to be vital that there is safeguarding in place that enables the vulnerable to be identified at an early stage and counselled/assessed accordingly, and that there should be definite requirements or guidelines that ensure this e.g. via thresholds for the number of

procedures undertaken, an age limit below which counselling and assessment is mandatory. Another suggestion made was that links to GP records should be used to identify any prospective patients with a history of psychological problems.

“I think maybe with certain things you should maybe see, like a therapist beforehand or something to make sure you’re ready for it, like 16, 18 year old girls wanting to get boob enlargements, it’s ridiculous.” (Female, 18-25, C2D, Manchester)

Case Study 5

- Female, 40s, single, children have left home
- Talks of having lost a lot of weight and admits she has food issues. She also described herself as having no self confidence any more and her hope that having ‘Botox’ will be the answer to wider problems.
- Used word of mouth recommendation from a family member to have ‘Botox’ at home from a mobile practitioner as this cost less than going to a beauty salon. Her relative has used this person for ‘Botox’ since she was in her early 20s (the respondent says that she has now had too much done and her face is starting to drop).
- Her aim is to fill out the lines on her face but is now wondering if dermal fillers might be better. *“I thought it would fill out the lines but it doesn’t, it just paralyses it, like I can feel it all paralysed up here.”*
- She says that she was unhappy with the experience – there was no consultation, the practitioner was in and out of her house quickly and left her with her face bleeding the first time. Although she was concerned that the practitioner did not ask her any questions, she went ahead anyway because the woman had come out to her home and the participant did not want to waste her time. She then asked the practitioner to come back three times in as many weeks to inject more, as she was unhappy with the results, ignoring advice from friends.
- She is now trying to raise funds by giving up smoking to be able to keep up the ‘Botox’ treatments and is confused about what the future commitment will be. *“Cheap is not always the best route to go down... she’s coming in, sticking injections in your face... I don’t know, it’s not very professional.”*
- Despite her ambivalence about the practitioner, she is considering being a ‘guinea pig’ for her to try out new treatments.

9.4 Follow-up and aftercare

It was widely anticipated that there are no guidelines in place at present for the follow-up and aftercare given for each procedure, a view that was supported by the experience of several patients. For example, a woman described the impressive aftercare she had received following laser eye surgery in a private clinic where she was given three follow-up appointments; the first, two days later for antibiotic drops, then after 4-5 days, then 3 weeks later, and furthermore, she was given the Consultant’s mobile number in case of

problems. She compared this to an opticians where she had enquired about the procedure where the follow-up was described as 'popping back in two weeks to see how it is going'. Similarly, a patient who had a breast enlargement had been given two follow-up appointments and the option to go back any time in the first year if she had any concerns; she found this reassuring compared to the follow-up provided to a friend who had the same procedure, but with a different practitioner/organisation.

The view was often expressed that there should be guidelines for levels of follow-up and aftercare tailored to different procedures.

9.5 Responsibility when things go wrong

There was consensus that, in the first instance, responsibility should lie first and foremost with the practitioner/organisation that has conducted the procedure, who, it was felt should follow up surgical/injectable/peel patients routinely, address any problems or put right anything that has gone wrong, and be responsible for finding a suitable replacement if the original practitioner is not available. It was, however, expected that the nature and extent of follow-up required will differ depending upon the severity of the procedure.

It was also proposed that systems should be put in place to track and record where things have gone wrong, in order to identify practitioners with recurrent problems and warn those who may consider using those practitioners. Additionally, it was proposed that there should be processes that ensure that the patient is fully informed about the particular implant or filler that is going into their body, to avoid uncertainty should, for example, problems be reported.

Some believed that the patient also has a responsibility to make an informed decision, to have realistic expectations, and to make sure there is adequate aftercare in place. It was felt that the prospective patient should take responsibility not to choose clearly 'back street' settings and practitioners, and also to accept work that is competently done. However, in order for them to do that, there needs to be put in place a framework that enables the prospective patient to find and understand the information they need.

The view of the vast majority is that morally, the NHS should not be responsible for putting right procedures carried out privately. The majority believed that the NHS should

not have had to pick up the pieces in the aftermath of the PIP scandal, although it was recognised that ultimately, in the situation where all else has failed, it will be the NHS that does so. Some therefore suggested that the NHS should have some way of claiming back the costs incurred either from the original practitioner/organisation, or from their insurer. Some queried why the PIP implants were not replaced under the practitioner's insurance.

"I think the private companies should pay. I don't think the NHS should have paid for it because if they were having it for cosmetic reasons then I just don't think it's the fault of the NHS." (Female, D, Young family, Considered Surgical Int., Nottingham)

"It shouldn't be the NHS because the NHS is struggling as it is. The private clinics make a lot of money from what they do, so they need to be held responsible if something goes wrong. It's the same as if you've had your house built, if it fell down, who would you go back to – the people who built it." (Female, C1, Post-family, Considered Non-surgical Int., Nottingham)

"I don't think it's the NHS's duty to repair something that a private hospital has done or you've decided to go privately and now it's gone wrong and you're not happy with it, I think if you've signed to pay that money and go privately, then you have to be prepared that if something goes wrong, that it's your responsibility." (Female, C1, Pre-family, Had Surgical Int., Manchester)

9.6 Seeking redress

Overall, currently there seems to be nowhere to go in the event of a problem with a cosmetic intervention, a situation which, it was felt, should definitely be addressed. Both patients and members of the public highlighted that they would not know where to go or who to approach and this was seen as a gap in the current framework. Most thought that they would go back to the practitioner or organisation who had conducted the original procedure and then, if not satisfied, would take their complaint to an 'official body' or the practitioner's/company's 'governing body'; however, they did not know who this would be. Some thought they might go to their GP for advice. The need was identified for some form of regulatory body/ombudsman to monitor problems and offer recourse; there is an expectation that there would or should be someone to turn to that will offer support, and that there should be a formal structure in place to enable the patient to gain redress in the event of something going wrong.

"Well, if you'd had your boobs lifted and it went all horribly wrong, who would you go to? Would you go to... I'd go to the doctors. But would the doctor wash his hands and say, 'well you had it done privately, go and sort it out with them'?" (Female, C1, Older family, Had Surgical Int., Leeds)

“You'd probably start off by complaining to the place where you had it done and then I think if you didn't get anywhere, you'd complain to their governing body. If that doesn't work, then I wouldn't know what to do, I wouldn't have a clue. I'd be stuck; I wouldn't know where to go next.” (Female, C1, Pre-family, Had Surgical Int., West London)

“You'd initially go to the place you'd had it done, wouldn't you? Then I would ring somebody like Consumers Direct I think. I'm not sure what I would do. Or maybe contact Trading Standards.” (Female, C1, Post-family, Considered Non-surgical Int., Nottingham)

Some examples were given during the course of the study of people experiencing problems and being left without support, who were unable to deal with a disinterested practitioner. The opinion was consistently voiced that there should be some point of arbitration and support for those needing it.

9.7 Insurance and indemnity cover

It was assumed that the organisation/practitioner would have insurance to cover them in the event of problems like PIP; if not already a requirement, it was felt this should definitely become one.

Participants also believed that there should be some back-up to protect the patient in the event of the organisation/practitioner no longer being in business. The idea of an ABTA type of scheme was sometimes brought up spontaneously and if not, participants were asked about it. There was universal support for such an initiative with most envisaging that membership of the scheme, recognised by a symbol or accreditation of some kind, could also become a criterion for selection.

The suggestion was also made that the patient should have the option to insure themselves, but this was not seen as a replacement for practitioner/organisation insurance and responsibility. Rather, it was felt to be further back-up for the patient.

However, it was envisaged that there will be circumstances when the patient may not want to go back to the same practitioner, for example if they are unhappy with the standard of work conducted and it was felt important that there should be some choice of how to redress the problem in this situation, for example, the patient should have the option to go elsewhere without having to pay again. Participants felt that an overarching regulatory body or membership organisation could have a role to play here in directing the patient to an alternative practitioner.

10 Practitioners

10.1 Introduction

Ten practitioners were interviewed; two surgeons, one General Practitioner, two nurses, two dental surgeons and three beauty therapists. While some of the clinical practitioners conducted surgical procedures, in these interviews, the focus was very much on non-surgical interventions and cosmetic injectables in particular. The next section (10.2) gives a picture of the marketplace and their practice as perceived by the practitioners; 10.3 considers their perceptions of the state of regulation in the market, and 10.4 sets out their priorities for future regulation.

10.2 Current market for non-surgical interventions

10.2.1 Perceived market

It was widely recognised that the market for cosmetic interventions is one that is increasing in size with procedures becoming more accessible, accepted and common in recent years. The springing up of clinics and salons has resulted in greater competition and the driving down of prices for certain procedures.

There was broad agreement about the composition of the market for non-surgical interventions; mainly women aged from their mid-20s through to their 60s, with most aged in the 40-50 range. Men were seen as an increasingly important part of the market.

“Guys definitely come in. Their wives drag them in...”

For what?

... Again, a range of things, ‘Botox’. A lot of men before would never think about coming in for ‘Botox’. We get a lot of younger males that come in regularly for ‘Botox’, laser hair removal, a lot of guys are conscious... It’s getting popular, as people know a little bit more about it now, whereas before, a lot of people didn’t know what was on offer for them.” (Beauty therapist)

While some people looked to cosmetic interventions to alleviate physical conditions (e.g. dermal fillers to help with the symptoms of teeth grinding, ‘Botox’ for excessive sweating, laser hair removal to help with the symptoms associated with polycystic ovary syndrome), the key motivation for many clients was tackling the signs of ageing. In the case of younger clients, the motivation might be to ‘prevent’ or delay those signs.

“If you are 18 or 20 or mid 20’s, it’s not a case of your not needing it, because it can be a preventative... Because if you think about it, when we hit the age of 25, that’s when your skin starts to age. And that’s when we need to address it, pretty much. So that’s why we get a lot of the younger ones. Some of them, yes, they don’t need it, and they want it anyway, but the majority of them come in as a preventative.” (Beauty therapist)

“There is surprisingly more and more men doing it, younger men and I believe, that there are more younger coming through that don’t want to develop the wrinkles, they want to stop it earlier on. I’ve seen people trying to persuade them to go earlier, saying this is the way forward, you need to start it earlier so you don’t develop the wrinkles.” (Nurse)

The decision to go ahead with a procedure could be triggered by certain life events such as a divorce, the search for a new job, a wedding. A divorce settlement might provide the means as well as the motivation to spend money on oneself undergoing a procedure that addresses a long disliked feature or which ‘refreshes’ one’s appearance. The outcome, all agreed, is the same - enhancement of one’s confidence.

“I’ve had a couple of ladies say, for instance they’re going for a promotion at work and they want to be their most confident and look their best for it, but mainly, they’re just noticing signs of ageing or something’s really getting them down. For instance, one lady, when she speaks to people, she covers her mouth because she hates the lines she gets round her mouth. So it’s a physical effect but it affects them psychologically.” (Doctor)

“I’ve had a few patients say, ‘do you know what, I’ve got to look good’. They want their teeth straightened, they want them whitened, they want to look younger, because every year they are competing with the younger person, the younger girl or the younger male, you know the alpha male coming through and they say, ‘do you know what, we want to look good as well’. Purely because I think you are competing, it’s a dog eat dog world and people, if they have got a great job, they don’t want to be taken over by somebody younger.” (Dentist)

“They generally come because they might have a feature that they don’t like or they just want to look more fresh, they don’t even often tell their partners that they want it doing, so it’s something they come and have done just to make themselves feel good.” (Dentist)

“I think it’s feeling better. I think it’s treating themselves to something and making them feel more confident, wherever they are going on their next step [after a divorce]. It’s making them feel a bit better about themselves because they don’t want other people to know that they are using it, they just want to feel like they have moved on a bit, I think.” (Nurse)

While procedures such as dermal fillers and ‘Botox’ were mostly offered individually, several practitioners commented on the move towards more combination treatments, such as ‘Botox’ plus dermal fillers and laser treatment for fine wrinkles, or laser skin resurfacing used in conjunction with chemical peels. One of the dentists spoke of

offering ‘the full face approach’, including both teeth and skin to make the patient look younger.

“I actually do ‘Botox’ and whitening together sometimes because you get a full face approach. I like the way that dentists can offer it because you can look at the face as a whole.” (Dentist)

It was suggested that the trend towards intervening at a younger age was driven by celebrity culture and a desire to have the ‘image and body of a model’. Several practitioners commented on the influence of reality TV programmes making patients request interventions with more ‘extreme’ and unnatural results; practitioners sometimes also spoke of trying to discourage them.

“The ‘Botox’ seems to be the youngsters. Anybody who watches ‘TOWIE’ or whatever, those kind of programmes or ‘Chelsea’, ‘Made in Chelsea’, they want to look frozen, they want to look like, ‘I don’t want no lines or wrinkles, prevention is better than cure’.” (Dentist)

“I have been doing chemical peels for over ten years actually, so when I first started doing chemical peels using glycolic acid and I have another blend which is salicylic and glycolic which is stronger again. When I first started doing them 10 years ago people wouldn’t have them done. You weren’t even allowed to use the word ‘acid’ and you used to have to explain that they weren’t as harsh as they sounded, but now people come to us going, ‘I want it to burn. I want to have aggressive treatment. I need to have that done’. And I’m now having to turn them away, and explain and try and discourage people from having ... and explain the risks of having too much.” (Beauty therapist)

“I saw a girl at the age of 24, she came and asked for an injection for ‘Botox’, ‘for fine lines on my forehead’ and I told her, ‘you’re quite young at the moment, I’m not going to give you any ‘Botox’ or anything. You have to wait at least for 3 or 4 years’.” (Surgeon)

A small number of practitioners reported being approached to administer injectable procedures in settings such as salons and hairdressers and one had been asked to do this at a ‘Botox’ party.

“I’ve been asked to do them and I’ve said I would do it but ‘it’s not going to be sat there drinking champagne, I’m going to be sat there for at least half an hour going through paperwork’ and they went, ‘oh no, we don’t want that, because it’s not fun, is it?’ I said, ‘I won’t inject anyone who’s been drinking’, so they don’t want to do it.” (Doctor)

10.2.2 Reaching the Market

Various channels and mechanisms were used by the practitioners to gain new clients, the principal one being word of mouth and referrals from existing clients. While some

felt that they did not need to market themselves as there was a steady flow of clients driven by the media promotion of cosmetic procedures, others were more active. A range of methods were used with the most extensive employed by the larger companies. One of the dentists commented on the increase in number of dentists offering 'Botox', some of whom (not himself) advertise a mobile service by advertising on their cars.

Channels and methods used by the practitioners who were interviewed included:

- Networking, corporate membership
- Websites (in one case with a YouTube feed about 'Botox', a blog and testimonials)
- Printed materials ranging from small leaflets through to glossy brochures
- Advertising (more limited and often with a local focus)
- Information evenings, wedding fairs.

Several practitioners used incentives to encourage clients to buy procedures, most commonly discounts for a course of treatments, introductory discounts or for referrals. Although a few practitioners had experience of promoting themselves via a third party discount provider and similar companies, most were scornful of such offers, feeling that they damaged the industry and were associated with more dubious practitioners who needed to market themselves aggressively. One of the dentists commented that the GDC had advised against using such companies because clients are meant to have an examination and consultation before being advised about treatment. The experience of the doctor who had used the tactic when starting up was that the companies running the offers would manipulate the copy to make them more attractive but also inaccurate. Commercially, more generally, they were not deemed to be worthwhile because while the tactic might bring new clients in, they were not the sort who remained with them and upgraded to other treatments.

"I personally don't think they should be allowed on there, now that I've done it and experienced it, I don't think it's appropriate to be on that. The companies that you deal with, they don't care about giving a good service [to the end client] and so I don't think the client gets a good service from them. They do sensationalise it, they want to put it all in their own words, I had to change their

copy all the time because it wasn't appropriate what they were putting, it wasn't accurate. And they're time pressured, I only want people who really want it doing rather than, 'it's 50% off and I've got to get it now before it runs out'. It's not the type of person that you want to have the treatment really.” (Doctor)

“It spoils my business because I have people coming in saying, ‘you can get it down the road from [name of third party discount provider] for £10’. And I’ll go, ‘get yourself away then’, because I’m not going to go into that. It causes a price war and I use good products, I pay proper wages and I have got a business to run and I have got overheads and you could not do the treatments properly for the price that they advertise.” (Beauty therapist)

Practitioners were mixed in their views on providing financial help to clients who could not pay in a single payment. A few liked the fact that it has made cosmetic interventions accessible for everyone (especially if at 0% interest) while others were more critical. One commented that they disliked seeing providers profiting from financial arrangements.

What seems to impress the client

Practitioners are very aware that their clients are particularly impressed by certain features that have little to do with competence. The appearance of ‘Harley Street’ in an address or training provider’s name was felt to carry cachet and similarly, the location and quality of the premises would figure highly in client decision making.

“Harley Street, I did my training at ‘Harley Street’, they’re based in Swindon (the company she trained with), I did it because it’s on the certificate and everyone goes, ‘ooh’. And I know it means nothing at all but I look at that and I think, ‘I bet they’re probably a decent outfit’ but they may not be, they could be fly by nights who rent a room and disappear.” (Doctor)

It was felt that many patients preferred to be treated by a medically trained practitioner for the competence this conferred but they may have little idea of what training the practitioner has had.

“A lot of people don't realise I'm a qualified doctor for instance, until they meet me or they want to know what training I've had and they might be put at ease then if you explain certain things to them.” (Doctor)

“People have peace of mind that this person has gone through a rigorous training. It should reassure people, but most of them don't know what it means.” (Surgeon)

However, several commented that they suspected that clients often assume anyone offering a cosmetic procedure must be qualified to do so and that the use of certain

titles might make more of an impression than letters after the name since these are meaningless to most people.

“I’ve asked patients what do they consider to be the optimum person to give them their treatment, does it matter to them that we’re nurses or doctors? No never. They said ‘no, no as long as you know what to do, we don’t mind’. I imagine there is a spectrum that I would never see that would go straight to the consultant and you know not want anybody else, but there is a big population in London of women in their forties who have got some disposable income and will probably want a slightly, not pay the big overheads, or just want it done well. So titles, because they don’t even think of the treatment, I don’t even think of the title, I think it doesn’t matter, you could say ‘Botox giver’ and that’s probably even better because they’d know what they’re getting. You know I don’t think it matters to a big population...”

So is the assumption then if someone is offering it they must know what they are doing?

... Yes, yes...

And do you think that would be the case in a beauty salon in which it’s offered, would that be the same, do you think?

... Yeah, if they came up on page 1 or 2 of Google, I think that would be fine”.
(Nurse)

Titles such as Cosmetic Practitioner and Aesthetic Practitioner which may be used if someone has had some training were felt to be potentially misleading because patients may assume that the competence of such practitioners is greater than it is.

*“I don’t want to take it away from them, if they’ve done their training, they may be very good at it and at the moment they can call themselves, at the moment, an ‘aesthetic practitioner’, be they a plumber or a taxi driver, but I personally, I think the public aren’t aware that anyone can do it and there’s no regulation to it.”
(Doctor)*

“I think using such terms is wrong because it misleads the patient because the patient thinks the aesthetic doctor is a fully trained plastic surgeon. I know some people call themselves aesthetic surgeons, but all they have done is a few courses.” (Surgeon)

“I think it makes them look like they’re more qualified, more like, hospital kind of qualified than they are. I do think it probably puts people thinking that, ‘oh well, they must be kind of better than she is, because they call themselves that and she calls herself that’.” (Beauty therapist)

The doctor in the sample chose to use the title ‘Cosmetic Physician’ because she felt that it communicated the fact that she is a qualified doctor who is performing non-surgical procedures. The beauty therapist who was given the title ‘Aesthetic

Practitioner' by the company she worked for, felt that it helped differentiate her from a 'less advanced' beauty therapist and elevated her status with clients.

"We are not nurses, we don't profess to be nurses, but we are more advanced than the normal beauty therapist. We have a little bit more knowledge of the skin and conditions and things like that than a beauty therapist would have.

So within your company, would you have beauty therapists and aesthetic practitioners?

No. We have aesthetic practitioners and then the nurses and doctors.

Do you think it's helpful to patients to have that ...?

Yes, definitely. It sounds a lot better than just 'therapist'. Because I think when you do tell people your job title, they will almost put you on a par with a nurse. Although we don't have the same qualifications as a nurse, I definitely think that people think we are more trustworthy." (Beauty therapist)

Several practitioners chose not to use letters after their name feeling that they are meaningless to clients or (for the beauty therapists in particular), that they might be seen as rather unimpressive.

One nurse's experience of helping patients in the NHS who have had a poor outcome after a private cosmetic procedure suggested that such people often have been given or absorbed very little information about the person treating them.

"Like when we have people coming in with problems, we say, 'who are they? Let us call them, let us talk to them' and they would have their private mobile number but when we looked them up on the GMC, they wouldn't necessarily be anything cosmetic." (Nurse)

10.2.3 Current Practice

Consultation and consent process

The offer of free initial consultations was very much the norm within the sample with some going ahead then and there with non-surgical procedures. A very small number charged a nominal amount for a consultation for certain treatments that could be offset against treatment, largely to ensure that prospective patients kept their appointment; others rejected the practice because they felt that it puts pressure on clients to go ahead so they do not feel they have wasted their money. The length of time for a consultation for injectables was estimated variously as 15 minutes to 'a huge amount of time' (in the latter case, this was the comment of a client who was comparing the

practitioner with other practitioners she had used). In one case, the consultation was provided by a beauty therapist trained in selling the procedures.

There was a widely held view that many clients arrive with a particular procedure in mind; they may have had the procedure before or know someone else in their peer group who has had it, or they may have done some research around it and feel it is right for them. Several practitioners commented that fewer people presented with an issue they wanted to tackle or a feature they disliked and were looking for advice on how to do this. Those clients who knew someone who had had the procedure done successfully would typically be more confident in going ahead with it themselves but these might be the people whose expectations needed careful management because of this point of comparison.

“Again, it depends what stage they’re at when they come to see me. If they’ve got friends who’ve had it done, they’re probably more likely to go for it whereas if they don’t know anyone who’s had it done and they don’t know about it and are very nervous about it... pretty much most people will end up having a treatment because by the time they’ve come and sought me out, they’ve kind of decided really but they have a consultation because I think they want to scope out the person doing it, quite rightly.” (Doctor)

Many practitioners described following protocols for recording information about the client, imparting information about the procedure, the associated risks, providing aftercare instructions; sometimes gaining signatures at each stage. In part, this was because of the threat of litigation which was felt to be real and increasing (and something that several practitioners had experienced).

Several, including the beauty therapists, spoke of taking a detailed medical history at the first consultation (and checking for changes in medication thereafter) in order to identify contraindications to treat. The therapist quoted here specialises in laser hair removal.

“You know, it’s amazing what clients I get in. I get diabetics in who’ve been tret (sic) in other clinics. Now, that is just an absolute no, no go area. You do not treat a diabetic, and they argue with me and go, ‘well, why? I’ve had it done.’ ‘Well, go back there. I’m not going to do you’. You know, I can’t believe some places.” (Beauty Therapist)

Practitioners talked of the range of information they would typically give to patients and the questions that might be asked. They often differentiated between those who thought they knew as much as they needed and who wanted to press on with the procedure and

those who wanted to know as much as they could. Practitioners sometimes expressed frustration at the former patients' lack of interest or willingness to engage with all the information they provided.

“And does anyone ask about, with the 'Botox' and the injectables, the nature of the substance that's going in?”

There's some people that don't, that just want it. You show them the before and after results, and 'I've seen it. My friend has it, and I want it. That's fine'. There's some people that want to know exactly what is being injected. Some people have done their research and again, you do get the person who wants to know exactly how much is going in there, into the face, what the product is, where it's from, when it expires. They want to know everything. But then, you do get the people that trust you, and again we are a reputable company, so we do get people who come in and do just purely trust on the basis of us being a reputable company.”
(Beauty therapist)

“Most people, they don't want to know as much as I tell them. I insist they know everything before they sign the consent and most people don't want to know about it, they just want to sign ... I think for most people it's just about the short term, 'is it going to look, am I going to be swollen, bruised?', that's what they're mainly worried about so I have to pin them down and say, 'you need to know about this, this and this', so it's mainly the short term effects.” (Doctor)

With respect to injectables and other non-surgical interventions such as laser hair removal, it was reported that some clients asked questions about the need to repeat the procedure (and the cost implications of this) because they are aware that they might, for example, wish to have further 'Botox' or they are concerned that they might have to if the effects are very noticeable.

With respect to consent, they talked of encouraging hesitant clients to go away and think about having the procedure. The doctor, for example, felt she provided a version of a two-stage consent process by asking patients on enquiry if they would like to come for a consultation, or consultation and possible treatment; this enables her to allow enough time to carry out whatever is required. Patients then have the option to go away and think about the procedure or have it done then and there.

While the practitioners in our sample were often keen to describe the care they took in ensuring their clients were able to give informed consent, some also commented on evidence they had of poor practice by other practitioners. For example, the beauty therapist who turned away clients with unrealistic expectations about laser hair removal acquired from other salons, or the nurse who told of patients she had seen in her NHS role who had been given inadequate information about their surgical procedure.

“But when we see problems, people always go, ‘I never knew there could be a problem’ and they seem to, one - not ask, and two - not be told. And there is, I don’t know whether there is a professional relationship which should warn you of your risks, but if you don’t know what to ask and that is very surprising, but that is for all cosmetic treatments. People say, ‘oh, I’m surprised I had a scar’ and you’re like, ‘you had a tummy tuck, how do you not have a scar?’ But they still come back and say, ‘I can’t believe I had a scar, why doesn’t it go away?’ But they’ve paid thousands of pounds for this.” (Nurse)

Psychological screening

Practitioners recognised that a small number of people needed to be deterred from having a procedure for psychological reasons, possibly as a result of dysmorphia or some other type of personality disorder or mental health issue. Warning signs might be their having successive procedures (one practitioner compared it to a form of self-harm), unrealistic expectations of the change that could be brought about physically or of the impact on their lives. With clear-cut cases, the decision not to treat was based not only on patient needs but concerns about litigation or other comebacks. They were sometimes aware that such patients would simply then go to a less scrupulous practitioner.

“I think if you’ve got an absolute fruitcake and you’d have to turn them away, I’d rather turn them away than, than treat them... That’s advice from my laser protection adviser. ‘If in doubt, don’t treat.’” (Beauty therapist)

“And then during that consultation, because I feel happy doing consultations as a GP, I would then be alert to people who maybe had a psychological problem and it wasn’t really suitable to be having that, but again there’s no guidance on it, no regulation on it, it’s just down to whether you want to be a conscientious person and I know if I said no to them, it wasn’t appropriate, there’s someone down the road who’ll do it and they’ll sell them another package on top of it.” (Doctor)

While they would not want to treat patients who clearly exhibited abnormal behaviour traits and indeed, on occasion refused to do so, there was little mention of referral for psychological assessment and counselling except by one of the nurses whose training helped her identify people who should not be treated. She would sometimes refer them for psychological assessment although it was their choice whether to take this up. She felt that there was a need for more training in the industry aimed at how you spot and manage such people.

“Sometimes it is very obvious that this is not someone we want to treat, i.e. sometimes you do have these people who just ring round clinic after clinic, they just come for the wrong reasons. Perhaps they are very obsessed with a certain thing, perhaps we don’t think it’s very healthy to treat this person, for all sorts of

motivational reasons. So yes, they probably might filter out those people, but sometimes it's not obvious... I think this is where we fall short a lot in this industry because having been to so many conferences, people talk about this issue, the people that have dysmorphia, the people that have anxiety disorders, people who have just very obsessive personality traits, so you are talking about personality disorders, these people do come into our clinics and you have to spot them, you have to pick them up early on before you get to the point where you are treating them.” (Nurse)

“I understand, well I hope I do, can pick up on people who have body dysmorphia because they will go to many practitioners and they are never happy and they will always blame something else. It is not to do with them, it's always the practitioner and then you shouldn't give it. That's when you, as a practitioner, say, 'actually, I don't think I can help you', and it's not easy because they want you to do it because that's why they've turned up, but you shouldn't do it.” (Nurse)

“I've had a couple of times when people have come because they are obsessed with the way they look, sometimes it's called dysmorphia or they're obsessed with having lots of treatment done.” (Dentist)

Aftercare

The arrangements for follow-up for non-surgical procedures depended on the practitioner and the procedure. They ranged from offering an 'open door' if a client felt something was amiss or if they had any questions, to one or more follow-up appointments which could be cancelled if clients did not feel they needed to be seen again, to follow-up by telephone to check the client is happy.

“It's immediately to contact me if they feel anything's gone wrong so that they know I'm there to follow up and I'm not just going to run off.” (Doctor)

“What we tend to do is, when we do carry out a treatment, whether it be 'Botox' or laser hair removal, chemical peels, we always have a follow-up appointment. It's always a one to two week gap ... You always have a skin assessment. We always take pictures beforehand and then we invite the client in for an assessment. Some feel they don't need it, they can come back as and when they need it. But we always make sure there is an appointment in place.” (Beauty therapist)

“I say come back between five and six days because it takes four or five days for 'Botox' to kick in and then I want to make sure that they don't have a droopy eye or something and that they are happy, or they ring me up and say, 'I'm absolutely fine, I don't want to come back'.” (Nurse)

If a follow-up appointment was offered for injectables, a typical interval seemed to be about two weeks to check that the desired effect had been achieved and in the case of 'Botox', to see if there was a need to 'top up' with any remaining toxin. 'After' photographs showing the results of the procedure may also be taken at this point. The

need for such aftercare was seen as clearly in the patient's interest but also in the practitioner's in ensuring that everything is as it should be and that the patient is satisfied.

The refusal to provide aftercare by some practitioners especially when a problem occurs was often viewed with contempt.

“Actually there are many medical professionals out there who will actually just not return their [patients'] calls, who will not reply to their emails and literally just not respond to them and ignore them and just not treat them, not deal with the problem... I've had too many people come and sit in my clinic and say, 'look I've got this problem, when it went wrong, they didn't want to help me'.” (Nurse)

10.3 Perceptions of current safeguards and regulation

10.3.1 Perceived Risks

A few practitioners expressed concern that the increase in take-up of procedures was associated with a lack of appreciation of the risks by patients and an assumption that the market was regulated. While the public's differentiation between surgical and non-surgical procedures in terms of risk was reflected by some practitioners, others felt that non-surgical carried as much risk of complications as surgical, especially given the lack of regulation. Whereas the inherently more risky cosmetic surgery requires high levels of insurance and qualifications, non-surgical procedures do not.

While injectables are seen as procedures in which greater regulation is needed, other non-invasive procedures are seen in a similar light largely as a result of what can go wrong. Those working in the NHS (but others too) report/have dealt with multiple incidents associated with non-surgical procedures arising from the work of other practitioners.

“People do this because they think that these procedures are completely safe but if something happens, then they don't know how to deal with the complications of procedures and that's why I think they need to regulate this industry properly. I can see burns after laser, I see different things, I see lump and infection after fillers and these are not things that should happen really.” (Surgeon)

These include the following:

- ‘Botox’; drooping eyelid, necrosis if it is injected into a blood supply (an antidote is then needed)
- Dermal fillers; lumps, infection, nose turning blue, disfigurement

“My biggest bug bear is that dermal fillers are not considered, are not under any sort of regulation and these are still injected into the skin and if injected wrong, they can cause a lot of issue.” (Dentist)

“But deep fillers are a very big high risk and they take away a lot of the soft tissue around it and are really disfiguring... It gets into little pussy cavities and then all the skin breaks down and then you just, we have to take them to theatre and wash it out and they just end up with very sunken faces, uneven, lumpy, with scar tissue on the outside because the blood supply is then compromised to the face, or wherever it is and it just becomes this lumpy, hard, scarred mess.” (Nurse)

One of the beauty therapists related an example of when there was an adverse reaction to a filler because the patient had not mentioned the medication she was on; she had to be taken to hospital.

- Chemical peels; the main risk was seen as burns - while deep peels are administered under general anaesthetic, even the superficial and medium are deemed to be potentially high risk if the peel is not correctly matched to the skin type
 - Laser hair removal; again burns of varying severity. One of the beauty therapists specialising in this procedure explained the importance of conducting patch tests before offering treatment, a practice that she understood from clients, was not always followed elsewhere. Similarly taking a medical history including medication was vital; diabetics should not be treated, and people on certain antibiotics and anti-histamines should wait before having treatment as they can burn more easily. If in doubt, she would email her laser protection adviser (a doctor) before treating.
- “I would do an extensive patch test first. If anything, I’d get them back a couple of times to patch test them, because, again, scarring looks far worse than hair. You can get rid of hair. You can’t get rid of scar tissue.” (Beauty therapist)*
- Teeth whitening; burning of the gums, nerve damage, anaphylactic shock

“If you look at these booths, it’s not a dentist doing the whitening, it’s some young kid at the weekend, putting on the gels, putting on the light, job done. What they don’t realise is that when you apply that gel to somebody’s tooth, 101 things can go wrong. First of all you have to assess that person, you have to clinically examine them, if they’ve got a hole, a cavity in their tooth and you put hydrogen peroxide in it, they are going to scream. Potential anaphylactic reactions, burning on the gums, causing the kind of burns that are really, really severe. So you probably think teeth whitening, nothing can go wrong. It can. You can cause nerve damage in the tooth.” (Dentist)

- Microdermabrasion; generally thought to be fairly safe (at least one practitioner thought it did very little), although the nurse practitioner explained that if there is too much abrasion, it can cause bleeding and the scarring that is achieved is not beneficial.

Even where such procedures are conducted by practitioners with medical training, it was felt that they may not know what to do if an adverse event arose, let alone have the necessary ‘antidotes’ to hand. A plastic surgeon described a GP calling him for advice because he had injected fillers into a patient and their nose was now blue – the GP did not have/had not heard of the injections you should give in this circumstance.

10.3.2 Quality of training

There was almost universal criticism of the training that is available for injectables even for clinicians trained in giving injections. The common view was that the training was often inadequate for clinicians and would certainly be so for beauty therapists without medical training.

“I don’t like beauticians doing these kind of treatments, going on a weekend course and learning how to. To me, it’s like they have got no medical background, they have got no training, they learn it for a weekend and right, they are let loose.” (Dentist)

Typically, it seemed to comprise a two day course for 'Botox' and dermal fillers and was regarded as very expensive. However, there also seemed to be only a few companies offering training which meant a lack of choice. In particular, it was reported that there seem to be very few opportunities for training on new products coming on to the market such as permanent fillers.

The key criticisms were around the nature of the training; it was largely (occasionally completely) theoretical with very limited opportunities to practise the procedures. A certificate is provided at the end to enable the practitioner to get medical indemnity.

“They need to then govern the people giving the training because that’s so inadequate and so hit and miss. The training that’s given, one day for dermal fillers and half a day to do the injecting. When I did it, there was six of us in a room, we did half a lip each or something. It’s ridiculous and then you can go off, you’ve got your certificate, you can do it and no-one to stop you.” (Doctor)

Some practitioners had sought to ‘top up’ this basic training, for example, with further courses (sometimes provided by manufacturers’ reps) or by paying for mentoring or for an experienced practitioner to oversee their practice. It was reported that the BACN also offers a buddying scheme for members and there are regional groups enabling ‘injectors’ to meet up and discuss new products and practice.

One practitioner reported how she had heard from others on the course she attended that clips on YouTube could be very useful for showing where to inject and another commented that social media played an important role in keeping in contact with discussion and views in the industry, internationally.

Some good practice was also cited however, for example, that from a dermal filler manufacturer offering 1:1 training from specialist clinicians who ensure trainees are confident in the procedure at the end of the course.

“There is a particular dermal filler which has been established for a long time, it’s very well known and they do a lot of training. It’s all nurse led and they train everyone. You go along, you are beside surgeons and dentists and so on, all people who specialise in this field and they train you, you know you have your own trainer, it’s one to one and they really walk you through everything and make sure you leave very confident in what you are doing and they are very supportive. But having dealt with other companies, I know that’s not consistent.” (Nurse)

The beauty therapists in the sample were not themselves administering injectables although in one case she was ‘selling’ the procedures in consultations and assisting the clinicians who came into the salon to carry them out. This therapist felt that the training she received from manufacturers was excellent and said that those taking the courses needed to pass exams at a certain level to gain their certificate.

“Within our company in terms of training we are always encouraged, even if we are unsure, if we are not quite hitting our selling potential we are then encouraged to have more training. The company is always holding training dates for us to go on. Always they are on hand; if we need any support, they always offer support. In that sense, very good...”

So the training that’s offered by some of the dermal filler manufacturers, although you don’t do the injections yourself, are they teaching you what to tell people about it, basically how to sell it?

... Yes, how to talk about it. Because if you think about it, we are the first port of call. We are carrying out the consultations, we are referring those clients to the doctor, so we need to know what we are talking about, to give the client as much information as we can. We are not obviously speaking from a doctor's point of view, we have very limited knowledge as far as that, but within the whole product range, we need to have just as much knowledge on it as the doctors.” (Beauty therapist)

The other therapists had both looked into the possibility of bringing in medically trained or other practitioners trained in injectables but had rejected the idea on several counts including the fact that the level of training they have received is inadequate. This meant that as a salon, they were potentially putting their business at risk for very little gain.

“I wouldn't let any other beauty therapist do that and I wouldn't let a doctor or a nurse come in. They might have gone up to Glasgow for a weekend, which is what they usually do, they do a two day course in Glasgow and they can inject people with 'Botox' and fillers ... I wouldn't let anybody like that do that to my face and I wouldn't let them do that to my clients either because I don't think they are qualified enough... I wouldn't have these people coming into my salon. I think it's back street... they come into the business with the attitude that they are going to do me a huge favour and offer me this huge great service that I can't do and use my business, my clients, my reception, everything, and pay me £20. So I just go 'go away'.” (Beauty therapist)

These therapists were more concerned with training in procedures such as laser hair removal and were aware that the training available from manufacturers could not be guaranteed to produce competent practitioners as it is not in their interests to fail anyone. They called for more rigorous and lengthier training to be available in emerging techniques and equipment, possibly through local colleges.

10.3.3 Quality of Products

Practitioners assumed that the products they use are good quality and 'Botox' at least, has MHRA approval. Similarly, many expressed confidence in the dermal fillers they choose to use, seeing them as produced by large reputable pharma companies and therefore thoroughly tested; one or two also believed fillers were prescription items because they obtain them from a pharmacy. Several practitioners chose to use only those fillers which are FDA approved because of the reassurance this gave and the FDA model of approval was suggested as something that could usefully be adopted by the UK.

“In the US there are only three or four dermal fillers that are FDA approved, medically approved, whereas in this country it doesn't seem to be, there are like hundreds. Now I know for a fact that if I'm injecting something into somebody's

skin, I've got to know that it's got to be safe because my name is on the door. I don't want to be sued, so I'll only use products that have been approved by the FDA." (Dentist)

While some practitioners felt that injectables have been used for a long time without long term health issues arising, others were less certain, expressing the suspicion that there may be no long term safety data. For example, the question was posed, what might be the consequences for today's 20 year olds having chemical peels, 'Botox' etc in decades to come?

There was broad recognition of the ever increasing choice in products such as dermal fillers in part, it was suggested, because it is easy to enter the UK market (one nurse thought there were more fillers available here than anywhere else in the world). While they might stick with a small number they know well and trust, other practitioners, it was suggested, might be attracted by novel untried products from new companies that are of questionable quality and efficacy, or acquire them from the internet based on price.

10.3.4 Perceived regulatory responsibility

A mixed picture was painted by practitioners of the current state of regulation in the non-surgical area, with variation even within a single field of practice. For example, the three beauty therapists thought they were variously regulated:

- by CQC and the local authority

"We are very heavily regulated. As I say, we are governed by the Care Quality Commission, so we go through all the correct procedures. We have the right policies and protocols, forever updating them, and as I said we have a lot of inspections. We are pretty tight when it comes to that...Making it clear about each of the procedures you are carrying out on the patient before you carry out the treatment. Making sure they fully understand the treatment before you are carrying it out. Making sure in the event of an emergency, what you need to do, what you need to carry out, what you need to tell the client. And following up the client, aftercare is a huge thing as well, making sure the correct notes are noted down." (Beauty therapist)

- in the past by CQC, now awaiting local authority licensing but meanwhile she is continuing to self-regulate according to CQC in the hope that proper regulation will be reintroduced

"I still pay every year for my medical protocols, and I still do it all like I would if I were registered with the CQC, which I believe when you're working with a piece of equipment like that [laser], it should be done like that." (Beauty therapist)

- no idea what the requirements are or who might set them down – so she is trying to self-regulate to fit in with the requirements of insurance companies, equipment manufacturers and Health and Safety regulations; while she dreads yet further regulation, she also can see that at least she would know that she meets the requirements

“I would know that I am absolutely doing the right thing because I could go on a website, or I could go somewhere, a business centre, and them to say, ‘right, you need to have this, this and this in place before you can practise’. And then you would follow the guidelines.” (Beauty therapist)

About half of those we interviewed were members of professional bodies with a cosmetic intervention specialism (BAAPS, BAPRAS, BACD, BACN). The doctor had looked into joining a professional body for her cosmetic practice but found nothing credible ‘with teeth’. She was however considering BCAM (formerly BACD) because of the educational opportunities it provides and the checks it carries out in terms of the training and length of time in practice of members.

“None of the others are, what’s the word, they’re not compulsory and the ones I’ve looked at, the regulatory ones, don’t seem to have any teeth so I’m not going to pay membership just to ... there’s one that contacted me, it’s basically a glorified, they’ll advertise your services to people, they’ll tweet about you, they’ll not regulate you at all so I’m not going to pay the money unless it’s a proper regulatory body.” (Doctor)

One of the dentists had found that BACD does not cover injectables. He was recommended by the GDC to join the IHAS which he understood to be a regulatory body; however he was deterred by a membership fee of £500 even though it would have indicated he met the ‘gold standard’ of practice for giving injectables (looking at the IHAS website, it appears that such practitioners are listed on the TYCT website). The subject of TYCT was raised by one of the nurses who was concerned that it was trying to fill the gap in assessing safety and quality in cosmetic procedures. She felt it was unlikely to succeed, in part because it is a profit making organisation and anyone can pay to be on the TYCT list, but also because health professionals should be answerable to their governing bodies such as the GMC and NMC.

“I think their aim is to kind of do what the CQC was meant to do, but then they are just another body that you are going to pay. Some people will probably get vetted, other people won’t. Some people will be submitted to quite stringent regulations, other people won’t because it varies from each inspector and area and I just don’t think it’s the best way forward.” (Nurse)

There was a general feeling that governing bodies and professional bodies could be doing more to help in the area of cosmetic interventions, for example:

- the GMC and NMC could be taking action against members when things go wrong for patients
- BAAPS could be pulling up members who refuse to help clients, as with the PIP implants,

Some clinicians also noted the disparity in sanctions that might be applied to different practitioners; while clinicians could be struck off, beauty therapists and others may only ‘get a slap on the wrist’.

10.4 Proposed Priorities for Regulation

10.4.1 Eligibility of practitioners

The majority of practitioners took the view that many of the non-surgical procedures should be provided only by clinicians or possibly, those with specialist training. The principal reasons were that only they:

- can recognise when a condition should be treated clinically and not using a cosmetic procedure for example, where an age spot is actually a melanoma
- can recognise adverse effects and deal with them e.g. differentiate between the expected temporary inflammation and the early signs of infection

“What worries me is you have beauty therapists now doing dermal fillers and ‘Botox’ and so what do they do when things go wrong? Because I know that actually when things go wrong it can be very complex, there is a lot of handholding needed and you have to be able to step up to the task, so what do they do? You know injecting is the easy part, but it’s actually managing everything else in between.” (Nurse)

“My view also is, I think it’s helpful to be a clinician to do this because you need to have experience of injecting, you need to be able to deal with complications should they arise, even though they’re seldom and you need to be able to give treatment in context of the medical history, rather than just giving it as a beauty treatment.” (Doctor)

- have the anatomical/ medical training to respond appropriately in the event of a problem

“And are we talking about Botox and dermal fillers here?”

Yes...

“Would you say the same about chemical peels?”

... Yeah, yeah because they are all drugs and they have something that can cause harm and you should know what causes harm and you should know what to do about it immediately without having to find somebody else who might not be on the premises.” (Nurse)

Some would go as far as to propose that all procedures that were discussed, except possibly microdermabrasion, should be conducted by clinicians or that practitioners should at least require a certain level of training plus supervision by medical practitioners. They might leave microdermabrasion and possibly the weaker forms of chemical peel to beauty therapists with specialist training. A couple of the beauty therapists felt similarly, suggesting that therapists carrying out such procedures should be trained to a level higher than NVQ Level 3.

“You shouldn’t be allowed to do them procedures, even microdermabrasions and chemical peels, laser, hair, skin stuff as a beauty therapist unless you have got advanced beauty training. You have done extra certificates because there’s Level 2, there’s a Level 3 in Beauty Therapy, and I think it should be after Level 3 that you can.” (Beauty therapist)

The dentists felt that teeth whitening, currently carried out by almost anyone, should come under dental regulations and be restricted to dentists because of the skills and knowledge needed to achieve a good and safe outcome.

“You need to understand a tooth before you do the tooth whitening, you need to understand where the tray’s margins should end, to stop sensitivity, trauma to the gums, you need to understand if a tooth is able to accept it or not, you need to understand if a patient can accept it or not or can tolerate it, so you need to have medical background and you should definitely have a dental background.” (Dentist)

However, it was noted that medical training was no guarantee of competence; specialist training was also required. For example, a suggestion from a dentist was that injectable procedures should be offered only by those who have a diploma in facial aesthetics as in the USA.

“We often get calls from people saying ‘I was in the dentist surgery and my face has gone black, what am I meant to do?’... The most recent one, we tried to get her to come and see us. We said, ‘let us just ... come and see us.’ She eventually rang back and said ‘no, no, he’s going to see me and he’s going to offer me treatment free for the rest of my life.’ Wow. But you can’t do anything about that ... so yeah, I think it’s very unregulated and it’s quite scary.” (Nurse)

10.4.2 Required training

The general view was that the training for administering injectables needs to be longer and more practical and there should be a means of ensuring that all training is of sufficient quality including that provided by manufacturers.

A couple of clinicians proposed that specialist training could perhaps be provided by mainstream medical colleges, particularly given that procedures such as ‘Botox’ and dermal fillers are used in reconstructive and other areas of medicine. The beauty therapists were keen for local colleges to offer more advanced training in non-surgical procedures.

Initial training to achieve accreditation should, it was felt, be followed up by CPD to keep up to date with emerging techniques and products.

“Once you’ve done your accreditation, you should be expected to have a five year cycle of continuing professional development or a ten year cycle, to keep up with a certain number of hours that you’ve done every year or every five years, to top up your skills and I think that is absolutely essential.” (Dentist)

“You do ten hours of CPD, you do this x, y and z and if you don’t do it, we need to see evidence of it once every five years that you are doing it, and that you’re up to date with your knowledge.” (Dentist)

There was also a call from a couple of practitioners for training to address issues of identifying patients with psychological issues and making an appropriate referral.

10.4.3 Marketing by providers

Practitioners had little appetite for banning the advertising of cosmetic procedures completely, feeling that practitioners should be able to promote their services.

However, it was commonly felt that guidelines/rules should be set down to address much of the practice that is misleading or potentially harmful – indeed, a few practitioners already assumed these were in place. It was suggested that rules should be established for such claims as, the results that can be achieved with procedures, the use of before/after photos that have either been digitally enhanced or are not the same

person, and for most, the offer of lifetime care which was seen as lacking credibility. The offer of discounted packages of different surgical procedures was seen as totally inappropriate because it undermined the seriousness of the procedures and the decision as to whether to have them.

“There’s certain types of customers, the types that will watch ‘The Only Way Is Essex’ and think it’s the norm that when you hit 19, you get a boob job because they don’t understand that breasts are not pneumatic and God didn’t make you that way. But it’s what everyone does, they don’t necessarily see it as ... you’re having a general anesthetic, you could die. It’s rare but they’ve got to give it the respect it deserves.” (Doctor)

“I had a client come, and she had some skin rejuv done, but it weren’t enough for her. Even though she’s only young, she doesn’t need anything else, you know, she wanted more, and she’s gone to another practice in Leeds and she paid, they told her if she paid, I think it was about three and a half thousand pounds, it would get her so many sessions of fillers and so many sessions of ‘Botox’ and do this, that and the other, and do you know what, it’s been shocking, and I think she’s paid all that money for what? To look worse, you know.” (Beauty therapist)

In addition, there was broad support for the banning of offers from third party discount providers or any offers that are time-limited.

The marketing of specific products also came under scrutiny. Just as ‘Botox’ cannot be advertised because it is a prescription drug, it was also suggested that this should apply to brands of dermal filler, advertising for which is appearing in public places. Such widely displayed advertising, it was suggested, helps drive ever younger people who are insecure about their looks to seek out specific solutions.

“For instance, something like one of the dermal fillers, being a big poster on the Tube or at a bus stop, it’s something that if someone wants it, they seek it out. You shouldn’t be sat at a bus stop looking at an airbrushed 19 year old, making yourself feel inadequate, because it’s not real. And I don’t think an advert should be making you think, ‘maybe I should have that’. I don’t think someone should think ‘I’m not happy with this and so I’m going to seek it out’.” (Doctor)

It also resulted in patients requesting particular brands of filler rather than the health professional advising the client on the best choice for them.

“There is one brand of dermal filler made by a very huge company, pharmaceutical company, and I don’t agree with their advertising campaign. It was a very big and a very powerful campaign and people were coming to the clinics, specifically asking for this dermal filler. It’s not necessarily the best. I’ve worked with this filler, I understand it well, I know what its limitations are and I know what it’s good for.” (Nurse)

Should dermal fillers become prescription items, this problem will of course disappear.

10.4.4 Settings in which procedures can be performed

There was broad support for the regulation of settings in which non-surgical procedures are carried out to improve patient safety in the context of a general concern about the lack of regulation in spas, gyms, hairdressers, shops and mobile operations.

The hope was that this would result in the prohibition of sessions in hotels, shopping malls and people's homes. It might also help constrain practitioners from overseas flying in and out and conducting procedures in hotel rooms (often a source of problems due to lack of aftercare that have to be picked up by the NHS) as well as mobile practitioners carrying out procedures at 'Botox' parties where alcohol is often involved.

"I think there's a definite need for regulation, absolutely, I think anyone can do it at the moment and there are often these clinics that pop up, maybe at a hotel or a salon and then they're gone the next day and you can't get hold of them, no matter what happens, so they've got no accountability. Why would they care if they do it right or wrong?" (Doctor)

The expectation was that all premises in which such procedures are carried out would need to be inspected and indeed the doctor had requested such an inspection but found that, as a clinician, she was exempt.

"For instance, the injectables, they can be done in any back room. I tried to look into it when I first started doing it, just through the local environmental health office and for instance, if someone's acupuncture or semi-permanent makeup, because they're needling, they get inspected, their premises gets inspected and they have to conform to certain rules. When I rang and said, 'can you do the same for me so I can get the certificate to say I can do that?', they said 'you're a doctor so it doesn't matter, we don't cover you.' So I could be doing it in some dirty toilet and because I've got that after my name, it doesn't matter." (Doctor)

CQC was mentioned in connection with this requirement although often with some reservations.

10.4.5 Quality of substances and devices

There was broad, often spontaneous, support for the move to make dermal fillers prescription items, subject to the same safeguards as 'Botox' or as medical devices. It was suggested that they should come under the aegis of the MHRA and be subject to its approval process.

"I do think that dermal fillers should become prescription because in the wrong hands actually, they really are quite dangerous for the reasons I mentioned before. I have people that do come into my clinics specifically to have things

corrected, have horrendous deformities around their eyes where they've had eye work done you know, all sorts of things. It's really awful." (Nurse)

"I just think if you are injecting, you need to know about the product you are using, the clinical trial and if there was a problem, what would you do, if someone had a reaction to it." (Dentist)

There was also some call for the same to be applied to chemical peels, at least those classed as medium and deep peels.

"Chemical peels, it's a difficult one because there's different grades on that. I think there's certain grades where they need to be governed more medically, I think the MHRA really needs to be involved with the stronger ones because some of them need to have a general anesthetic to apply them because they're so painful." (Doctor)

There was also a call for greater regulation of machinery/products that go into the body. While the CE mark might be adequate for non-invasive machinery (such as lasers), it was seen as inadequate for invasive procedures since the design specification may be changed after initial approval (as with the PIP implants).

10.4.6 Record keeping and registers

Detailed patient record keeping as applied in the medical sector was seen as something that should be a requirement for all practitioners including those working in the non-surgical area.

The first response to a national register for implants was very positive although after giving it some thought, a couple of practitioners became less enthused, feeling it unnecessary on the basis that these records are kept by surgeons and should also be sent to GPs. They therefore saw it as a costly measure that would not help patients from overseas who come to the UK for procedures or those from the UK who have procedures overseas; patient groups with which a lot of the problems lie. Proper record keeping, appropriate sharing of information and adoption of a practice of giving patients a card with all the necessary details about the implant should suffice, it was suggested.

In the event of a register for implants being set up, while some practitioners felt it should not be possible for patients to opt out (after appropriate reassurances about data protection and confidentiality), others felt otherwise. If patients opted out, it was suggested that this would also need to be recorded. One of the beauty therapists had herself had breast augmentation some years previously and thought she was put on to

a register whereas her friend who had had the procedure more recently was not. Her view and that of one of the nurses was that agreement to go on the register should be part of the consent process.

The idea of a register for injectables was not supported on the grounds that the injected substances are metabolised within a fairly short time. Moreover, proper record keeping, if enforced properly, should be sufficient, for example, a requirement for the stickers listing the type of filler/expiry date/batch number to be peeled off and attached to the patient records and for patients to be told which type of filler they have in their body.

10.4.7 Consent and psychological assessment

The unanimous view was that there should be a two-stage consent process for surgical procedures with a cooling off period of perhaps 3-4 weeks. There was also some support for a two-stage process for injectables (for first treatment and periodic reviews) albeit with a shorter interval. However, most felt that the latter would inconvenience the practitioner (who might lose the client) and the patient who is certain that they want the procedure. It was suggested that ways would be found to circumvent such a regulation if brought in.

Those who worked by themselves were more sanguine about such a change; it was recognised that it would be the larger, more commercial companies that would object.

“For me, no [it would not be a problem] because of the way I work. I think for other people, they employ sales teams, medical ethics are different to how you get a sale, so for them, yes, it’s all about getting them to sign on the day so they’re committed. So for them, I think there would be but for me, because I’m always keen to make sure someone does it for the right reason, then no, it wouldn’t make a difference.” (Doctor)

“As a practitioner it wouldn’t be great. From a practitioner point of view, because once that person walks out of the door you might lose them as a customer... Unless they are hesitant, then yes, I would definitely encourage that. But then again, once that person is out of the door we can’t always guarantee that they will come back.” (Beauty therapist)

Other formalities that were suggested around the consent procedure were:

- A requirement for signatures to show that the patient has been given and has read/ heard information about the procedure, its associated risks and required ongoing maintenance, as well as signatures showing consent

“I think there should be somebody who regulates even just your paperwork, that you are actually getting a client to consent to it properly. All the information is on that paper, it’s there, so the client can read it, and they’ve signed for it.” (Beauty therapist)

“How do you do that unless you get somebody to sign a tick box? We should all sign tick boxes, I don’t know how else you could do it.” (Nurse)

- The provision of formal aftercare instructions including the spelling out of the responsibilities of the practitioner if something does go wrong.
- The provision of the complaints procedure including the regulatory body to which complaints could be referred.

One of the nurses wished to see established referral routes for people where counselling/psychological assessment is required. She saw it as down to the practitioner who has assessed such patients to suggest that they speak to someone although they cannot be made to do so. Other practitioners did not feel it was either desirable or practical to assess everyone especially for non-surgical interventions. Overall, this seemed to be seen as more of a training requirement than a subject for regulation.

10.4.8 Safeguards in the event of something going wrong

The commonly held view was that it is up to the practitioner or the organisation in which he/she is working to take responsibility for the proper follow-up and aftercare of a patient. This might mean for example, paying for a private prescription for antibiotics in the case of an infection. For something like dental implants, the requirement for aftercare might stretch far into the future.

“You know one of my friends said to me last week, because he does a lot of dental implants he said, when he did the dental implant, I thee wed. Because you are married to the patient once you do a dental implant because in ten years, if anything goes wrong, who are they going to go and see? - the person who inserted the dental implant.” (Dentist)

In the case of the PIP implants, the feeling was that practitioners or companies should have removed the implants and replaced them or paid the NHS to do so and many simply could not understand how the PIP providers and the large cosmetic surgery companies could have got away with not doing so or how they did not seem to have insurance cover that enabled them to do so. It was suggested that individuals should

have had to answer to the GMC. A lone voice suggested that providers should have sought redress from the MHRA who approved the PIPs for use.

A few practitioners made the point that while the original practitioner should deal with the problem, they may not be in the best position to remedy it and should refer onwards accordingly. Their sometime reluctance to refer on may not be in the patient's best interests. Moreover, patients may not be keen for the same practitioner to try and resolve the problem.

If an adverse event becomes life-threatening, then NHS treatment would certainly become necessary because no private setting could cope but again, it was felt that the NHS should be reimbursed. The specialist plastic surgery nurse pointed out that the NHS will remove the implant or infection but will not reconstruct unless there is major trauma or the patient is re-referred due to psychological impact.

"I think if you are sick, the NHS is the right place for you because of our system and our set-up, we don't judge, we treat the clinical side, not for financial reasons. Whether we could then charge somebody for that, that would be possible... and you know we don't replace, so if you came in with one infected implant, we take out one, we don't take out the other and we don't replace... For cosmetic problems, I think we do if the GP will then have to re-refer and tell us that they are having problems psychologically or whatever. It's not often, but there have been some big ones that they had, like buttock filling and that necrotising fasciitis so have lost a huge area and we have done reconstruction on her." (Nurse)

Some of the implications that were suggested for insurance requirements were for insurance to cover unforeseen complications, not just malpractice, and possibly, for insurance to be focused on the individual practitioner rather than the clinic – this might help ensure that properly qualified practitioners are conducting the procedures. There was also strong support for an ABTA-like insurance scheme as a safety net for the public in a regulated environment although not as a replacement for proper insurance arrangements by individual practitioners and clinics.

Some took the view that the patient also has to bear some responsibility if he/she takes part in less regulated practice e.g. if treated in a hotel room, at a 'Botox' party or if treated overseas. There was a suggestion that patients should be able to take out insurance although this might be difficult for injectables because the results are individual and there are so many factors affecting the outcome.

“I had a patient that had been to one of the hotels and had injections, fillers to her buttocks and they both got infected and she had to come to us and the lady who did the injections came from Canada, did the injections in one of the hotels here and left and the lady came to us and she was admitted in an NHS hospital for three weeks. We had four operations on her, terrible infection.” (Surgeon)

“An individual policy for that treatment that you take out at the time of consent for instance, so that if you came back and there’s an adverse effect that needs treatment then you’ve got it covered from an insurance policy.” (Doctor)

It was also felt that patients should be provided with an established route for progressing their complaint against a practitioner.

10.4.9 Need for a regulatory body and compulsory membership

There was a strong feeling among these practitioners that there should be a regulatory body charged with responsibility for regulating cosmetic interventions. In terms of existing organisations that might be candidates, some clinicians felt that the GMC and NMC could perform this role; others that a single body would be preferable, both to create a level playing field across different types of cosmetic practitioner and to ensure that the regulatory body has teeth. CQC was also brought into the picture and while some saw it as potentially offering rigour and ensuring patient safety, some concern was expressed about consistency of enforcement across all practitioners and of practitioners being overloaded by its requirements.

The key requirements suggested for a regulatory body, based on the areas discussed, were:

- Mandatory membership with strict eligibility criteria. This would include a requirement for specialist training including CPD

“I think there needs to be a regulatory body that everyone who does it has to have a compulsory membership and I accept they’ll have to pay for that because they’ve got to pay somehow for the regulation. That will stop the people who are just fly-by-nights doing this for a quick buck anyway.” (Doctor)

- Provision of training or accreditation of training by other providers

“Somewhere to go to, to get extra training if you want to, I’ve had to seek out from other people, really dig deep to find where I can have it done whereas if that regulatory body was able to give you advice on how to get that done.” (Doctor,)

- Provision of the means (such as a website) by which clients can check practitioner’s details/ verify credentials

*“They should be able to, like, the whole breast enlargement thing, you can look on the BAAPS website, can’t you, you can make sure they’re BAAPS registered, but there should be something like that for this kind of, I don’t, injectables, to me.”
(Beauty therapist)*

- A last stop for client complaints with the powers to investigate/ adjudicate/ sanction providers if necessary
- The keeper of a national register of implants should one be established
- Setting up of compulsory ABTA-type insurance scheme for members (but not as a replacement for stricter insurance requirements for practitioners/ companies).

11 Appendices

11.1 Patient/considerer depth profiles

Depth	Gender	SEG	Age	Life stage	Procedures experienced	Procedures that have been considered/might be considered in the future
1	F	C2	50	Older Family	Non surgical: Injectable cosmetic treatments Surgical: Nose job	None
2	F	C1	27	Pre-Family	Surgical: Breast enlargement	Non-surgical: Microdermabrasion Surgical: Nose job, liposuction, tummy tuck
3	F	C1	30	Young Family	Non-surgical: Microdermabrasion Surgical: Breast enlargement	Non-surgical: Injectable cosmetic treatments, chemical peel, cosmetic dental treatments
4	F	C1	41	Older Family	Non-surgical: Injectable cosmetic treatments Surgical: Laser eye surgery	Non-surgical: Chemical peel, laser hair removal, cosmetic dental treatment Surgical: Breast enlargement
5	F	C1	33	Pre-Family	Surgical: Nose job, breast enlargement	Non-surgical: Injectable cosmetic treatments
6	F	B	27	Pre-Family	Non-surgical: Chemical peel, microdermabrasion, laser hair removal, cosmetic dental treatment	None
7	F	C1	46	Older Family	None	Non-surgical: Cosmetic dental treatments Surgical: Breast enlargement
8	F	D	46	Post-family	Non-surgical: Injectable cosmetic treatments	Non-surgical: Chemical peel, cosmetic dental treatment Surgical: Face/neck lift, other face/neck surgery, liposuction, tummy tuck
9	F	D	57	Post-family	Non-surgical: Injectable cosmetic treatments, laser skin resurfacing	Non-surgical: Laser skin resurfacing

Depth	Gender	SEG	Age	Life stage	Procedures experienced	Procedures that have been considered/might be considered in the future
10	F	B	27	Pre-family	Non-surgical: Laser hair removal	Non-surgical: Injectable cosmetic treatments, microdermabrasion, cosmetic dental treatments Surgical: Tummy tuck, laser eye surgery
11	F	B	34	Young Family	Non-surgical: Cosmetic dental treatments	Surgical: Nose job, Breast enlargement
12	F	D	33	Young Family	None	Non-surgical: Laser hair removal, laser skin resurfacing Surgical: Nose job
13	F	C2	37	Young Family	None	Surgical: Breast enlargement, cosmetic dental surgery
14	F	B	31	Pre-family	None	Surgical: Breast enlargement, liposuction, laser eye surgery, cosmetic dental surgery
15	F	C1	24	Young Family	None	Non-surgical: Cosmetic dental treatments Surgical: Breast enlargement, liposuction, tummy tuck
16	F	C1	51	Older Family	Non surgical: Injectable cosmetic treatments, Microdermabrasion	Surgical: Liposuction
17	F	B	39	Young Family	Non-surgical: Cosmetic dental treatment	Non-surgical: Injectable cosmetic treatments, chemical peel, Microdermabrasion, Laser skin resurfacing Surgical: Laser eye surgery
18	F	C1	40	Pre-family	None	Non-surgical: Injectable cosmetic treatments, chemical peel, microdermabrasion, laser skin resurfacing, laser hair removal, cosmetic dental treatment
19	F	C1	41	Post-family	None	Non-surgical: Injectable cosmetic treatments, chemical peel, microdermabrasion, laser skin

Depth	Gender	SEG	Age	Life stage	Procedures experienced	Procedures that have been considered/might be considered in the future
						resurfacing, laser hair removal, cosmetic dental treatment Surgical: Tummy tuck, cosmetic dental surgery Non-surgical: Microdermabrasion
20	F	C2	35	Young Family	None	
21	M	C1	62	Post-family	Surgical: Face/neck lift, other face/neck surgery (eyelids), laser eye surgery	Non-surgical: Cosmetic dental treatment Surgical: Liposuction
22	M	C1	32	Young Family	Non-surgical: Cosmetic dental treatment Surgical: Laser eye surgery	Surgical: Laser eye surgery
23	M	C2	23	Pre Family	None	Non-surgical: Laser hair removal, cosmetic dental treatment Surgical: Laser eye surgery, cosmetic dental surgery
24	M	B	37	Young Family	None	Non-surgical: Cosmetic dental treatment Surgical: Cosmetic dental surgery, laser eye surgery

11.2 Recruitment questionnaires

11.2.1 Public and Patient

Hello, my name is.....I am working on behalf of Creative Research and Acumen Research. I wonder if you would be interested in taking part in some market research we are conducting to find out the views and experiences of the public with regard to the cosmetic treatments and cosmetic surgery industry. The research is an opportunity to give your opinions and to contribute your views to the future of that industry.

Workshops (WS1-9): It involves taking part in a discussion with other people like yourself, to share views and ideas. This would last for to 3.5 hours (W1) / 2 hours (W2-W9). In return for your time, I can offer you £80 (W1)/£60 (W2-W9) as a contribution towards your expenses.

Depths (D1-24): It involves taking part in a face-to-face interview to discuss your experiences and opinions. This will last for 1.5 hours. In return for your time, I can offer you £40 as a contribution towards your expenses.

Paired Depths (PD1-4): It involves taking part in a face-to-face interview along with a friend, to discuss your experiences and opinions. This will last for 1 hour. In return for your time, I can offer you £20 (PD1/3) / £30 (PD2/4) as a contribution towards your expenses.

Recruiter: please fill in the following details

RESPONDENT DETAILS

Explain that you need to record the respondent's contact details so that they can be contacted in the event of a change of plans (e.g. the moderator is ill) and also for quality control procedures. Reassure respondents that no personal details or responses will be passed on to anyone not directly concerned with the research without their express permission.

Name:

Address:

Postcode:

Telephone:

Email address:

Give Respondent DATA PROTECTION card and read out

"The group discussion or interview you take part in will be audio recorded and a transcription will be produced. This card describes how the information you provide will be used and the steps that will be taken to protect your confidentiality. Please sign below to indicate your agreement with this procedure.

Respondent signature:

PD1-4: You must get signed consent from both parents. Two copies of the signed consent letter must be returned to the Office in advance of the interview. Alternatively, you must bring the signed consent letter to the research interview and hand it to the moderator. You must not ask the teenagers to bring the letters with them as we then have no guarantee it has been signed by the parents

<u>METHOD OF RECRUITMENT</u>			
FROM RECRUITER'S DATABASE		FREE FOUND (In Street/House to house etc)	
OTHER (PLEASE WRITE IN):			
<u>RECRUITER DECLARATION</u>			
I DECLARE THAT THIS IS A TRUE RECORD OF AN INTERVIEW WITH THE NAMED RESPONDENT WHICH WAS CONDUCTED IN ACCORDANCE WITH THE INSTRUCTIONS AND THE MRS CODE OF CONDUCT. I AGREE TO BE BOUND BY THE DATA PROTECTION ACT 1998.			
SIGNATURE: _____			
PRINT NAME: _____ DATE: _____			
For Creative Research use only Respondent ID			

Once this questionnaire has been completed, it constitutes sensitive personal data – please see notes at the end regarding how it should be treated

KEY DEMOGRAPHICS

D1 SOCIAL GRADE OCCUPATION OF HEAD OF HOUSEHOLD:

ASK THE FOLLOWING FIVE QUESTIONS TO CLARIFY HEAD OF HOUSEHOLD INFORMATION:

IF RETIRED, ASK FOR PREVIOUS OCCUPATION, IF PRIVATE PENSION RECEIVED

IF LOCAL AUTHORITY OR CIVIL SERVICE OR ARMED FORCES, ASK GRADE/RANK

IF SELF-EMPLOYED OR MANAGERIAL, ASK FOR NO. OF EMPLOYEES RESPONSIBLE FOR

ASK FOR DETAILS OF TRAINING/QUALIFICATIONS INDUSTRY (WRITE IN)

NOW CODE SOCIAL CLASS

AB	1	WS1: ABC1C2	PD1-2: ABC1	D1-24: as found but please recruit a spread
C1	2	WS2-4: ABC1	PD3-4: C2D	
C2	3	WS5-7: C2D		
D	4	WS8-9: ABC1C2		
E	5	CLOSE		

D2 Gender

Male	1	All respondents in W8/W9 and D21-24 to be male
Female	2	All respondents in W1 – W7, PD1-4 and D1-20 to be female

D3 Age: Write in and code below _____ Recruit a spread in each workshop/across Depths

14-15	1				PD1/3	
16-17	2				PD2/4	
18-25	3	WS2/3 all to be 18-25		WS1 all to be 25-55	WS8 all to be 18-40	D1-24 all to be 18-55
25-40	4	WS4/5 all to be 25-40				
40-55	5	WS6/7 all to be 40-55			WS9 all to be 40-55	
56+	6	CLOSE				

D4 Working Status				D5 Ethnicity (code here and at Q4)		
Working full time	1	At least half in all workshops/depths to be working full time	White	1	No quotas but ensure a spread of ethnicity in each workshop/ across all Depths	
Working part time	2		Asian	2		
Not working	3		Black	3		
			Other	4		
Code the workshop/paired depth/depth this screener relates to						
WS1	1	Female/25-55/ABC1C2	WS6	6	Female/25-40/C2D	
WS2	2	Female/18-25/ABC1	WS7	7	Female/40-55/C2D	
WS3	3	Female/25-40/ABC1	WS8	8	Male/18-40/ABC1C2	
WS4	4	Female/40-55/ABC1	WS9	9	Male/40-55/ABC1C2	
WS5	5	Female/18-25/C2D				
PD1	1	Female/14-15/ABC1	PD3	1	Female/14-15/C2D	
PD2	2	Female/16-17/ABC1	PD4	2	Female/16-17/C2D	
D1	1	Female/Had surgical intervention	D16	16	Female/Considered non-surgical intervention	
D2	2		D17	17		
D3	3		D18	18		
D4	4		D19	19		
D5	5		D20	20		
D6	6	Female/Had non-surgical intervention	D21	21	Male/Had surgical or non-surgical intervention	
D7	7		D22	22		
D8	8		D23	23	Male/Considered surgical or non-surgical intervention	
D9	9		D24	24		
D10	10					
D11	11	Female/Considered surgical intervention				
D12	12					
D13	13					
D14	14					
D15	15					

SCREENING

S1. SHOW CARD A Can I just check, do you or any of your immediate family work in any of the following professions or occupations?					
Market Research or Marketing	1	CLOSE	GPs, Hospital doctors, any nurses, any health care assistants, people working in the private medical sector, dentists, dental nurses	4	CLOSE
Public Relations or Journalism	2		Any profession/job related to cosmetic procedures	5	
Advertising	3		The cosmetic/beauty industry/a company that makes or sells products for the face/body/hair	6	
			Beautician/beauty therapy	7	
			None of these	8	CONTINUE
S2a. Have you <u>ever</u> attended a GROUP DISCUSSION or IN-DEPTH INTERVIEW before?			S2b. What was the subject under discussion?		
No	1	GO TO Q1	IF PREVIOUS SUBJECT RELATED TO THIS PROJECT, THANK & CLOSE. OTHERWISE ASK Q2c		
Yes	2	GO TO S2b			
S2c. How long ago was that?			S2d How many group discussions & depth interviews have you attended in the last 3 years?		
Less than 6 months	1	THANK & CLOSE	1-6	1	GO TO Q1
More than 6 months ago	2	GO TO S2d	7 or more	2	THANK & CLOSE

ASK ALL

Q1. Do you strongly object to cosmetic surgery and/or cosmetic treatments such as a facelift or Botox, for example, for moral or religious reasons?

Yes	1	CLOSE
No	2	Continue

IF RECRUITING WS1-9 / D1-24 ASK Q2a- 2f

Q2. I would like to show you a list of the different types of cosmetic treatments and procedures available today. SHOW CARD B. Ask a) to d) and record below

a) Which of these have you heard of?

b) Cosmetic procedures are sometimes performed under the NHS or carried out privately (e.g. through BUPA) on medical grounds; for example, breast reconstruction following a mastectomy. Cosmetic procedures can also be carried out privately (i.e. paid for) for non-medical reasons. Which of these treatments and procedures have you ever had and paid for privately for non-medical reasons?

c) And which, if any, have you personally ever considered or looked into having privately? By this, I mean you have gathered information, made enquiries, asked for advice etc. **Recruiter: please probe to ensure the respondent actively looked into this**

d) Which might you consider in the future?

		a) heard of	b) had	c) have considered	d) might consider
Non surgical	Injectable cosmetic treatments such as Botox or dermal/soft tissue fillers	1	1	1	1
	Chemical peel	2	2	2	2
	Microdermabrasion	3	3	3	3
	Laser skin resurfacing	4	4	4	4
	Laser hair removal	5	5	5	5
	Cosmetic dental treatments such as teeth whitening or veneers#	6	6	6	6
Surgical	Face/neck lift	7	7	7	7
	Other face/neck surgery	8	8	8	8
	Nose job	9	9	9	9
	Breast enlargement or reduction	10	10	10	10
	Liposuction/sculpture	11	11	11	11
	Tummy tuck	12	12	12	12
	Cosmetic dental surgery e.g. implants#	13	13	13	13
	Laser eye surgery	14	14	14	14
Any other treatment or procedure not listed above – please record and check eligibility with office	15	15	15	15	
None of these	16	16	16	16	

No more than 1 respondent in a workshop to have only had/considered having any form of cosmetic dentistry.

SEE BELOW FOR QUOTAS

a) No quotas but please record	
b) WS1-7: Close if respondent has had <u>any</u> of the treatments WS8-9: 3-4 to have had or actively considered having one or more treatment/procedure; recruit a spread	D1-5: all to have undergone a surgical procedure – codes 7-14 D6-10: all to have undergone a non-surgical procedure – codes 1-6 D21-22: all to have undergone either a surgical or a non-surgical procedure – codes 1-14
c) WS1: 3-4 to have actively considered having one or more treatment/ procedure; recruit a spread WS2-7: no quotas WS8-9: 3-4 to have had or actively considered having one or more treatment/procedure; recruit a spread	D11-15: all to have actively considered a surgical procedure – codes 7-14 D16-20: all to have actively considered a non-surgical procedure – codes 1-6 D23-24: all to have actively considered either a surgical or a non-surgical procedure – codes 1-14
d) No quotas	No quotas

IF RECRUITING D1-24 ask Q2e

Q2e. Did you experience any problems or difficulties with any of the following

Finding information about the cosmetic intervention you were considering	1	Patients (D1-10, 21,22): no more than half to have experienced problems Considerers (D11-20, 23, 24): no quotas; as found
Deciding which treatment was right for you	2	
Deciding who would carry out the treatment	3	
With the treatment itself	4	
Following the treatment	5	

IF RECRUITING D1-D10 ask Q2f

Q2f. Did you undergo the procedure in relation to a wedding you were planning/attending?

Yes	1	Check with office regarding quotas
No	2	

IF RECRUITING PD1-4 ASK Q3a) and 3c)

Q3. I would like to show you a list of the different types of cosmetic treatments and procedures available today. SHOW CARD B. Ask a) to d) and record below

a) Which of these have you heard of?

		a) heard of	b) had	
Non surgical	Injectable cosmetic treatments such as Botox or dermal/soft tissue fillers	1	1	DO NOT ASK BUT IF RESPONDENT VOLUNTEERS THE FACT SHE HAS UNDERGONE AN INTERVENTION, PLEASE RECORD UNDER b) had
	Chemical peel	2	2	
	Microdermabrasion	3	3	
	Laser skin resurfacing	4	4	
	Laser hair removal	5	5	
	Cosmetic dental treatments such as teeth whitening or veneers	6	6	
Surgical	Face/neck lift	7	7	
	Other face/neck surgery	8	8	
	Nose job	9	9	
	Breast enlargement or reduction	10	10	
	Liposuction/sculpture	11	11	
	Tummy tuck	12	12	
	Cosmetic dental surgery e.g. implants	13	13	
	Laser eye surgery	14	14	
Any other treatment or procedure not listed above – please record and check eligibility with office	15	15		
None of these	16	16		

SHOW CARD C AND ASK Q3c

c) Which ONE of these most closely reflects your attitude towards these cosmetic interventions?

I would definitely consider having a cosmetic intervention if I needed one in the future	1	No Quotas
I might consider having a cosmetic intervention if I needed one in the future	2	
I don't know if I would consider having a cosmetic intervention but am not opposed to the idea in principle	3	
I would definitely not consider having a cosmetic intervention even if I was told I needed one in the future	4	CLOSE

Q4. Record respondents ethnicity SHOW CARD D					
White	White British	1	Black	Caribbean	7
	White other	2		African	8
Asian	Indian	3		Mixed	Other Black
	Pakistani	4	White and Black Caribbean		10
	Bangladeshi	5	White and Black African		11
	Other Asian	6	White and Asian		12
No quotas but recruit a mix in each workshop			Other mixed		13
			Other	Other ethnic group (write in)	14
IF RECRUITING WS3, WS4, WS6 or WS7:					
Q5. Record willingness to participate in a follow up telephone interview lasting about ½ hour if selected					
Yes, definitely prepared to take part		1	At least 4		
Probably/maybe prepared to take part		2			
Not prepared to take part		3	No more than 2		

SHOW CARD A

Market Research or Marketing

Public Relations

Journalism

Advertising

GPs, Hospital doctors, any nurses, any health care assistants, people working in the private medical sector, dentists, dental nurses

Any profession/job related to cosmetic treatments/procedures

The cosmetic/beauty industry/a company that makes or sells products for the face/body/hair

Beautician/Beauty therapy

None of these

SHOW CARD B

1. Injectable cosmetic treatments such as Botox or dermal/soft tissue fillers
2. Chemical peel
3. Microdermabrasion
4. Laser skin resurfacing
5. Laser hair removal
6. Cosmetic dental treatments such as teeth whitening or veneers
7. Face/neck lift
8. Other face/neck surgery
9. Nose job
10. Breast enlargement or reduction
11. Liposuction/sculpture
12. Tummy tuck
13. Cosmetic dental surgery e.g. implants
14. Laser eye surgery
15. Any other treatment or procedure not listed above
16. None of these

SHOW CARD C

I would definitely consider having a cosmetic intervention if I needed one in the future

I might consider having a cosmetic intervention if I needed one in the future

I don't know if I would consider having a cosmetic intervention but am not opposed to the idea in principle

I would definitely not consider having a cosmetic intervention even if I was told I needed one in the future

SHOW CARD D

White	White British White Other
Asian	Indian Pakistani Bangladeshi Other Asian
Black	Caribbean African Other Black
Mixed	White and Black Caribbean White and Black African White and Asian Other mixed
Other	Other ethnic group

DATA PROTECTION

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Your personal details (such as name, address, phone number) will not be disclosed to anyone else without your permission other than Creative Research, the company carrying out the research.

The recordings/transcripts will only be listened to/watched/read for research purposes. Excerpts from the recordings/transcripts may be used to illustrate the research findings. This will always be done in a way to protect your identity (e.g. comments will not be attributed).

In exceptional cases the recordings/transcripts will be listened to/watched/read by people from the client organisation working on this project. In these circumstances, where possible we will go through the material first to delete any references to people's names or anything else that could identify them.

Anyone from the client organisation who listens to/watches/reads the recordings/transcripts will sign an undertaking that they will respect the anonymity of those taking part.

Any other material or information generated by you, such as ideas written down on paper, will be subject to the same strict controls.

You have the right to **withdraw your consent** at any point in the interview/discussion. You may also withdraw from the interview/ discussion at any point. Please sign to indicate your agreement with this procedure.

Recruiter Guidelines

Purpose

The research is being conducted on behalf of the Department of Health. The research is being conducted to find out the views and experiences of the general public with regard to cosmetic treatments and cosmetic surgery industry, including how the industry is regulated, and to contribute to decisions affecting the future of that industry.

We want to conduct 1 workshop (WS1) as a pilot in advance of the main study which will last for 3.5 hours. The other workshops – W2 – W9 – will last for 2 hours. There is an incentive of **£80** for the 3.5 hour group and of **£60** for the 2 hour groups. The workshops are structured by gender, age and SEG as shown below.

WS1	1	Female/25-55/ABC1C2	WS6	6	Female/25-40/C2D
WS2	2	Female/18-25/ABC1	WS7	7	Female/40-55/C2D
WS3	3	Female/25-40/ABC1	WS8	8	Male/18-40/ABC1C2
WS4	4	Female/40-55/ABC1	WS9	9	Male/40-55/ABC1C2
WS5	5	Female/18-25/C2D			

We are also conducting 4 friendship paired depths with teenage girls with the sample structured by age and SEG. The interviews will last for 1 hour and there is an incentive of £20 for those aged 14/15 and £30 for those aged 16/17.

PD1	1	Female/14-15/ABC1	PD3	1	Female/14-15/C2D
PD2	2	Female/16-17/ABC1	PD4	2	Female/16-17/C2D

Finally, we also want to conduct 24 depths with women and some men who have either undergone a cosmetic procedure or who have actively considered doing so. This part of the sample is structure by gender, age and whether respondents have undergone or seriously considered undergoing a cosmetic procedure. The interviews will last 1.5 hours and the incentive is £40.

D1	1	Female/Had surgical intervention	D16	16	Female/Considered non-surgical intervention
D2	2		D17	17	
D3	3		D18	18	
D4	4		D19	19	
D5	5		D20	20	
D6	6	Female/Had non-surgical intervention	D21	21	Male/Had surgical or non-surgical intervention
D7	7		D22	22	
D8	8		D23	23	Male/Considered surgical or non-surgical intervention
D9	9		D24	24	
D10	10				
D11	11	Female/Considered surgical intervention			
D12	12				

D13	13			
D14	14			
D15	15			

Your Task

You may be asked to recruit a workshop, one or more paired depths and one or more depths. In the case of the Paired Depths and Depths there are some quotas that apply across the total sample, and you will be informed of what to look for.

Screening and Exclusions

Please do not recruit anyone who works or has members of their family who work in any of the types of job on Card A (S1).

Our usual restrictions on previous attendance at groups/depths etc also apply (S2a-d).

You should not recruit anyone who is strongly opposed to cosmetic surgery/cosmetic interventions/ treatments, for example, on moral or religious grounds (code 1 @ Q1).

For all respondents:

- **Working status:** at least half of the respondents in each group should be in full time employment (code 1 @ D4)
- **Ethnicity:** ask at Q4; code at Q4 and D5; no quotas; but please ensure a mix of ethnicities within each workshop.

Please ensure that ALL respondents are comfortable with this discussion subject and prepared to share their views openly.

Please note that we are only interested in interventions made for **cosmetic** reasons, **carried out privately and paid for**. We are not including a treatment or surgery undergone for **medical** reasons, for example reconstructive surgery for a breast cancer patient following a mastectomy. This includes treatments carried out privately (e.g. under health insurance) as well as things carried out under the NHS.

Where respondents are recruited on the basis that they have considered having a cosmetic procedure, **it is very important that they have actively done so**. For example, they should have gathered information, made enquiries etc. **Please probe to ensure this is the case.**

Workshops

Please recruit a total of 8 participants per workshop as follows:

SEG (D1):	Gender (D2):	Age (D3):
WS1: ABC1C2 WS2-4: ABC1 WS5-7: C2D WS8-9: ABC1C2	WS1-7: female WS8-9: male	WS1: all to be 25-55 WS2/3: all to be 18-25 WS4/5: all to be 25-40 WS6/7: all to be aged 40-55 WS8: all to be 18-40 WS9: all to be 40 to 55 recruit a spread of ages within each workshop. You should not recruit anyone under 18 or over 55.

Cosmetic treatments (Q2a-f)

Please note: with the exception of WS8 & 9 you must not recruit anyone who has ever had any of the treatments/procedures on Card B – however, they may be eligible to take part in a Depth interview.

If you are in any way unsure as to whether the treatment described by the respondent is eligible please check with the office

WS1:	WS2-7:	WS8-9 (men):
exclude anyone who has ever had any of the treatments/ procedures on Card B 3-4 respondents should have considered/looked into at least one of the cosmetic treatments/ interventions listed on Show Card B; please aim to get a spread of treatments/interventions no more than 1 respondent to have only considered any form of cosmetic dentistry	exclude anyone who has ever had any of the treatments/ procedures on Card B no quotas in terms of which treatments/interventions have been looked into or might be considered in the future	3-4 respondents should have either had or considered/looked into at least one of the cosmetic treatments/interventions listed on Show Card B; please aim to get a spread of treatments/ interventions. no more than 1 respondent to have only considered any form of cosmetic dentistry

Participation in follow-up research – WS3, WS4, WS6 and WS7 (Q5)

2 respondents at each of these workshops will be selected at the workshop to take part in a follow-up telephone interview of 30 minutes duration. They will be given some materials to read between the group and the interview, which will be arranged by the moderator at a mutually convenient time. There will be an additional incentive of **£15** as a thank you for participation. Please ensure that ALL respondents are aware of this and establish their willingness to participate in a follow up interview. No more than 2 respondents per workshop to be unwilling to participate in a follow-up interview.

Paired Depths

Please ensure you obtain parental consent for each member of a friendship pair. You should either ensure two signed consent letters are sent to the Office in advance of the interview or you should bring them to the interview venue and hand them over to the moderator. You must not ask the teenagers to deliver the letters as we will have no way of ensuring the parents have signed them.

Both members of the pair should:

- meet the age and SEG quota
- must not rule out the possibility of undergoing some form of cosmetic intervention in the future (codes 1-3 @ Q3c)

You should record which interventions the respondents are aware of (Q3a). You should not ask if they have undergone any of the interventions but if this information is volunteered, please record it under 3b).

Depths

SEG (D1):	Gender (D2):	Age (D3):
There are no quotas but across the sample we need a spread so check with office	D1-20: female D21-24: male	all to be aged 18-55 We need to recruit a spread of ages across the sample so check with the office

Cosmetic treatments (Q2a-f)

If you are in any way unsure as to whether the treatment described by the respondent is eligible please check with the office

D1-D5	D6-D10	D11-15	D16-20	D21-22	D23-24
all to have had a surgical intervention – (codes 7-14 @ Q2b)	all to have undergone a non-surgical procedure (codes 1-6 @ Q2b)	all to have actively considered a surgical procedure (codes 7-14 @ Q2c)	all to have actively considered a non-surgical procedure (codes 1-6 @ Q2c)	all to have undergone either a surgical or a non-surgical procedure (codes 1-14 @ Q2b)	all to have actively considered either a surgical or a non-surgical procedure (codes 1-14 @ Q2c)
If respondent has only undergone/considered a dental intervention (codes 6 and/or 1 @ Q2b/c, you must check with the office before recruiting – we only want 1 such respondent across the whole sample					
We would also like to recruit 1-2 women who has had a pre-wedding cosmetic intervention (Q2f) again, please check with the office as we only need a total of 2 of these					

Data Protection and Confidentiality

Please make sure every respondent has read the Data Protection card and given their signed consent.

Front Page

Please complete the details on the front page:

- the respondent contact details
- respondent's signature indicating agreement with how the information they provide will be used
- the method you have used to find people – if you are using your own database please remember the restrictions on previous attendance
- the recruiter declaration.

Data Security

Once a questionnaire has been completed, it will contain information that is classed as 'personal sensitive data' – this is because it includes information that can be used to identify the respondent along with their answers to a number of different questions. This means it needs to be kept securely. You should keep it with you at all times when you are out in the field and make sure the information is not on view to someone else. For example, keep it in an envelope and/or keep it in a briefcase. When you are at home, it should be kept in a secure location, such as a locked drawer or cupboard and not somewhere where a visitor to your home can see it.

On the day of the interview/group, **if you are asked to do so**, you should take all the questionnaires to the venue in an envelope and hand them over to the moderator in person. If someone else is hosting the interview/group on your behalf, you should ensure they comply with these instructions. If for any reason this is not possible, you should send the completed questionnaires to our offices at the address at the bottom of the page using **Special Delivery** - you must not use the ordinary post. If you provide all the respondent details electronically, once the job has been completed and any back checking has been carried out, you must destroy any paper questionnaires. This should be done by shredding (or burning) – you must **not** put them in your household domestic waste.

Good luck!

11.2.2 Practitioners

Hello, my name is.....I am working on behalf of Creative Research and Acumen Research. I wonder if you would be interested in taking part in some market research we are conducting on behalf of the Department of Health to find out the views and experiences of professionals with regard to regulation in the cosmetic treatments and cosmetic surgery industry.

The research is an opportunity to give your opinions and to contribute your views to the future of that industry and to help determine the level and type of regulation put in place for the future. It involves taking part in an interview that would last for 1.5 hours. In return for your time, I can offer you £nn [refer to guidelines for value of incentive depending on type of respondent] as a contribution towards your expenses.

Recruiter: please fill in the following details			
<u>RESPONDENT DETAILS</u>			
Explain that you need to record the respondent's contact details so that they can be contacted in the event of a change of plans (e.g. the moderator is ill) and also for quality control procedures. Reassure respondents that no personal details or responses will be passed on to anyone not directly concerned with the research without their express permission.			
Name:			
Address:			
Postcode:			
Telephone:			
Email address:			
<u>Give Respondent DATA PROTECTION card and read out</u>			
"The group discussion or interview you take part in will be audio recorded and a transcription will be produced. This card describes how the information you provide will be used and the steps that will be taken to protect your confidentiality. Please sign below to indicate your agreement with this procedure.			
Respondent signature:			
<u>METHOD OF RECRUITMENT</u>			
FROM RECRUITER'S DATABASE		FREE FOUND (In Street/House to house etc)	
OTHER (PLEASE WRITE IN):			
<u>RECRUITER DECLARATION</u>			
I DECLARE THAT THIS IS A TRUE RECORD OF AN INTERVIEW WITH THE NAMED RESPONDENT WHICH WAS CONDUCTED IN ACCORDANCE WITH THE INSTRUCTIONS AND THE MRS CODE OF CONDUCT. I AGREE TO BE BOUND BY THE DATA PROTECTION ACT 1998.			
SIGNATURE: _____			
PRINT	NAME: _____		
	DATE: _____		
For Creative Research use only Respondent ID			

Once this questionnaire has been completed, it constitutes sensitive personal data – please see notes at the end regarding how it should be treated

Q1. We are interested in talking to professionals who currently conduct **non surgical** cosmetic procedures privately for **cosmetic reasons**. For this study, we are not including cosmetic procedures carried out for medical reasons/because they are clinically indicated, either via the NHS or privately. Do you personally currently conduct any of the following procedures for cosmetic reasons? **RECORD ALL CURRENTLY CONDUCTED**

Recruiter please note:

We are **ONLY** interested in non surgical procedures but respondents who conduct **BOTH** surgical and non surgical procedures are eligible.

We need to speak to the practitioner who conducts the procedures – if it is someone else within their practice please ask to speak to that person and ask them to participate in the research.

Injectable cosmetic treatments such as Botox or dermal/soft tissue fillers	1	Please recruit a spread
Chemical peel	2	
Microdermabrasion	3	
Laser skin resurfacing	4	
Laser hair removal	5	
Cosmetic dental treatments such as teeth whitening or veneers#	6	
Any other treatment or procedure not listed above – please record and check eligibility with office	7	

No practitioner to be recruited conducting solely cosmetic dental treatments – please aim to recruit dentists who are also conducting other non surgical procedures as well as cosmetic dental treatments

Q2. Which **ONE** of the following best describes your current practice?

I regularly conduct cosmetic procedures for cosmetic reasons	1	
I occasionally conduct cosmetic procedures for cosmetic reasons	2	
I rarely conduct cosmetic procedures for cosmetic reasons	3	No more than 2 to rarely conduct cosmetic procedures for cosmetic reasons

Q3. What is your current job title/role? What is your area of speciality? Record fully in respondents own words and then code below		
Doctor – GP	1	
Doctor – other (record fully)	2	
Nurse/nurse practitioner	3	
Dental Practitioner	4	
Beauty therapist	5	
Other – please record full details and check eligibility with the office	6	
Q4. Where do you carry out these cosmetic procedures? Code all that apply		
in a general surgery/practice	1	
in a private clinic	2	
in a dental practice	3	
in a private hospital	4	
in a beauty salon	5	
in a spa/health club	6	
in a bespoke high street outlet dedicated to non-surgical cosmetic procedures	7	
Other: please record full details	8	
For doctors please ask Q5		
Q5 How much of your time is spent in direct patient care as opposed to training or administration?		
Write percentage:	%	If over 60% of time spent in direct patient care – continue If less than 60% of time spent in direct patient care - close
Q6 Record gender		
Male	1	No quotas but aim for a spread
Female	2	

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Anyone from the client organisation who listens to/watches/reads the recordings/transcripts will sign an undertaking that they will respect the anonymity of those taking part.

Any other material or information generated by you, such as ideas written down on paper, will be subject to the same strict controls.

You have the right to **withdraw your consent** at any point in the interview/discussion. You may also withdraw from the interview/ discussion at any point. Please sign to indicate your agreement with this procedure.

Recruiter Guidelines

Depth interviews of 1.5 hours duration with Practitioners

You will be given your precise quota in terms of the types of professional to recruit by the office. This is likely to include

- doctors/dentists conducting non-surgical cosmetic interventions
- nurses involved in conducting/assisting with non-surgical cosmetic interventions
- dentists involved in conducting cosmetic dentistry
- beauty therapists or equivalent carrying out non-surgical cosmetic interventions

All respondents should currently conduct **non surgical** cosmetic procedures privately for **cosmetic reasons**. We are not including cosmetic procedures carried out for medical reasons/because they are clinically indicated, either via the NHS or privately (e.g. through BUPA).

However:

- Practitioners who carry out BOTH non surgical and surgical procedures are eligible
- Practitioners who carry out cosmetic procedures BOTH for cosmetic reasons and because they are clinically indicated are eligible

Non-surgical interventions include:

- Injectable cosmetic treatments – e.g. Botox (Botulinum toxin type A) and dermal/soft tissue fillers
- chemical peel
- micro dermabrasion
- laser treatments e.g. hair removal, skin pigmentation correction, vein treatment, laser skin resurfacing
- Cosmetic dental treatments such as veneers or teeth whitening.

Please ensure that a spread is achieved of those conducting injectable treatments, chemical peels, microdermabrasion, laser treatments (Q1).

No practitioner to be recruited conducting solely cosmetic dental treatments – please aim to recruit dentists who are also conducting other non-surgical procedures as well as cosmetic dental treatments – injectable treatments are most likely.

We wish to speak to the person carrying out the cosmetic procedures, not to someone else within their practice.

No more than 2 to rarely conduct cosmetic procedures for cosmetic reasons (Q2).

Please record where the respondent carried out the cosmetic procedures (Q4).

No doctors recruited to spend less than 60% of their time in direct patient care (Q5).

Please recruit a mix of male and female respondents (Q6).

Please check with the office if there are any questions regarding the eligibility of respondents on the basis of their job title.

Incentives

The following incentives can be offered:

Doctors - £150

Dentists - £120

Nurses/equivalent - £65

Beauty therapists/equivalent - £50

If you are unsure of the level of incentive to offer a practitioner please contact the office.

Data Protection and Confidentiality

Please make sure every respondent has read Card D and given their signed consent.

Front Page

Please complete the details on the front page:

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- respondent's signature indicating agreement with how the information they provide will be used
- the method you have used to find people – if you are using your own database please remember the restrictions on previous attendance
- the recruiter declaration.

Data Security

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If instructed to do so, on the day of the interview/group, you should take all the questionnaires to the venue in an envelope and hand them over to the moderator in person. If someone else is hosting the interview/group on your behalf, you should ensure they comply with these instructions. If for any reason this is not possible, you should send the completed questionnaires to our offices at the address at the bottom of the page using **Special Delivery** - you must not use the ordinary post.

Good luck!

11.3 Discussion Guides

11.3.1 Workshops with the public

Introduction

- Moderator introduction – purpose of the research, reiterate confidentiality, explain about recording etc, outline the agenda for and focus of the discussion
- Respondents briefly introduce themselves: first names, age, family circumstances, what they do for a living

Initial Perceptions Regarding Regulation of the Cosmetic Industry

- Moderator to explain that we are interested in their views regarding the level of regulation that should be in place for the cosmetic procedure industry. By regulation, we mean rules that are laid down by the government or by the authorities it has appointed. If these rules are not followed, there are repercussions such as being stopped from practising or even legal action.
- Explain that we are not going to discuss this in detail now but that we would just like to start by getting a simple overview of their views
- All respondents to be given an individual sheet on which to answer the following question (NB to be repeated at the end of the discussion)

Based on what I know right now, I think that

- The cosmetic procedure industry should be more tightly regulated than it is at present
- The amount of regulation in the cosmetic industry is probably about right
- There is probably too much regulation of the cosmetic procedure industry
- I really don't know

Awareness and Perceptions of Cosmetic Procedures

- The group is given a **series of cards with the procedures** on them and asked to set them out on the table in groups in any way that makes sense to them. We will explore reasons for the groupings, what qualities define/describe each and differentiate them from others.
 - Moderator to use the groupings made to explore perceptions regarding surgical versus non-surgical procedures, invasive versus non-invasive procedures – what do they understand by these terms; do they make sense as a way of dividing up the procedures
- What are the benefits/advantages of these procedures, why might people want to have them, what might their motivations be
- Self completion exercise (NB to be repeated at the end of the discussion) – respondents are given a list of the cosmetic procedures and asked to rate each on a scale of 0 to 10 where 0 is not at all risky and 10 is extremely risky
- The group is then asked to return to the groupings they have made – how would they group them on the basis of the degree of risk associated with that procedure. We will explore the perceived level of risk, how respondents are defining risk, how respondents discriminate between procedures on the basis of risk. **This 'map' will be used as a reference point thro' out the discussion so leave it on the table or if it helps, write the groupings up on the flip chart**

- What do these different levels of risk mean in terms of the protection needed for people having these procedures – are they all the same, are different levels of protection needed for different levels of risk?
- Each participant is given **a list with a brief description of each of the main procedures** of interest (**stimulus 1**) and these are compared with what they already knew. Any surprises, any they might consider/ have considered, for example, any that appear more/less risky to require more/less protection than they had imagined. Why is that? **Make changes to ‘risk map’ if necessary.**

The Cosmetic Procedure ‘Journey’

- Moderator explains that we would now like to work together through the journey that someone might go on if they were thinking about and then going through a cosmetic procedure (explain that we know that not everyone is likely to follow this path and show **a diagram of the journey** with its milestones so the group can see where they are going). We want to hear what they would expect to happen at each stage and what they would like to happen, and to compare this to the current situation where relevant.

Finding out about cosmetic procedures and deciding whether the cosmetic route is the right one

- Imagine they are considering having a cosmetic procedure – where would they go for information/where have they looked for information in the past
- Who would they expect to provide this information, who do they think should provide it, via which channels?
 - If there are considerers in the group, explore how they went about informing themselves – what information did they look at, from where, what was most influential, what was most useful, what if anything was unhelpful/misleading?
- To what extent are they aware of advertising of cosmetic procedures - do they think there is a lot, a little, too much, too little. Are any mediums (e.g. press, magazines, email, texts) more or less suitable for advertising cosmetic procedures and why?
- What might be the benefits and disadvantages of advertising cosmetic procedures?

Show **advertising stimulus (includes examples that illustrate with a number to call, free consultation, incentives to call, incentives to decide; (stimulus 2)** – spontaneous reactions to what they see

- Prompt for views on
 - free consultation,
 - financial incentives e.g. 0% finance packages etc,
 - packages of treatments together (e.g. you go into get a boob job and they offer nose job too at a discount)
 - lifetime aftercare guarantee
 - time limited deals (does this make them less likely to shop around/take time to consider)
- When they see advertising like this with a number to call – who do they imagine they are talking to, what level of expertise would the person the other end of the phone have?
- And who do they think will be carrying out the procedures covered in the adverts? In what setting?
- Should there be a ban on advertising cosmetic procedures – why/why not, all procedures or just some, all channels or just some, all providers or just some?

Deciding to go ahead and with whom

- What would happen next? What do they expect / hope the next stage of the process will be – eg. go for a free consultation, do some more research - what information are they looking for / what else might they look for (eg. how impressive the setting is, who they see at the consultation etc). Would they go to more than source?
- What information would they want to help them decide whether to go ahead
 - eg. the risks associated with the procedure
 - the safety of the devices or materials used
 - how long the devices/ treatments will last (are they aware of the 10 year life of implants). Probe in particular about whether they would look into the type of implant in the case of breast enlargement.
 - the cost of the procedure – how would they judge whether the procedure was reasonably priced; in the case of breast implants, would they think about the cost of replacing them in the future
- Do these apply across the 'risk map' or might they vary depending on level of risk ie. **Probe for surgical vs non-surgical procedures**
- Looking at the 'risk map', what sort of practitioner would they expect to be able to carry out each of the procedures. What skills/ training would equip them to carry each procedure out
- **Looking at a list of practitioners (stimulus 4)** pick out the ones that have not been covered so far - What do they understand by these titles – which procedures might they be able to carry out and why? What level of training would they expect them to have to enable them to do this (list covers surgeon, GP, cosmetic doctor, aesthetic doctor, anaesthetist, nurse, dentist, beauty therapist, cosmetic practitioner). If necessary, prompt on a beauty therapist administering dermal fillers
- Should titles such as 'Aesthetic Doctor' or 'Cosmetic Practitioner' be allowed?
- What information would they like to know about the practitioner that was going to perform a procedure on them? What information would they expect/want to be available to enable them to make an informed choice, what if anything should be required/regulated?
- Explore the importance of information on
 - the training the practitioner has received, whether it should be specialist training specific to the procedure they are carrying out. Should doctors or surgeons have to state the area of medicine they qualified in, eg GP or vascular surgery? Should they be required to have specialist training in particular cosmetic procedures?
 - the letters they have after their name to show their qualifications – **ask for spontaneous views then show list of examples** what do they think they mean? How do they make them feel? Are they helpful?
 - the experience of the person performing the cosmetic procedure – how long they have been performing this for, how many times they have carried out that particular procedure, their success rate
 - their membership of professional bodies and hence meeting the professional standards set by those organisations. Show names of organisations Have they heard of The British Association of Aesthetic Plastic Surgeons (BAAPS), the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), the British Association of Cosmetic Dentistry (BACD) and the British Association of Beauty Therapy and Cosmetology (BABTAC)

- What do they think it means to be a member of these sorts of bodies? **Explain what membership means if time [see end of topic guide]** Is this sufficient?
- who they are employed by, whether they are also employed by the NHS or not
- How would they find out this information, whose responsibility do they think it should be to find this out, should it be provided automatically, by whom

Stimulus re the different levels of training/qualification of different types of practitioner (stimulus 5) is shown

- Explore their views on the level of required training/ competence/ experience, on the information the prospective patient should be told
- Prompt/explore views regarding where responsibility should/should not lie to provide information to the patient regarding the practitioner if they want to find out more – the patient, their GP, the Government/Dept of Health, the hospital/establishment where the surgery is taking place, the BMA (British Medical Association), the GMC (General Medical Council), the Royal College of Surgeons, CQC, the practitioner carrying out the procedure – how would the prospective patient most readily access this information, what would reach them
- Explore response to the usefulness of websites like TYCT which, through their websites, direct consumers to practitioners they recommend. How useful do they think these sort of services are for choosing a practitioner? What are their expectations of a website providing such a service, ie. who decides which practitioners might go on it, what checks are carried out, (by whom and how often), how is it funded, what information would they find helpful to be included on such a site? **show screen grab**

Feeling reassured about quality and safety

Explain that we are going to share with them some information about some example procedures and the level of safeguards in place for some of the procedures we have been discussing. These cover both the equipment being used and the setting in which it takes place.

Show stimulus about safety and quality assurance for devices and organisations for different procedures (stimulus 6)

- Explore views on this - is this felt to be adequate, is more/less regulation required?
- Is it right that this should vary in this way? We will refer back to earlier discussions about how they would group the procedures, levels of risk, type of practitioner, setting etc. to see if they have a bearing on the regulatory structure
- How would they expect the standards of private providers and the NHS to compare? Should private organisations meet the standards required of the NHS?

Undergoing a cosmetic procedure (briefly cover the following)

- Imagine now they are at the point of having a cosmetic procedure
- What process should be in place to ensure that the prospective patient gives their informed consent to go ahead with the treatment – explore spontaneous views and probe –
 - what checks should be in place to make sure the patient has been properly informed and has had the chance to be sure they wish to go ahead with the treatment?
 - at what stage should he/she give consent?
- Explore perceived need for

- psychological assessment – making sure that the person having the procedure is doing so for good reasons and does not have unrealistic expectations of what it will do for them (for all patients, which patients?)
- counselling – support in deciding whether having the procedure is the right thing to do or whether another course of action might be better (for all patients, which patients?)
- the level of health checks that should be carried out.
- Explore views on a two stage consent process whereby there is a ‘cooling off period’ after the prospective patient has consented to have the procedure and they then have to give their consent again –
 - is this a good idea, what advantages would it have?
 - what disadvantages might there be?
 - how long should the gap between the two stages of consent be?
- Looking at the ‘risk map’, do their views on the consent process vary?

Follow-up to a cosmetic procedure

- Imagine now that they have had the treatment – what follow-up and after care would they expect to be provided - is there a need for routine follow-up?
- Who do they think should be responsible if there is a need for more after care than expected or something goes wrong, who should be responsible for rectifying the problem – the organisation providing the treatment, the practitioner, the NHS, is it the responsibility of the patient? If they think the practitioner – what happens if they have gone out of business?
 - Explore further - what do they think the role of the NHS should be in this situation. If a cosmetic procedure goes wrong who should pay for further treatment that is needed medically. Explore implications for who should bear this cost
- If they were in this situation and wanted to make a complaint, who would they go to for help and advice, who would they complain to – what should be in place to protect someone in this situation?
- What insurance arrangements should the practitioner/organisation have in place? Should there be a scheme like ABTA in the travel industry for organisations offering cosmetic procedures?
- Refer to ‘risk map’ - Any differences for other types of cosmetic procedure in terms of level of follow-up, what happens if things go wrong, need for insurance etc.
- Following on from any views raised spontaneously during the group, as appropriate – have they heard any of the debate regarding PIP breast implants – what have they heard, what impression did it give/leave them regarding the cosmetic procedure industry, what opinions did they have on the information they have heard, what implications, if any, were there regarding protection for those undergoing cosmetic procedures in the future, any changes that are needed
 - As needed, explain that the NHS had to step in and remove implants from some of those women who had them fitted (NB either because the provider would not/could not provide the service or because the patient was unwilling/unable to pay for removal) – what are their views on this, is this right, who should have borne the cost of this removal?

What other safeguards should be in place -

- Explain that the NHS has registers of certain medical devices, for example pacemakers or artificial hip joints, whereby they collect information on operations where these devices are inserted and monitor the performance of the devices. If a problem with a particular device comes to light the registers mean patients can be traced.
- What are their views regarding the idea of setting up national registers of patients /implants in order to be able to trace patients should a problem occur –
 - what barriers might there be to setting up such registers (eg. women unwilling to have their details recorded as having breast implants)
 - what benefits would they provide
 - who should fund them?
 - should women have the right to opt out of being on the register?
 - is this an area where there should be requirements regarding notifying the appropriate Authorities that a procedure has taken place/ when there is a problem with a procedure – what obligations should there be, upon whom?
 - would they want their details on a register so they could be contacted in case there was a safety issue?

Areas needing change/Summary of views

- Looking back at the journey, what are the points at which they feel most concern, or where they think priority needs to be given to changing things e.g.
 - the Information that should be provided
 - the required qualifications, training and experience of practitioners, membership of professional bodies
 - the processes that practitioners must adhere to
 - safeguards for patients?
- Finish with repeated individual questionnaires to track if views have changed as a result of the discussion
 - perceived risk associated with different procedures
 - attitude to regulation in the industry

BAAPS

Not for profit set up to advance education and best practice in aesthetic plastic surgery for the benefit of the public. It acts in the interest of its members, all of whom are in private practice. About 230 surgeons are registered with it. They undergo background screening including of their listing on the General Medical Council (GMC). Members also have to return an annual audit of their work. Public can search for members on its website.

BAPRAS

Again, its aim is to advance education in all aspects of plastic surgery. It holds scientific meetings, runs training courses, and owns the Journal of Plastic Reconstructive and Aesthetic Surgery.

BACD

British Association of Cosmetic Dentistry was set up by dentists operating in the field who wanted to share their knowledge. It provides a forum for dentists and lab technicians plus other dental professionals to share knowledge and experience. Accreditation is possible but not compulsory for members. It involves submission of before and after pictures, followed by a Viva exam.

BABTAC

The Association of Beauty Therapy and Cosmetology is not for profit. Prospective members have their qualifications vetted to ensure they meet national/international standards and members have to work to a code of ethics and accepted good practice in terms of the treatments and therapies they offer and their relationships with their clients.

11.3.2 Depths with patients and those considering cosmetic interventions

The first three sections of the guide and the last section are largely the same as for the discussions with the public.

Experience of Cosmetic Procedures

- Which of the procedures on the list has the respondent ever had/considered (NB moderator – double check against recruitment profile to make sure that all are mentioned) and why
- (NB please focus first on the procedure the respondent has been recruited for – if others have been had/considered please compare throughout whether their experience/views are any different for the other procedures they have either had or considered)
- Ask the respondent to give a very brief overview of the steps they went through (as a list – NB moderator to write the list as numbered steps so the respondent can see what is needed, don't expand at this stage)
- The moderator will reflect these steps in using the following guide to explore their experience, keeping in mind that we are interested in their experience so far as it relates to the issues surrounding regulation of the industry.

Finding Out About Cosmetic Procedures

- When and how did they first start thinking about having the procedure – how did they know it existed, how did they first start thinking it was something they might have, where did that information/thought come from, what influenced them, what prompted them to look into it
- What did they do, who did they speak to, did they talk it through with anyone, take any advice at this stage
- What opinions did they hear, take note of at this early stage, how did family and friends react, did they talk to a healthcare professional (e.g. their GP) at all, if so, what advice/information did they give them – what influenced them in their decision to go ahead/find out more, in what way
- How did they go about getting information about the procedure – where did they look, what did they look at – explore channels, any media/websites/advertising that were looked at/had an influence, other sources of information used – what was found most/least useful, what influenced them/did they take into account, what if anything was unhelpful/misleading, how did the information/advertising make them feel
- Was it difficult to get information, was there too much/too little information, how did they begin to filter/narrow down the information they found – what went well, what was found difficult, what could have improved their experience/made it easier to find their way through the advertising/information/media in this area
- How do they feel about the advertising of cosmetic procedures in general? What might be the benefits and disadvantages of advertising cosmetic procedures?

- Very briefly show **advertising stimulus (stimulus 2)** – spontaneous reactions to what they see
- Did they respond to any adverts they came across when deciding whether to go ahead with an intervention including any online?

IF YES

- What response did they get, if they phoned who did they speak to, what was their role, what information/advice did they give them, how did this person make them feel – if reassured, what was it that reassured them/gave them confidence
- Were they offered any incentives or deals to have the procedure – what were they offered, how did they respond to this, how did it make them feel? Depending on their experience/what has been said, explore views as needed on approaches such as
 - free consultation,
 - financial incentives e.g. 0% finance packages etc,
 - packages of treatments together (e.g. you go into get a boob job and they offer nose job too at a discount)
 - lifetime aftercare guarantee
 - time limited deals (does this make them less likely to shop around/take time to consider)

ASK ALL

- How did they/were they intending to fund the procedure – were they offered any financial packages/the opportunity to borrow the money, explore the extent to which these were seen/offered/influential/their views on them
- Should there be a ban on advertising cosmetic procedures – why/why not, all procedures or just some, all channels or just some, all providers or just some?

Choosing a Practitioner

- How did they go about choosing someone to conduct the procedure? What types of practitioner did they see offering the procedure, what types did they consider?
- **NB Considerers** – did they look into who might conduct the procedure, did they go and see anyone/have a consultation with anyone – explore based on their experience where appropriate. If not explore what they would do/their opinions.
- What did they want to know about the practitioner? What information did/would they look for regarding the practitioner, did they compare practitioners - if so, on what basis, if not, why was this, what reassured them regarding the practitioner they chose, how did they judge their capabilities/suitability to carry out the procedure?
- Did they look at any websites/other sources of information that compared practitioners – which were they, how did they influence them, what would have been more helpful/enabled them to compare practitioners more easily, explore whether websites that recommend practitioners were looked at, their views on this, on voluntary sites versus regulated lists of practitioners
- What went well, what was found difficult, what could have improved their experience/made it easier to assess the practitioner
- Probe as appropriate/necessary in more detail - what information did they look for/what was available, from where, how important/influential was this information - what was useful/what could have been better/what would they have liked that was not available with regard to;

- the training the practitioner had received, whether they were specialists in that cosmetic procedure. Explore whether they think doctors or surgeons should have to state the area of medicine they qualified in, eg GP or vascular surgery? Should they be required to have specialist training in particular cosmetic procedures?
- the letters they had after their name to show their qualifications – did they look for this, what letters were they looking for, what would they recognise and be reassured by; **show list of examples** do they recognise any of them? what do they think they mean? How do they make them feel? Are they helpful?
- the experience of the person performing the cosmetic procedure – did they look into how long they have been performing this for, how many times they have carried out that particular procedure, their success rate
- their membership of professional bodies and hence meeting the professional standards set by those organisations. Have they heard of The British Association of Aesthetic Plastic Surgeons (BAAPS) and the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), the British Association of Cosmetic Dentistry (BACD) and the British Association of Beauty Therapy and Cosmetology (BABTAC)
- What do they think it means to be a member of these sorts of bodies? **Explain what membership means if time [see end of topic guide]** Is this sufficient?
- who they are employed by, whether they were also employed by the NHS or not
- Did they try to find out more about any of these things – where did they look for that information, if not, where would they look, who should provide this information
- Prompt/explore views regarding where responsibility should/should not lie to provide information to the patient regarding the practitioner if they want to find out more – the patient, their GP, the Government/Dept of Health, the hospital/establishment where the surgery is taking place, the BMA (British Medical Association), the GMC (General Medical Council), the Royal College of Surgeons, CQC, the practitioner carrying out the procedure – how would they most readily access this information, what would reach them
- Explore response to the usefulness of websites like TYCT which, through their websites, direct consumers to practitioners they recommend. How useful do they think these sort of services are for choosing a practitioner? What are their expectations of a website providing such a service, ie. who decides which practitioners might go on it, what checks are carried out, (by whom and how often), how is it funded, what information would they find helpful to be included on such a site? **show screen grab**

Stimulus re the different levels of training/qualification of different types of practitioner (stimulus 5) is shown

- Explore their views on the level of required training/ competence/ experience; should doctors or surgeons have to state their area of specialism, should they be required to have specialist training in particular cosmetic procedures. Did they encounter/use titles such as ‘Aesthetic Doctor’ or ‘Cosmetic Practitioner’ – what do they think about these job titles, what do they tell them, should they be allowed?

Feeling reassured about quality and safety

- How did they assess the quality of the procedure, what information was available to help them feel reassured about the procedure in terms of its quality, how safe it was for them

- How did they expect/find the standards of private providers and the NHS to compare? Did they expect private organisations to meet the standards required of the NHS/to exceed them, why is this?
- What information and advice (if any) were they given or did they seek regarding safety, or regarding the risks involved, how did this information influence or affect them/their decision making. Explore the extent to which they were advised regarding
 - the risks associated with the procedure
 - the safety and nature of the devices or materials used
 - how long the devices/ treatments will last (are they aware of the 10 year life of implants). Probe in particular about whether they did/would look into the type of implant in the case of breast enlargement.
 - in the case of breast implants, would they think about the cost of replacing them in the future

Explain that we are going to show them some information about the level of safeguards in place for different procedures. These cover both the equipment being used and the setting in which it takes place.

Show stimulus about safety and quality assurance for devices and organisations for different procedures (stimulus 6)

- Explore views on this - is this felt to be adequate, is more/less regulation required? Explore views on the differences between procedures, the standards for the procedure they had/considered

Undergoing a cosmetic procedure

Patients

- What process of assessment/evaluation that they were suitable for the treatment did they have - what checks did they have, what were they asked, did they have counselling/other assessment, were they asked about why they had chosen to have the procedure
- What process did they go through in terms of giving their consent for the procedure to go ahead - explore in detail with patients – at what point did they sign to give consent to their procedure, at what point did they pay for the procedure, were they given opportunities to reflect, did they feel they could withdraw if they wanted, were they at any point worried about losing their money
- At what stage did they give the final go-ahead/when did they feel they were committed to the treatment – did they feel under pressure at any point, in what way, what was the reason for/source of the pressure felt
- Did they have any concerns at this point, what were they, did they discuss them with the practitioner, how were these concerns addressed

Considerers

- We will focus here on any experience they have had in terms of consultation/counselling given; if they have not gone this far, considerers will be asked about what they would expect/want to happen.
- What process should be in place to ensure that the prospective patient gives their informed consent to go ahead with the treatment – explore spontaneous views and probe – what checks should be in place to make sure the patient has been properly informed, has had the chance to be sure they wish to go ahead with the treatment, at what stage should he/she give consent?

- What process do they think is necessary to make sure the patient has been properly informed about the treatment and has given their consent? Explore perceived need for
 - psychological assessment (for all patients, which patients?)
 - counselling (for all patients, which patients?)
 - the level of health checks that should be carried out.

All

- Explore views on a two stage consent procedure whereby there is a 'cooling off period' after the prospective patient has consented to have the procedure and they then have to give their consent again – is this a good idea, what advantages would it have, what disadvantages might there be, how long should the gap between the two stages of consent be?

Follow-up to a cosmetic procedure

Patients

- What follow up did they receive following their procedure – explore what follow up/aftercare was provided, by whom, whether they felt this was adequate, what if anything could have been better
- Did they experience any problems following their treatment
- If so, what did they do
 - who did they go to, what action was taken – did they return to the original practitioner, go to the NHS, why
 - what support or advice did they get/from whom, what helped them
 - did they complain or contact the authorities, why/why not, who did they contact, why them, with what results
 - what recourse did they feel they had, why
 - how was the problem resolved, who was it resolved by
 - what could have helped them deal with this situation
 - looking back, what might have prevented the problem from occurring, what changes in the process they went through could have protected them/prevented the problem they experienced

Considerers

- Imagine now that they had/have gone ahead and had the treatment they were considering - what follow-up and after care would they expect to be provided - is there a need for routine follow-up?

All

(as appropriate following on from discussion with patients regarding any problems experienced)

- Who do they think should be responsible if something goes wrong, who should be responsible for rectifying the problem – the organisation providing the treatment, the practitioner, the NHS, is it the responsibility of the patient?
 - Explore further - what do they think the role of the NHS should be in this situation, if a cosmetic procedure goes wrong who should pay for further treatment that is needed medically, explore implications for who should bear this cost

- If they were in this situation and wanted to make a complaint, who would they go to for help and advice, who would they complain to – what should be in place to protect someone in this situation?
- What insurance arrangements should the practitioner/organisation have in place? Should there be a scheme like ABTA in the travel industry for organisations offering cosmetic procedures?
- Following on from any views raised spontaneously, as appropriate – have they heard any of the debate regarding PIP breast implants – what have they heard, what impression did it give/leave them regarding the cosmetic procedure industry, what opinions did they have on the information they have heard, what implications, if any, were there regarding protection for those undergoing cosmetic procedures in the future, any changes that are needed
 - As needed, explain that the NHS had to step in and remove implants from some of those women who had them fitted (NB either because the provider would not/could not provide the service or because the patient was unwilling/unable to pay for removal) – what are their views on this, is this right, who should have borne the cost of this removal?
- What other safeguards should be in place
 - Explain that the NHS has registers of certain medical devices, for example pacemakers or artificial hip joints, whereby they collect information on operations where these devices are inserted and monitor the performance of the devices. If a problem with a particular device comes to light the registers mean patients can be traced.
 - What are their views regarding the idea of setting up national registers of patients /implants in order to be able to trace patients should a problem occur – what barriers might there be to setting up such registers (eg. women unwilling to have their details recorded as having breast implants), what benefits would they provide, who should fund them? Should women have the right to opt out of being on the register? Is this an area where there should be requirements regarding notifying the appropriate Authorities that a procedure has taken place/ when there is a problem with a procedure – what obligations should there be, upon whom?

Areas needing change/Summary of views

- Taking into account everything that's been discussed, does it make them feel any differently about the industry for cosmetic procedures?
- **(Patients)** Knowing what they now know, would they have gone ahead in the same way or done things any differently (e.g. requested more information – what about?)
- **(Considerers)** Might they reconsider going ahead or approach it in a different way e.g. ask more questions, do more research?
- Overall, what are the points at which they feel most concern, or where they think priority needs to be given to changing things/where is change most needed, where is more regulation required/not required e.g.
 - the information that should be provided
 - the required qualifications, training and experience of practitioners, membership of professional bodies
 - the processes that practitioners must adhere to
 - safeguards for patients?

11.3.3 Paired depths with teenagers

This is an abbreviated and more tailored version of the guide; again it begins and ends in a similar way to the other guides with the public (we have removed those sections from what follows).

Introduction

- Moderator introduction – purpose of the research, reiterate confidentiality, how the information is used/not used, explain about recording etc, outline what is going to happen during the discussion
- Reassure them that if there are any words we use that they don't understand, to tell us and we will try and express them in a different way.
- Respondents briefly introduce themselves: first names, age, year at school, family/siblings, what do they like doing in their spare time, how long have they known each other
- Tell us a famous female that they really admire, why her? If not for physical reasons, what about one that they admire for her looks, why her?

Awareness and Perceptions of Cosmetic Procedures

- The respondents are given a **series of cards with the procedures** on them and asked to work together to set them out on the table in groups in any way that makes sense to them. We will explore reasons for the groupings, what qualities define/describe each and differentiate them from others.
 - Moderator to use the groupings made to explore perceptions regarding surgical versus non-surgical procedures, invasive versus non-invasive procedures – what do they understand by these terms; do they make sense as a way of dividing up the procedures
- Have they heard of these procedures, which ones do they think they know what they are – where have they got that information from, how do people get to know about these procedures – explore influences - media, internet, peers, older girls, parents, family members etc
- Is it something girls their age talk about, what do they say, what have they seen/heard, what impression did it give them? Anything else they have heard about this area – what is that, who/where did they hear it from?
- Do they think that a lot of people have these sorts of procedures? What sorts of people?
- Why might people want to have these procedures, what might their reasons/motivations be? If young people are mentioned, in particular probe for their motivations.
- Self completion exercise (NB to be repeated at the end of the discussion) – each respondent is given a list of the cosmetic procedures and asked to rate each on a scale of 0 to 10 where 0 is not at all risky and 10 is extremely risky
- The respondents are then asked to return to the groupings they have made – can they group them on the basis of how risky they think they are – how are they deciding how risky these are, what kind of things are they thinking about, where has that information come from – family, friends, the media, the internet etc. This 'map' will be used as a reference point throughout the discussion so will be left out

- Do they have any thoughts about what is needed to make sure that the people having these procedures can have them safely – if they look at the different groups they have made, will this be different depending on which procedure it is?
- The participants are given **a list with a brief description of each of the main procedures** of interest (**stimulus 1**) and these are compared with what they already knew. Any surprises, any they might consider/ have considered, for example, any that appear more/less risky to require more/less protection than they had imagined. Why is that? **If necessary adjust 'risk map'**.

Advertising and Information about cosmetic procedures

- Is there advertising or information about cosmetic procedures in the magazines they read, websites or blogs they visit, on Facebook/Twitter/other social media sites, in other media they look at (where) – what have they seen, where, what impression has it given them of the way companies advertise cosmetic procedures/surgery? Does it influence people? In what way?
- Show **advertising stimulus (stimulus 2)** – spontaneous reactions – what do they notice, what impressions does this advertising create, do they think it would influence girls their age, why/why not, if not is there something they have seen that influences girls of their age?
- What effect do they think advertising like this has on the self image and emotions of someone looking at them, of someone who didn't like something about themselves and was interested in cosmetic procedures?
- What might be the good and bad points about advertising cosmetic procedures? Should there be a ban on advertising cosmetic procedures – why/why not, all procedures or just some, everywhere or just in certain places? Or should advertising be limited or controlled in some other way? What about social media – should these procedures be allowed to be advertised on social media/other internet sites, why/why not

Information about the procedure and the people who carry them out

- What sort of information should people be told about the procedure they are thinking of having? For example, taking a breast enlargement and having a dermal filler injected, what should people be told? Prompt if necessary -
 - the risks associated with the procedure
 - the safety of the devices or materials used
 - how long the devices/ treatments will last (are they aware of the 10 year life of implants)
 - the cost of the procedure.

Looking at a list of practitioners (stimulus 4)

- What do they understand by these titles – which procedures would they expect them to be able to carry out and why? – refer to their groupings to explore (list covers surgeon, GP, cosmetic doctor, aesthetic doctor, anaesthetist, nurse, dentist, beauty therapist, cosmetic practitioner). Should titles such as 'Aesthetic Doctor' or 'Cosmetic Practitioner' be allowed? What do they think they mean?
- What information do they think anyone considering having a cosmetic procedure should have to be told about the person carrying it out?
- Explore importance of information on
 - the training the practitioner has received, whether it should be specialist training specific to the cosmetic procedure they are carrying out. Should doctors or

surgeons have to state the area of medicine they qualified in, eg GP or vascular surgery? Should they be required to have specialist training in particular cosmetic procedures?

- the letters they have after their name to show their qualifications – **ask for spontaneous views then show list of examples** what do they think they mean? How do they make them feel? Are they helpful?
- the experience of the person performing the cosmetic procedure – how long they have been performing this for, how many times they have carried out that particular procedure, their success rate
- their membership of professional bodies and hence meeting the professional standards set by those organisations. **Show names of organisations** Have they heard of The British Association of Aesthetic Plastic Surgeons (BAAPS), the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), the British Association of Cosmetic Dentistry (BACD) and the British Association of Beauty Therapy and Cosmetology (BABTAC)? What do they think it means to be a member of these sorts of bodies?
- who they are employed by, whether they are also employed by the NHS or not

Undergoing a cosmetic procedure

- What process should be in place to ensure that the person is sure they definitely want to go ahead with the treatment – explore spontaneous views and probe – what checks should be in place to make sure the person has been properly informed, has had the chance to be sure they wish to go ahead with the treatment, at what stage should he/she give consent?
- Explore perceived need for
 - psychological assessment – making sure that the person having the procedure is doing so for good reasons and is not expecting something from it that is unrealistic (for all patients, which patients?)
 - counselling – support in deciding whether having the procedure is the right thing to do or whether another course of action might be better (for all patients, which patients?)
 - the level of health checks that should be carried out.
- Explore views on a two stage consent process whereby there is a ‘cooling off period’ after the prospective patient has consented to have the procedure and they then have to give their consent again – is this a good idea, what advantages would it have, what disadvantages might there be, how long should the gap between the two stages of consent be?
- Looking at the ‘risk map’, do their views on the consent process vary?

Follow-up to a cosmetic procedure

- What follow-up and after care would they expect to be provided after someone has had the procedure – should the person who conducted it be required by law to follow up/see them again? How does this vary by procedure?
- Who do they think should be responsible if there is a need for more after care than expected or something goes wrong, who should be responsible for putting things right – the organisation providing the treatment, the practitioner, the NHS, is it the responsibility of the patient? If they think the practitioner – what happens if they have gone out of business?

- Explore further - what do they think the role of the NHS should be in this situation. If a cosmetic procedure goes wrong who should pay for further treatment that is needed medically. Explore implications for who should bear this cost
- If they were in this situation and wanted to make a complaint/needed help, who would they go to for help and advice, who would they complain to – what should be in place to protect someone in this situation?
- Following on from any views raised spontaneously, as appropriate – have they heard anything about the debate regarding PIP breast implants – what have they heard, what impression did it give/leave them regarding the cosmetic procedure industry, what opinions did they have on the information they have heard, what changes might be needed
 - As needed, explain that the NHS had to step in and remove implants from some of those women who had them fitted (NB either because the provider would not/could not provide the service or because the patient was unwilling/unable to pay for removal) – what are their views on this, is this right, who should have borne the cost of this removal?
- Explain that the NHS has registers of certain medical devices, for example pacemakers or artificial hip joints, whereby they collect information on operations where these devices are inserted and monitor the performance of the devices. If a problem with a particular device comes to light the registers mean patients can be traced.
 - What are their views regarding the idea of setting up national registers of patients /implants in order to be able to trace patients should a problem occur – what barriers might there be to setting up such registers (eg. women unwilling to have their details recorded as having breast implants), what benefits would they provide, who should fund them? Should women have the right to say they don't want to be on the register?
 - Should there be a process in place so that a record is kept of all procedures that have taken place/ when there is a problem with a procedure – what should have to happen, who should be responsible for passing this information on – the patient or the person carrying it out?

11.3.4 Practitioners

Introduction

- Moderator introduction – purpose of the research, reiterate confidentiality, explain about recording etc, outline the agenda for and focus of the discussion
- Respondent to introduce themselves fully : name, job title/role, overview of their practice, areas of specialism, environment (s) they practise in, general patient population and profile seen
- Are they employed/self employed – if employed who by, (as appropriate to practitioner) do they work solely in private practice or do they also work for the NHS in any capacity

Initial Perceptions Regarding Regulation of the Cosmetic Industry

- Completion of questionnaire about attitude to regulation of the industry.

Cosmetic Intervention Practice

- Moderator shows list of cosmetic interventions of interest – which of these do they personally carry out, are there any others that they are involved in/are carried out at their practice but not by them? (NB moderator – double check against screener to ensure all mentioned/covered)

- Approximately how often do they carry out these procedures?
- What is their patient population like for cosmetic interventions, has this changed over time, in what way?
- What tend to be the motivations of the patients they see, what prompts them to have the interventions they conduct? – explore perceptions of both physical and psychological motivations for having the cosmetic interventions, explore for each intervention conducted
- What kind of enquiries do they get, at what stage in their thinking do patients tend to be, what do they think determines whether they carry on beyond that first enquiry or not, how do they handle enquiries, who handles them?
- Ask to describe their history of conducting cosmetic interventions – when did they first start carrying out these procedures, how has their practice changed/grown over time, which procedures if any have they added to their repertoire, why?
 - what training/qualification have they undertaken in this area, what was conducted originally, what have they added as their practice has grown, do they carry out any CPD in this area, what do they do? – moderator to probe for specific details of training/qualifications, what has been most beneficial to them.
 - what are their views on the quality of training that's available (eg. short courses from manufacturers) and how it is marketed.
- (As appropriate) Have they encountered titles such as 'Aesthetic Doctor' or 'Cosmetic Practitioner' – what do they think about these job titles, are they helpful in defining roles?
- Do they belong to any professional/membership organisations, which ones, what do they see as the benefits of membership? – for them as practitioners, for their patients
- What letters can they put after their name – which do they think are the most helpful for their patients, why?
- What do they think the requirements should be in this area, why, is there a need for more regulation, for more self regulation, why/why not?

Marketing Cosmetic Procedures

- How do they market their services for cosmetic procedures – explore channels, which media they use, whether they have a website (NB get address so we can look at it) as well as other sources of business (e.g. word of mouth) - what do they find most/least useful, what generates the most business for them?
- If possible/appropriate ask to see examples of their advertising/for copies of any brochures used etc
- Do offered any incentives, or deals or run any promotions for their cosmetic procedures – what do they offer, to which patient groups, via which channels? Depending on what has been said, explore views on strategies such as free consultation, incentives to enquire - 0% finance packages etc , packages of treatments together, financial incentives to respond and the extent to which these are found effective
- Do their patients tend to need financial help in undergoing the procedure, how do patients tend to finance procedures, do they experience any problems e.g. with bad debt?

Show advertising stimulus (stimulus 2) – spontaneous reactions to what they see. Prompt for views on

- free consultation,
- financial incentives e.g. 0% finance packages etc,

- packages of treatments together (e.g. you go into get a boob job and they offer nose job too at a discount)
- lifetime aftercare guarantee
- time limited deals (does this make them less likely to shop around/take time to consider)
- Say that they may be aware that it has been suggested that there be a ban on advertising some cosmetic procedures – how do they feel about this, why/why not, all procedures or just some, all channels or just some, all providers or just some?

Quality and safety

- How did they assess the quality of any materials they use, what information is available to them, how do they evaluate quality and safety – of materials, of procedures?
- What improvements, if any would they like to see regarding quality and safety in the cosmetic intervention industry – of materials, of procedures, of any other aspects of the industry?
- What information do they find that patients want to know regarding
 - the risks associated with the procedure
 - the safety and nature of the devices or materials used
 - how long the devices/ treatments will last
 - in the case of breast implants, the cost of replacing them in the future
- Self completion exercise – the respondent is given a list of all cosmetic procedures and asked to rate each on a scale of 0 to 10 where 0 is not at all risky and 10 is extremely risky
- Explore further – how would they group these procedures on the basis of the degree of risk associated with that procedure? We will explore the perceived level of risk, how practitioners are defining risk, how they discriminate between procedures on the basis of risk
- How do these different levels of risk affect practice in the industry – their own, other people's, what do they mean in terms of the protection needed for people having these procedures – are they all the same, are different levels of protection needed for different levels of risk?
- What systems are in place for when something goes wrong with a procedure? How do they advise their patients?
- If there was a safety incident what would they do, who would they tell?
- Who do they ask for advice on performing procedures or if something goes wrong?
- Do they keep records of what treatments or products they've administered to whom?

Explain that we are going to show them some information about the level of safeguards in place for different procedures. These cover both the equipment being used and the setting in which it takes place.

Show stimulus about safety and quality assurance for devices and organisations for different procedures (stimulus 6)

- Explore views on this - is this felt to be adequate, is more/less regulation required? Explore views on the differences between procedures, the standards for different procedures – are these felt to be fair to practitioners, to patients, to support them adequately, explore views on the extent of regulation required in this area

Undergoing a cosmetic procedure

- What process of assessment/evaluation do they go through, what counselling/advice/psychological assessment, health checks do patients need ?
- What process do they go through in terms of gaining patient consent for the procedure to go ahead? - explore in detail – at what point did they sign to give consent to their procedure, at what point do they pay for the procedure, do they find that many patients change their minds, do they have problems with payment for procedures, do they feel both practitioner and patient are adequately protected?
- Explore views on a two stage consent procedure whereby there is a ‘cooling off period’ after the prospective patient has consented to have the procedure and they then have to give their consent again – is this a good idea, what advantages would it have, what disadvantages might there be, how long should the gap between the two stages of consent be?

Follow-up to a cosmetic procedure

- What follow up do they provide following their procedures? – explore what follow up/aftercare is provided, by whom
- What insurance do they have in place – are there policies/procedures available that protect them as practitioners from adverse events, what if anything could be better?
- Who do they think should be responsible if something goes wrong, who should be responsible for rectifying the problem – the organisation providing the treatment, the practitioner, the NHS, is it the responsibility of the patient?
 - Explore further - what do they think the role of the NHS should be in this situation, if a cosmetic procedure goes wrong who should pay for further treatment that is needed medically, explore implications for who should bear this cost
- Following on from any views raised spontaneously, as appropriate – have they heard any of the debate regarding PIP breast implants – what have they heard, what impression did it give/leave them, what impact has it had, any changes that are needed
 - As needed, explain that the NHS had to step in and remove implants from some of those women who had them fitted (NB either because the provider would not/could not provide the service or because the patient was unwilling/unable to pay for removal) – what are their views on this, is this right, who should have borne the cost of this removal?
- What other safeguards should be in place
 - Explain as needed/appropriate that the NHS has registers of certain medical devices, for example pacemakers or artificial hip joints, whereby they collect information on operations where these devices are inserted and monitor the performance of the devices. If a problem with a particular device comes to light the registers mean patients can be traced.
 - What are their views regarding the idea of setting up national registers of patients /implants in order to be able to trace patients should a problem occur – what barriers might there be to setting up such registers (eg. women unwilling to have their details recorded as having breast implants), what benefits would they provide, who should fund them? Should women have the right to opt out of being on the register? Is this an area where there should be requirements regarding notifying the appropriate Authorities that a procedure has taken place/ when there is a problem with a procedure – what obligations should there be, upon whom?

Areas needing change/Summary of views

- Overall, what are their views on the future of regulation in the industry, where is change needed, what is working well at present, explore where is more regulation required/not required e.g.
 - the Information that should be provided
 - the required qualifications, training and experience of practitioners, membership of professional bodies
 - the processes that practitioners must adhere to
 - safeguards for patients?
- Explore their views on regulation versus self regulation in the industry – are there areas where self regulation could be improved, in what ways would they like to see this done?
- Any other changes they feel are needed – to protect patients, to protect practitioners?

11.4 Stimulus for discussion

11.4.1 Questionnaires to capture attitude to regulation and perceived risk

Based on what I know right now, I think that

The cosmetic procedure industry should be more tightly regulated than it is at present	<input type="checkbox"/>
The amount of regulation in the cosmetic procedure industry is probably about right	<input type="checkbox"/>
There is probably too much regulation of the cosmetic procedure industry	<input type="checkbox"/>
I really don't know	<input type="checkbox"/>

Please give each procedure a score from 1 to 10 in terms of how risky you think it is. A score of 1 would mean it is not at all risky, 10 would mean it is extremely risky

Botox	
Dermal/soft tissue fillers	
Chemical peel	
Micro-dermabrasion	
Laser skin resurfacing	
Laser hair removal	
Teeth whitening	
Dental veneers	
Face/neck lift	
Other face/neck surgery	
Cosmetic nose operation – ‘nose job’	
Breast enlargement	
Breast reduction	
Liposuction/ sculpture	
Tummy tuck	
Dental implants	
Laser eye surgery	

11.4.2 Information about procedures

1: Cosmetic procedures: what they are and what they set out to do

Botox	Used for the temporary reduction of facial and neck wrinkles	A small amount of botulinum toxin is injected into muscle, it works by weakening or paralysing certain muscles or by blocking nerves
Dermal/soft tissue fillers	Used to plump out the skin and reduce the appearance of wrinkles. May be temporary or permanent	A series of small injections of collagen, fat, and other tissue fillers and the area is gently massaged
Chemical peel	Used to minimise the appearance of acne, chicken pox, and other scars as well as wrinkles, age spots, freckles etc.	Application of acid to remove old, dead skin cells and promote new skin growth. There are three types of peel; superficial, medium and deep
Micro-dermabrasion	Used to soften fine lines and wrinkles, help smooth coarsely textured skin, decrease the appearance of scarring, decrease pore size, and reduce age spots	Involves the application of tiny rough grains to buff away the surface layer of skin
Laser skin resurfacing	Used for the treatment of wrinkles, sun damage, scars, stretch marks and very fine veins	Laser resurfacing is a technique used during laser surgery
Laser hair removal	Used to remove small and large areas of unwanted hair from the body	Uses a laser beam or intense pulsed light to heat and damage hair follicles. Several treatments may be needed
Teeth whitening	To whiten teeth	Uses bleaching gel sometimes in combination with a laser to speed up the whitening process
Dental veneers	They are used to improve the appearance of discoloured, chipped, worn or gappy teeth.	Dental veneers are wafer-thin, custom-made shells of tooth-coloured materials designed to cover the front surface of teeth. They are stuck to the front of the teeth changing their colour, shape, size or length.
Face/neck lift	Used to smooth skin, remove wrinkles, tighten cheeks etc.	Involves an incision around the hairline and behind the ear, the skin is pulled tight, excess skin is trimmed away and the incisions are closed.

Other face/neck surgery	For example, cheek or chin implants to shape the cheeks or chin, reshaping of the eyelids, pinning back of the ears	
Cosmetic nose operation	Surgery to change the shape of the nose, reposition the bridge, remove bumps or alter the tip	
Breast enlargement	Enlargement of the breasts	Uses fat grafts, saline, or silicone gel implants
Breast reduction	Where required due to back pain, may be performed on the NHS. Men may have their 'man boobs' treated in this way	Removal of skin and glandular tissue to reduce the size of breasts
Liposuction/ sculpture	Fat removal to reduce size and shape the body	Removal of fat deposits by a traditional suction technique or ultrasonic energy
Tummy tuck	Used to reshape and firm the abdomen	This surgery takes several forms but involves an incision across the abdomen, the removal of fat using liposuction, the stretching of the skin, the removal of excess skin and the closure of the incision. The 'belly button' is also often relocated
Dental implants	Alternative to dentures where the root of the tooth has been removed	Usually made of titanium, the implants replace the 'root' of the tooth. They are placed within the jaw bone which grows around the implant to strengthen it. The crown or bridge replaces the actual tooth and fixes into the implant
Laser eye surgery	Used to rectify problems with vision so that people may no longer have to wear spectacles or contact lenses	This surgery uses a laser to permanently change the shape of the cornea

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11.4.4 Practitioner titles, examples of letters after name and professional bodies

Practitioners who might carry out cosmetic procedures

Surgeon

GP

Cosmetic doctor

Aesthetic doctor

Anaesthetist

Nurse

Dentist

Beauty therapist

Cosmetic practitioner

MBBS, BDS, MFDS RCS

MB, CHB, FRCS (Ed), FRCS (Plast).

Dip Pod.M. M.Ch.S. S.R.Ch

JP, MBBS, PGDipMS, CRadP, BTEC (Med Laser), MSRP, MSCPS

BAAPS

British Association of Plastic Surgeons

BAPRAS

British Association of Plastic Reconstructive and Aesthetic Surgeons Discussion Guide

BACD

British Association of Cosmetic Dentists

BABTAC

British Association of Beauty Therapy and Cosmetology

11.4.5 Levels of training/qualifications of practitioners

5: **Qualifications needed to carry out surgical and non-surgical cosmetic procedures**

Surgeons are doctors who have undertaken basic medical training and who go on to specialise in surgery. They spend 2 years training in basic surgery and then 5 or 6 years specialising in a particular type of surgery. If they specialise in plastic surgery, they would then become registered on the Specialist Register of Plastic Surgeons. Only surgeons on this Register can become a member of professional bodies such as BAAPS and BAPRAS.

However, surgeons who specialise in other forms of surgery may perform cosmetic surgery operations. They do not need to have had special training in cosmetic surgery or experience of that type of surgery so for example, a surgeon who usually operates on veins could perform face lifts.

Doctors have to be fully registered as doctors to be able to carry out cosmetic surgery unsupervised outside the NHS (in private practice). They do not have to be surgeons and they do not have to say what kind of doctor they are. Some might call themselves a '**Cosmetic Doctor**' or an '**Aesthetic Doctor**'.

Guidance from the General Medical Council makes clear that doctors are expected to only practise in fields in which they are competent. Currently doctors decide this themselves and the GMC is only involved if there is a complaint.

From December 2012, doctors' competence will be assessed by an annual appraisal that includes feedback from patients and colleagues, review of complaints and information about outcomes for patients.

Dentists are able to work in the private sector once they are registered with the General Dental Council after a 5 year course of study. They are allowed to prescribe the botulinum toxin for Botox injections and some dentists offer such treatments as well as dermal filler treatments.

Nurses undertake at least 3 years of study and practical experience before they qualify and register with the Nursing and Midwifery Council (NMC). The code of conduct of the NMC states that nurses should recognise and work within the limits of their competence. After qualifying, some nurses may choose to specialise in non-surgical cosmetic procedures but they could carry these out without this specialist training.

Beauty therapists typically train for 1-3 years to carry out a variety of treatments. They also study anatomy and physiology, health and safety in the workplace and salon management. The range of qualifications they can achieve may not include training in all non-surgical procedures.

Some non-surgical procedures such as dermal fillers can be carried out by beauty therapists and hairdressers.

Anybody can call themselves a '**Cosmetic Practitioner**'.

Short courses may be offered by the manufacturers of products (like dermal fillers) and machinery (like lasers and intense pulsed light machines) to doctors, dentists, nurses and beauty therapists who wish to buy and use their products.

11.4.6 Home page of Treatments You Can Trust (TYCT) website

The screenshot shows the homepage of the Treatments You Can Trust (TYCT) website. At the top left is the logo for the IHAS Register of Cosmetic Treatment Providers, Quality Assurance Mark. A search bar is located at the top right. A navigation menu includes links for Home, Injectable Treatments, Patient Information, Registration, Links, Blog, and Contact Us. The main content area features a 'Welcome' message, a 'Which Treatments' section, and a 'News & Announcements' section. A central banner encourages users to look for the TYCT Quality Assurance Mark before booking and to find their registered cosmetic injectable provider.

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Welcome

to Treatments You Can Trust Web Portal.

We are the Department of Health backed register of regulated cosmetic injectable providers managed by the Independent Healthcare Advisory Service (IHAS). This site is designed to provide information to patients considering injectable cosmetic treatments

To register as a treatment provider on this site click [Registration](#) on the bar above.

Look for the **TYCT Quality Assurance Mark** before you book!

Find your **TYCT Registered** Cosmetic Injectable Provider here!

Which Treatments

If you are considering cosmetic injectable treatments then this site is intended for you.

We can guide you to treatment providers who have been checked and registered by TYCT. Registered Providers are fully qualified, trained and insured and they will deliver treatments which comply with our standards delivered in facilities which are clean, hygienic and comfortable.

Click the link above for [injectable Treatments](#) for more information.

News & Announcements

New Registrants in Your Area

August 2012

Stock Road Dental Surgery in Essex and Shiphay Dental Practice in Devon have been granted the Quality Assurance Mark. Search the register to find qualified providers and clinics near you.

News Release

25 July 2012

6: Safety and Quality Assurance for Cosmetic Interventions

Breast Implant

A breast implant is classed as a medical device and must carry a CE (European Conformity) marking showing it has been checked by an EU body and that it meets the requirements for that type of device. Once this mark is awarded the implant can be marketed in all EU countries without further controls. The manufacturer must monitor the long term safety and performance of the implant.

As well as the qualifications of the doctor themselves, as a surgical procedure, the hospital or other organisation for whom the doctor works will be regulated by the Care Quality Commission (CQC) and will need to meet their requirements.

Injectables

Botox is a prescription only medicine and must therefore have been approved by the MHRA (Medicines and Healthcare products Regulatory Agency). Research in the form of clinical trials would have provided information about the safety, efficacy (how well it works) and any known side effects. However, **dermal fillers** may or may not be regulated as medical devices depending on whether they are said to be for medical use or not. They may therefore be controlled in the same way as any general product for consumer use, eg. a paperclip or a pair of shoes.

An organisation injecting substances in order to enhance someone's appearance does not have to be regulated by the Care Quality Commission (unless they also carry out surgical procedures) but will be covered by the general Health and Safety at Work regulations.

Chemical Peel

Chemical peels fall outside of the cosmetic products regulations.

An organisation providing chemical peels would also come under the general Health and Safety at Work regulations.

Laser Hair Removal

The laser beam used to damage the hair follicles has to be CE marked as a medical device because it also has a medical purpose, as it can be used for surgical procedures. However, other systems used for hair removal in the same way (intense pulsed light) would not be CE marked as they are usually only used for non-medical procedures.

There is not a single scheme for regulating or licensing clinics offering cosmetic procedures in England but clinics would come under their Local Authority licensing requirements. They would also come under the general Health and Safety at Work regulations.

Liposuction

The equipment used in liposuction does not have to carry a CE mark if the manufacturer does not claim it has a medical purpose. If it is used in cosmetic procedures, then it is regulated under the Health and Safety at Work Act.

Liposuction is a surgical procedure and therefore has to be carried out in a setting that is regulated by the CQC.

Face Lift

This is a surgical procedure and therefore has to be carried out in a setting that is regulated by the CQC.

11.5 Instructions for follow-up interviews with selected workshop participants

Dear research participant

Thank you very much for taking part in the group discussion about cosmetic procedures and for agreeing to take part in a further telephone interview. The aim of the interview is to explore your views after you have had a little more time to think about the issues discussed.

The interview will be conducted by the person who ran the discussion and they will arrange a convenient time in the next few days with you. The interview will last about 30 minutes and we can offer you a further £15 as a thank you for your time – please make sure that the interviewer has your full address so that we can send this to you after the interview.

At the end of this discussion, the group facilitator should make sure you have a copy of the information you looked at during it

- A list of all the cosmetic procedures, with descriptions of what they are
- A list of the different types of practitioners
- Information about the qualifications needed to carry out surgical and non-surgical procedures
- Information about safety and quality assurance for cosmetic interventions.

Please could you re-read this information, and think about the following questions in preparation for discussing your own views on each of them. If you wish, please discuss them with friends and family so you can tell us their views but we are particularly interested in what you have to say after having the opportunity to think about the issues a little more.

1. For which particular cosmetic procedures, if any, is there a need for greater protection for the people who have them? Why do you think these procedures in particular, need more protection?
2. Which particular cosmetic procedures don't need any more regulation – where what is in place seems adequate? Why do these procedures seem to have enough protection in place?
3. What differences are there between surgical and non-surgical procedures? Is the level of regulation or protection required the same or different? In what ways?
4. Are the qualifications that practitioners need in order to be able to carry out surgical and non-surgical procedures sufficient? Which, if any, practitioners are you concerned about in terms of their qualification, experience or ability to carry out these procedures?
5. Is the safety and quality assurance in place for cosmetic procedures sufficient? What, if any, are areas that concern you and where you feel more should be done to ensure the safety and quality of procedures?
6. Do you have any further ideas about monitoring procedures and practitioners? In particular, how should information be kept about patients or procedures so that they can

be contacted if there is a problem (like the setting up of a national register that was talked about during the discussion)?

7. Is there anything else you would like to raise as an issue or concern in terms of cosmetic procedures?

Thank you for your help with this important research. We look forward to speaking to you again.

Date of interview:

Time of interview:

Name of researcher: