Just as in all societies, all cultures have at one time or another constrained women’s bodies, similarly all religions have dictated women’s dress and demeanour, too. Religions have directed women to cover their heads, and their hair. Hair has been classed as provocative, ungodly, and fated to send men into frenzies … Up until the 1960s, the Roman Catholic Church and the Church of England required women to wear hats to church, and Judaism continues to direct women to cover their heads: wigs replace or camouflage women’s hair still … \(^1\)

1. **Her Crowning Glory**

Historically, a woman’s hair has been at the heart of women’s attraction. Lustrous locks, twirling curls, sweeping bangs, short bobs, blonde beauty, burnished manes, Titian tresses, brunette mops, gamine cuts, glossy ringlets, jet black braids, cornrows, and even topknots, plaits and short-cropped, flat-chopped fringes fill the pages of romance novels, abound in period and contemporary television and feature films, and are seen on the streets or emerging from beauty parlours in real life. Psychologists contend that sexually alert women employ their hair wantonly, flipping tantalising strands over one shoulder, cheekily twirling wisps around a suggestively cocked finger, or dipping their heads to look up from under seductive fringes, flirting. Monica Moore and Diana Butler’s research, observing women’s behaviour in a variety of student recreational and relaxed settings, identified eleven techniques they attributed as designed
to appeal to men’s sexual interest. Of these eleven methods, two placed hair in the forefront as alluring. The ‘head toss’ saw the woman flipping her head backward, then briefly lifting up her face. For the ‘hair flip’, the woman ‘raised up one hand, pushing it through her hair’. Women who engaged in these practices were readily approached by men, whilst women who did not were more likely to be left alone. Conventional attractiveness was not a lure on its own. Less attractive women received male attention over and above that directed to those with eye-catching features or a more striking appearance, so long as they employed one or other or more of these identified practices.

That the women’s hair flipping or head tossing might be unconscious, force of habit, or simply a consequence of fringes or strands falling into the eyes rather than flirting, has some force. The truth may be that at least in some instances men project their own desires onto these actions, interpreting them wrongly as seeking male attention. For the hair signifies danger, too.

That women’s hair is provocative, driving men mad with desire, lies at the root of the insistence that it be hidden from view. Religion and culture have mandated the covering of women’s hair, even at the pain of death. During the Inquisition, when witches were burned at the stake, Heinrich Kramer and Jacob Sprenger’s *Hammer [or Anvil] of Witches*, published in 1486 and followed by many more editions, classified all women as evil, or at least potentially so. Hair and dress featured at the heart of women’s wickedness. Citing Proverbs xi, ‘As a jewel of gold in a swine’s snout, so is a fair woman which is without discretion’, Kramer and Sprenger declared women perfidious in the tradition of St Paul who, in his Letter to Timothy recorded in 1 Tim. 2:9–12, declared that women should ‘come with shamefacedness and sobriety; not with braided hair, or gold, or pearls, or costly array …’. This chimes with 1 Corinthians 11:6, ‘If a woman does not cover her head, she should have her hair cut off; and if it is a disgrace for a woman to have her hair cut or shaved off, she should cover her head’. Yet the Bible was not alone. The modesty required of women adherents to Islam at one time demanded that they repudiate the wearing of hair tied on atop the head in buns or displaying a side parting. This, it was considered, would be to adopt the style of Western women, non-believers, or prostitutes. Constructing a bun on the top of the head was likened to creating ‘the hump of a camel, leaning to one side’, and associated with ‘immoral’ women. As for parting the hair on the side, this too was associated with immorality, blasphemy or Western ways. Ultimately, despite such rulings not necessarily being immutable, controls over how
women’s hair is worn may remain. Hence one authority surmises that the prohibition on side partings and buns arose from such styles ‘having been a fashion unique to [unbelievers] and immoral women at one time’. Once the fashion ceased to be exclusive to certain women, the ban against hair being worn in this way ceased. Nevertheless, according to this same authority, a plait worn to one side and hanging down a woman’s back, or hair pulled back into a bun or tress at the nape of the neck, is acceptable, but only if covered by the hijab. The same would follow for head hair, however worn, so long as the hijab is obligatory apparel.

The law has not been immune from characterising women’s hair as signifying malevolence, wickedness or looseness of character. Judges considering the status of woman-as-witch tapped into the hair-as-signifier-of-evil trope, too. In 1599 the English judge Sir Richard Martin surmised that the hair of a witch ‘could not be cut off’, and centuries later this trope was followed by a deliberate albeit contradictory shearing off women’s hair, they being charged with having collaborated with the enemy during the First and Second World Wars. Meanwhile, religious demands that women’s hair be ‘not seen’ in public or in the church, synagogue or mosque conformed to St Paul’s diktat. Christian women were compelled to wear hats to church on Sundays, Jewish women must wear wigs covering their real hair, and the donning of scarves by Muslim women remains culturally or, for some, religiously required.

As for hair being a feature of women’s beauty, this leads to timeless public concentration, boosted by the media, encompassing gossip and celebrity magazines, television, Hollywood, Cannes and the BAFTAs, and social media in all its permutations. Marilyn Monroe’s bloneliness accompanies remembrance of Greer Garson’s flaming red hair, with a digression into royalty-as-celebrity with Diana Spencer’s fringe and hairstyle variations, thence to Kate Middleton’s lanky locks and Meghan Markle’s deliberately dishevelled ponytail, on to television land and Jennifer Aniston’s hair of many colours—the ‘poker straight brown, brown curls and waves, black streaks, flaming brown …’, then back to earlier Hollywood and Lauren Bacall’s ‘dirty-blonde hair … worn in [the] deeply-parted waves she insisted on doing herself’, and salons offering hair styled short, hair styled long, quiffed side partings, full-bodied curls and finger waves, elegant up-dos, wisps, tufts and waist-length manes. This in turn emphasises the historical use of heat, cold, vinegar, lemons and lemon juice, dyes and potions for altering or enhancing women’s hair colour, curls or straight strands, whilst the recent glorification of
greying phenomenon has prompted a move from the traditional cover-up to the flaunting of it. Yet perms, hair-straightening and ironing, curling, extensions and other hair enhancements give rise to risk, danger and damage, promoting litigation against hairdressers, dye-manufacturers and producers of hairdressing equipment. In addition to civil wrongs including false and misleading advertising, these prompt criminal activity and prosecution, too.

An Australian report confirms the gaoling of an airport baggage-handler who combed women’s luggage for hair from brushes and clothing, amassing some fifty samples neatly packaged in plastic. This earned him a maximum two years’ imprisonment. In the United Kingdom, cutting off a woman’s hair is recognised as actual bodily harm. In DPP v Smith, Mr Smith’s ex-girlfriend went to his house and, discovering that he was asleep in bed, went upstairs to his bedroom. Upon her waking him, Mr Smith pushed her down on the bed, sat on her, grabbed her hair (which she wore in a ponytail), and cut it off. Apart from the push and ponytail grab, the cutting of the hair was the sole physical attack. The ex-girlfriend bore no bruises, scratches or cuts. Nor was there evidence of psychiatric injury, although she experienced emotional upset and distress. Mr Smith was charged with ‘assault occasioning actual bodily harm’ under Section 47 of the Offences Against the Person Act 1861. The magistrate held there was no case to answer, deciding that the cutting of hair did not constitute ‘actual bodily harm’. As there was no charge of common assault, Mr Smith went free. However, the appellate court decided otherwise. Relying on earlier decisions the court said that actual bodily harm requires no ‘evidence of external bodily injury’, nor a break in the skin’s surface, nor a bruise. Sir Igor Judge, president of the court, went on to remark that hair is ‘an attribute and a part of the human body’. Even if the hair above the scalp’s surface is ‘no more than dead tissue’, he said, ‘it remains part of the body and is attached to it’. Whilst so attached, ‘it falls within the meaning of “bodily” in the phrase “actual bodily harm”’. It concerns the individual victim’s body:

It is intrinsic to each individual and to the identity of each individual ... [An] individual’s hair is relevant to his or her autonomy. Some regard it as their crowning glory. Admirers may so regard it in the object of their affections.
There was no suggestion that Mr Smith did anything with his victim’s hair other than cutting it. However, reports from India, Kashmir and Myanmar confirm haircut crimes that do involve more. Gangs and lone thieves lurk in alleyways or blatantly accost women on the street. Similarly, police in Venezuela warn of gangs roaming the malls and stealing women’s hair at gunpoint. Women and men known as ‘piranhas’ focus on long-haired women in Maracaibo shopping centres, stalking them, then forcibly chopping off their hair or demanding they tie their hair into a ponytail before the scissors relieve them of their locks. Once having departed the victim’s head, the hair is sold for $US 600–$US 800 depending upon length. It ends up as extensions matched to the colour and texture of the new owner’s hair.  

Although hairdresser and beauty salons are generally regarded as havens of calm and tranquillity away from the world’s hurly burly, even a substitute for expensive counselling and advice, a client may wonder about the possibly less peaceful origin of the hair being affixed to her head as extensions. Setting this prospect to one side, salons can be places of peril in other regards. Despite the absence of ‘HazMat’ signs, water, chemicals and electrical equipment are a treacherous combination. Just as for supermarkets and shoppers, clients face slipping on damp floors, with the added danger of hair remnants, soap-suds or gels and other slick substances. Yet this is the least of the risks. Dyeing, bleaching, washing, conditioning, braiding, weaving extensions into the hair or applying adhesives to fix them to the scalp, and even cutting or trimming can lead to disaster—for the client and the salon.

Generally, hair salons test dyes on clients at least 24 hours before appointments, yet such testing is not infallible. From the United Kingdom, to Australia, to the United States, to China, salons are sued, sometimes successfully, sometimes not, where hair ‘snaps off an inch from the scalp’ after bleaching, causing the loss of extensions plus depression and humiliation, ‘falls out in clumps, ... turning into a “mullet” after a poor dyeing job’, or a ‘severe allergic reaction’ leaves the client ‘with swollen eyes and burns covering her face’.  

A plan to go forth with ash green tresses gently framing the face goes awry when a client, visiting a Sichuan salon, undergoes four applications of the dye, only to ‘become bald and experience burns on her scalp ...’. In New York, an aspiring Brazilian model has a photo-shoot cancelled as, in spite of anticipating emerging with ‘spectacular hair that would help launch her modelling career’, she loses her ‘golden locks’, winding up ‘with a
disastrously scorched, patchy head’. An appointment stretches into eight hours, commencing with the client suffering ‘stinging’ as if fire or hot pepper were being ‘rubbed into her head’ albeit the potion used is a ‘natural organic product’ applied to hydrate the hair. Then, her hair begins to fall out, wisps then strands spreading around her. Tendrils fall, burn and crumble about her feet when a straightening iron is used on her bangs. The would-be supermodel looks in the mirror. The result? ‘Freaking out’, going ‘into shock’, then suffering ensuing ‘physical and emotional trauma’. Her hair and scalp ‘burned, her modeling plans ruined, and she cannot show herself publicly’. In short, runs the law suit, ‘she looked like a “monster”’. It could be six years, an expert says, ‘before her thin hair and chronically greasy scalp return to normal’. 20

In 2018 a woman was reported as suing a beauty salon for £1 m claiming ‘her hair treatment caused her a life-changing stroke’. Lawyers alleged that during a £200 ‘cut and colour’, their client’s hair was washed six times ‘to get the colour right’. This saw the client ‘collapse from a condition described by experts as “beauty parlour syndrome”’. The ‘impact of the sink on the back of her neck’ led to the stroke, ‘turning her life upside down’, leaving her not only in social isolation, but ‘isolated from [her] own body’. The 47-year-old nurse, treated to the visit by her husband, ‘left the salon with a headache’ she attributed to going without eating during the lengthy appointment. However, the following day ‘she lost her sight and felt dizzy’, then passed out. She said doctors at St John’s Hospital, Livingston, told her she had suffered a stroke which her solicitors argued resulted from ‘dissection of the vertebral artery – a clot caused by trauma in the neck which stops blood getting to the brain’. With no family history of strokes, this mother-of-two was left unable to drive, she could not work, the family home was sold, and she ‘struggles to speak, read and write’, her independence lost entirely. The claim is that the salon staff failed to ask their client to attend for a hair ‘strand test’, which ‘would have prevented the need for it to be re-washed six times’. The salon is said to have been negligent ‘by failing to offer her a front-facing sink or to provide neck protection during the treatment’. 21

In such a case, both direct liability on the part of the salon is central to a claim, as well as vicarious liability coming into play. The construction of the salon, including the style of the sink, would be advanced as the direct responsibility of the salon. A claim might also be launched against
the manufacturer of the sink, on the basis of its being unsafe and ‘responsible’ for the stroke. What brings vicarious liability into the equation is the stated failure of staff to have the client undergo the hair ‘strand test’. If such a failure can be proven on the balance of probabilities, together with establishing a causal relationship between the failure and the client injury, the question then becomes one of whether the salon itself bears responsibility for staff error. If the staff or staff member responsible come within the category of ‘employee’ or are working in a capacity ‘akin to employment’, the issue is one of whether what the staff did—or, here, failed to do—was a result of activity being taken by them on behalf of the salon owner or operator. Was the staff’s activity a part of the business activity of the salon and was the staff member or members under the control of the salon owner or operator.\textsuperscript{22} If so, liability is established and the salon is answerable. Contributory negligence could apply where a client who knew she should undergo the strand test went along with the staff oversight, happy to avoid that step. This would affect the level of damages or compensation, reducing them consistent with the percentage of the negligence attributed to her fault.

Styling products and a vast range of hair treatments employ chemicals, requiring careful monitoring particularly of the length of time they are left on the hair. Damage to hair or head caused by the application of shampoo, conditioner, mousse, dyes and other hairdressing paraphernalia raises issues of liability. Because clients’ reactions differ, some may be allergic to individual products or particular chemicals. Burns to the scalp and other injuries can result from treatments reacting against the client’s skin or hair. Allergic reactions can follow on failure of hygienic practices by salons or hairdressers, with diseases or rashes transmitted from one client to another. Bald, scaly patches on the head can be caused by scalp ringworm, and painful skin blistering results from impetigo. Dermatitis is painful and recurring, whilst influenza and other viruses and even Hepatitis B or C, or HIV/AIDS can be spread by failures of cleanliness and lack of sanitising brushes and combs. Salons need to take care not only with equipment and products and the premises as a whole, but must ensure staff maintain their own bodily cleanliness and health regime. Health and safety regulations must be followed scrupulously, with attention paid to the chemical components in so many beauty products. Not only hair and heads can suffer damage. Chemicals can cause eye injuries, too. Meanwhile, the simple act of cutting and trimming hair can be hazardous, blades slipping to nick or cut neck, scalp or ears, generating
their own scramble of litigation. Cuts can cause harm beyond the cuts themselves, through potentially generating an exchange of bodily fluids.

In *An Introduction to Beauty Negligence Claims*, Greg Almond cites a case where general damages (for pain and suffering) were awarded in the amount of £7250 (in 2020 currency levels £9750). In *Smith v Hair Associates* the injuries were not only physical but mental or emotional, a combination likely to follow a vast number of such claims, if not all. Perhaps understandably, where the harm included chemical burns to the scalp and permanent patches of baldness, the claimant suffered psychological damage and mild adjustment disorder, for which cognitive behavioural therapy (CBT) was recommended. This case involved a failure to carry out a patch test where 17-year-old Ms Smith sought a half-head highlights treatment, something she had previously had done at a different salon. The procedure involves applying highlight solutions and foils to the hair, with the hairdresser beginning from the back of the head. Ms Smith immediately suffered a burning sensation and, reaching back, found the foils were extremely hot. Despite her request that the hairdresser pause and remove the foils, the hairdresser continued with the process, assuring her that all was well. When with the continuing application the burning sensation did not cease, but increased, a second request to ‘stop’ was obeyed. The hairdresser herself then apparently experienced the foils as being overheated. The evidence was that she began removing the foils, then donned gloves to continue taking them from Ms Smith’s hair and head. After the solution was washed out, Ms Smith felt patches indicating to her that clumps of her hair were missing. The salon manager, called to address the problem, assured her that all was well, instructing the hairdresser to continue to dry and style the hair.

Later that month, and suffering pain and blistering, Ms Smith visited her medical practitioner who diagnosed burns to the scalp and loss of hair. Referred to a burns specialist, she underwent a skin graft. This required many operations and left her with horizontal scarring on the back of her head. It was unclear whether the damage was caused by the products or lack of care in handling them. The salon alone was proceeded against and accepted liability. However, in accordance with the principle established in *Donoghue v Stevenson*, liability can lie with the manufacturer of hair products, as with beauty treatments. Furthermore, in accordance with *Watson v Buckley and Osborne, Garrett & Co Ltd (Ogee)*, distributors of these products can be liable, too. This covers not only products employed by professionals in salons or at clinics or spas, but products
used at home. Users can suffer hair loss, delayed regrowth or permanent loss of hair, and painful reaction to chemicals in hair products. Reaction to hair dye can involve burning or blistering of scalp or skin, particularly the neck area, swelling to head, face or eyes, and flaking or itching of the skin, often causing rashes or swelling.

Although it related to shock and gastro-enteritis rather than any of these conditions, Donoghue v Stevenson, a landmark case, illustrates the way liability is established as against the manufacturer. Here, the manufacturer of ginger beer, Stevenson, was liable to Donoghue, a consumer, when a foreign object found its way into the manufacturing process. The ginger beer was bottled in opaque glass. Mrs Donoghue did not realise until the last of the contents were poured out that a snail in an advanced state of decomposition inhabited the bottle. Stevenson argued against liability for the harm suffered, denying there was any relationship between the company and the consumer. A friend, and not Mrs Donoghue, had purchased the drink at the café where they sat enjoying company and conversation—at least, until the desiccated snail appeared. This meant that Mrs Donoghue had no action in contract. Accordingly, Stevenson contended that she had no remedy. The House of Lords held otherwise. As the manufacturer, Stevenson’s expectation was that persons such as Mrs Donoghue would consume the product—after all, that was the purpose of producing ginger beer for the market. Hence, Stevenson owed a duty of care to Mrs Donoghue under the ‘neighbour’ principle. If a fault in production caused injury to her as a consumer, this was a breach of that duty and Stevenson was liable to her in negligence for her injuries. Albeit Caparo Industries Plc v Dickman has effected some modification of this rule, the principle remains. If it is ‘fair, just and reasonable’ to find a duty of care lying between the parties, and there is a sufficiently proximate relationship between them, the manufacturer will be liable for harm their product causes.

As for product distribution, in Watson v Buckley and Osborne, Watson, a hairdresser, contracted with Ogee Ltd, the distributor, to purchase hair dye. Without testing the dye, Ogee assured Watson that it was ‘perfectly safe’. Watson had requested that the dye contain no more than 4 per cent chromic acid. Unfortunately, it contained 10 per cent chromic acid, a failure in the manufacturing process. In using the product, Watson developed dermatitis, and sued Ogee. The initial negligence lay with the manufacturer in making a production error in percentage of chromic acid
in the dye. However, Ogee’s failure as distributor to test the dye or otherwise take steps to ascertain the acid composition or product safety, meant that liability extended to them. A duty was owed to the end user, in this case Watson. Ogee were careless in promoting the dye as safe. Ogee could not argue a lack of liability simply because they were not the manufacturers so were not the original creators of the negligence. Just as the manufacturer in Donoghue v Stevenson knew and intended that the ginger beer was to be consumed, Ogee knew and intended that the product they passed on was designed for use by ‘end users’. Their duty of care included the necessity of taking reasonable precautions to ensure that the product was safe. Failing to do so rendered them liable. Here, if the skin condition had developed on one of Watson’s clients, Watson would have been in the position of the café that sold the ginger beer to Mrs Donoghue’s friend. Albeit a contractual responsibility could arise, liability for negligence would not fall upon Watson as the hairdresser, but upon Ogee as the distributor—as well as upon the manufacturer.

This picture is matched in other ways by the beauty or hair product that fails to live up to its promise. Although it may not result in injurious damage and harm, promises of golden glory, shining brilliance or long-lasting colour and conditioning can fall short. False, deceptive or misleading advertising is a problem not only in the pharmaceutical industry, but with hair, cosmetic and beauty products. The prevalence, possibility and even probability of false promises is such that generally these are covered by consumer or trade practices law. The Australian regulatory system is contained in the Consumer and Competition Act 2010 (Cth), whilst in the United Kingdom Consumer Protection from Unfair Trading Regulations governs the conduct of advertisers. In the United States, deceptive advertising, misleading labelling and similar practices are covered by state and federal laws. The Federal Trade Commission Act 1914, the Food, Drug and Cosmetic Act 1938 and the Uniform Deceptive Trade Practices Act 1966 are a clear source of authority for taking action where beauty and cosmetic industries engage in promoting their products as able to achieve miracles or other unrealistic transformations.

2 OH! MY FACE … A RETROUSSE NOSE & PINNED EARS

False advertising is prevalent when it comes to body image. Nowhere has the clamour for youth and youthful beauty been more pronounced than on the face. Male faces, like women’s, age. Oscar Wilde’s The Picture
of Dorian Gray (published initially in the July 1890 issue of Lippincott’s Monthly Magazine) captures well the desire to remain youthful, at the cost of selling one’s soul to the devil. Yet though men, like women, may seek eternal youth not only in fiction, the passage of years has greater implications for women than for men. Older men remain attractive in conventional terms, nowhere more visibly than in film. Examples abound of actresses playing mother to actors who are of or about the same age, or even younger than their ‘sons’. In Forest Gump, Sally Field (born 6 November 1946) played Tom Hanks’ (9 July 1956) mother. The eleventh Star Trek movie (2009) saw Winona Rider (29 October 1971) ‘mother’ Zachary Quinto (2 June 1977). Perhaps the apotheosis of this Hollywood ‘woman:ancient, man:youthful’ message occurred in the Alexander biopic, with Angelina Jolie (4 June 1975) playing mother to Colin Farrell (31 May 1976).

No elixir of youth yet having been discovered, plastic, cosmetic or aesthetic surgery is called upon to undo the ageing process or at least disguise it. Facial reconstruction is not new. From before and after the time of ‘The Man in the Iron Mask’ (c. 1640-19 November 1703), when speculation arose as to precisely who it was behind the mask and whether the mask was to conceal identity or degenerative features, various methods have aimed at making the face young or reconstructing it to cover up flaws or time-related changes, including disease as well as ageing.

In this renovation, the nose features prominently alongside cheeks, cheekbones and facial skin, as do ears. In the nineteenth century sexually transmitted diseases resulted in nasal damage. Syphilis could be injurious to adults who engaged in unprotected sexual intercourse. It also created secondary victims, babies being born with damaged noses or even without a nose at all. In his major work Making the Body Beautiful Sander L. Gilman recounts the ‘cultural history of aesthetic surgery’. He references the work of Viennese practitioner Johann Friedrich Dieffenbach, who made his name pioneering ‘repair and replacement’ of body parts, including the nose. Flattened or depressed nasal tips were built up through employing external excisions that reconfigured the skin. A flap of skin from an arm was partly sliced, the arm raised to face height, and the flap attached to the nose. This meant that blood and nutrients remained passing through the flap, so that the graft had a high chance of success. The flap was severed from the arm and wholly stitched to the nose, once the graft had ‘taken’. Dieffenbach also proposed a ‘gold
bridge’ to repair sunken noses, although the only known instance of this operation was satisfactory until the bridge began to shift, going from right to left, then collapsing altogether into the nasal sinuses. Later surgeons such as Harold Delf Gillies saw that it was not only the outer flesh of the nose and the bridge that affected sunken and otherwise defective nasal organs. The mucous nose lining was recognised by Gillies as essential to nasal construction, its absence through disease being part of the problem. The grafting of a new epithelial lining into the new nose meant lifting the nose from the face so that the lining could be incorporated, then stitching the organ back into its original position. This early surgery targeted flapping or ‘bat’ ears, too, although ears presented far less difficulty. Cartilage could be removed from behind the ears so as to shorten the distance from skull to the body of the ear, the remainder then stitched flush against the skull. Where they reached major wagging proportions, lobes could be trimmed before stitching the remaining cartilage flat.

Yet not only disease dictated surgical interventions. Cultural expectations or notions of what is normal led to people of particular ethnic or race backgrounds seeking out surgeons for aesthetic reasons. The flat broad nose associated with Africa, the long or pendulous nose fitting into an anti-Semitic trope, the snub or sunken ‘Oriental’ nose all required ‘correction’ so that their owners could fit expectations of ‘normality’. The dominance of the Western or Caucasian stereotype dictated surgical correction so that long noses were shortened, flat noses built up by raising bridges, short noses extended by the addition of cartilage. Today, rhinoplasty is a cosmetic surgical intervention commonly sought after. The American Society of Plastic Surgeons calculated numbers of rhinoplasty operations increasing between 1997 and 2005 by almost 47 per cent. In 2013 rhinoplasty was rated as the fifth most common cosmetic surgical procedure worldwide, ‘accounting for 8.8% of the total surgical procedures globally’, with ‘an increase in the diversity of demographics seeking the procedure across ethnic, gender, age and socioeconomic backgrounds’.

Pinning of ears is also high on the list of cosmetic surgical interventions, although it may now be so common as to raise little attention—unless something goes wrong. So long as ears are flat to the head, they are relatively innocuous, albeit studs and earrings, sometimes in multiples, can make them a spectacular feature. However, noses do go through fashions. The straight Roman nose has been seen as handsome, as has the aquiline nose—although not when gracing women’s faces. Rather, the
retroussé nose has been a ‘must’ for women, the small, upturned nose, or one ‘shapely’ and ‘tip-tilted’ giving an edge to those seeking an acting career or more broadly show business success. There is a history here, for as far back as the sixteenth century according to Agnolo Firenzola (1493–1546) this was the favoured contour, albeit the upturn should be modest, not too exaggerated. Neither, however, should the nose tip ‘drop’. Declaiming upon the ‘Beauty of Women’, Firenzola pronounced that the profile was equally important as face-on appearance:

... besides being of a proper size [the nose] must be narrow rather than wide, and taper from the top to the base ... and at the tip should turn up very little and stand out as it were in relief; colored but not red; with an almost invisible line marking the boundary of the two nostrils, which at first must rise and then softly slope away and finally end, diminishing both at the same line.38

Contentions that women have undergone rhinoplasty to make themselves more attractive (whilst if admitting it, women are minded to assert that the operation is to make them feel ‘normal’) arise in discussion of Marilyn Monroe and more recently Marie Osman, Jada Pinkett Smith, Scarlett Johannsson, Meghan Markle ...39 Yet everyone seems to end with the same nose shape, small, shapely, tip-tilted, upturned (though only slightly). One of the first to announce with great fanfare that she was to subject herself to ‘a nose job’, the Australian stage performer and one of Australia’s first television stars, Dawn Lake, had her straight nose altered to conform to just this shape.40 Perhaps because she went from an exceedingly straight nose to the upturned tilt, a pronounced change, she considered it necessary to make it public to avoid scoffing or speculation. She gained an ordinary nose of the standard manufactured type, and great publicity. Fortunately, nothing went wrong. This was not so, however, for Mrs Mijin Zahir who was unhappy with her ‘new’ nose immediately after she saw it. The surgeon undertook revision surgery but neither this, nor three subsequent operations (carried out by a different surgeon) mollified her. Mrs Zahir did not, however, succeed in her claim. In Zahir v Vadodaria41 the court said that the question to be answered by expert witnesses and hence by the court was ‘whether the surgical technique used was acceptable’. That was the measure to determine liability, not whether the patient was or was not satisfied.
In *Making the Body Beautiful*, Sander L. Gilman observes that the impetus to change one’s nose was not invariably associated with fame and celebrity or seeking them, or appearance for appearance sake, but addressed racism and notions of morality. Thus, he says, angst associated with changing the shape of the nose ‘was rooted in notions of the permanence of racial markers’. Miscegenation lay at the heart:

In early twentieth century discussions of ‘mixed races’, it was often the ‘impure’ physiognomy that gave a clue to the decline of the pure races … In the United States and in Germany, where ‘racial mixing’ had resulted in ‘mixed-race’ individuals with perceived qualities of both races, there was a constant anxiety about having ‘black’ or ‘Jewish’ features. To be seen as ‘mixed race’ was to be seen as being of lower moral character.42

This did not, however, dictate wholesale attempts to rejuvenate the face in its entirety. Although facial reconstruction received a major impetus as a consequence of harrowing damage to the faces of soldiers wounded in battle during the First World War, the desire to halt the ageing process has been pre-eminent for many women. Facelifts first concentrated upon the skin. This approach addressed sagging, tired-looking and wrinkled skin comprising folds, furrows and grooves as the most evident sign of ageing. It is no surprise that the remedy was seen as pulling the skin tightly back behind the hairline and stitching it firmly. This meant that stitches were hidden behind the ears and could be covered by the hair. Bobs conveniently concealed scars where the wrinkles were removed from the forehead, and curls could be arranged to cover scarring from drawing the skin of the cheeks back towards or even behind the ears. Suzanne Noel is one of the earliest recognised plastic surgeons who worked on women’s faces. The foundation of her knowledge and practice was her experience in training with the facial reconstruction team working to recover or improve the often seriously marred looks of wounded soldiers.43

For Noel’s clients, beauty or regaining youth for reasons of vanity was not always the impetus. Women who had found independence through moving into fields formerly occupied solely or mainly by men were at risk of losing their jobs to demobbed soldiers returning from the front. The imperative to remain youthful or at least youthful looking in order to retain employment was a strong incentive to seek out Noel’s skills. This followed, too, for women making their name on the stage or in the
escalating film industry. Suzanne Noel promoted her work by emphasising that ‘looking younger’ or ‘looking better’ meant that women were energised, regaining joy in life and the feeling of being wanted in the workplace as well as being desirable as women. She said that aesthetic surgery was a procedure to be ‘highly respected’ and that its ‘moral worth’ should be ‘favoured everywhere’. However, the technique had its limitations. Skin can be stretched only so far, before a woman takes on the visage of a china doll or, worse, finds her features settled into a rictus grin, ordinarily the consequence of facial muscles contracting when the body is gripped by tetanus or strychnine poisoning. Skin also loses its elasticity when tugged and pulled as required to remove the sagging, and can eventually become wafer-thin. This makes it more susceptible to wrinkling and drooping. Thus, albeit the second facelift by this method can be longer lasting, with a lengthier time before flaccidity or ‘bagging’ appear, the loss of skin elasticity means that the procedure can set up a cycle of stretch and pin, sag and droop, stretch and pin, sag and droop. Eventually, those subjecting themselves to what at first appears to be a rejuvenating process find they are not only ageing, but their appearance is worse than had they simply let nature take its course.

Surgeons began raising doubts about the longevity of the results. A reassessment of the practice led to the recognition that the surface skin was imprinted with a problem that lay deeper. The face comprises ligaments and muscles, and it was here that the next steps were taken. The new technique was applied beneath the skin, Tord Skoog leading the change with his landmark work, *Plastic Surgery: New methods and refinements*, published in 1974. Skoog posited that the fibrous tissue and muscle lying beneath the subcutaneous fat immediately below the skin of the face should be the target of surgeons seeking to ‘tighten’ and render more youthful looking the faces of their patients. A student of anatomy, he recognised that it is not only the skin that ages, but the layers of flesh, muscle and fibre that create the face. Firm, youthful muscles and fibres are a significant part of the foundation of the flesh of the face. As they grow slack with age, this underlying laxity both matches and underpins the sagging of the skin.

This was not, however, the full answer. Osteoporosis or ‘bone loss’ produced the final answer for plastic or aesthetic surgeons seeking to cater to clients who wished to stem facial ageing or, in reality, disguise it. The face is attached to the skull and most specifically to the bones that surround the cavities that hold the eyes and mouth and the lesser
nasal cavity. Bones shrink with age and some wear thin, lessening their capacity to hold up the tissue, muscle and fat comprising the face. The new technique built on this understanding, with the advantage of less risk of nerve damage being caused through operating solely on the fibrous tissue and muscle. On the other hand, the technique requires superior skill and advanced training. Rebuilding bones, incorporating fatty tissue or injecting paraffin wax is a specialised technique. This means that those who are less skilled may stay with the fibrous tissue and muscle approach, albeit it requires its own dexterity and ability to circumvent the nerves of which there are many in the facial area. It means that those without the requisite expertise may venture into this more complicated field of surgery, with its own consequent risk.\textsuperscript{46}

Each facelift technique has its own hazards, from the stretching of the skin, to the focus on the underlying layer of fibrous tissue and muscle, and thence to the bone structure and attachment of the facial flesh of skin, tissue, muscle and fat. Nerve damage is one of the principal risks. It can cause relatively minor discomfort including numbness, tingling or mild though persistent pain. However, it can also result in paralysis, lop-sidedness, sagging or weakness of muscles. During the operation, a failure to separate the tissues accurately or ensure skin flaps have a sufficient blood supply through the procedure, or any delay in stopping bleeding all have potential consequences. One of the worst outcomes can be necrosis of the skin, a result of late diagnosis of blood leaking around the sutures. Clots can be removed, but this involves going into the seamline of the cut, which has its own dangers. Wounds can suppurate, where carelessness results in hair getting into the surgical lesion. Hypertrophic scars are relatively rare, however, tension on the seamline and skin that is susceptible to scarring can result in unsightly marks, blemishes or pockmarks. Pigmentation of the skin is another possibility, as well as the contours of the face being deformed or asymmetrical. The loss of hair follicles can be permanent, causing patches of baldness requiring restoration by further surgical intervention. Though risk of infection is low, this can occur with minor or major consequences depending upon its severity and how soon it is addressed. Even where non-surgical interventions such as laser treatment are selected to avoid cutting and anaesthetic (which has its own danger), the operation can fail.\textsuperscript{47}

In the midst of speculation as to whether this ageing film actress or that, this older supermodel or that, this maturing celebrity or that has submitted to the knife or taken up other anti-ageing techniques,
horror stories centred on plastic surgery gone wrong abound. The ubiquitous facelift is the source of many stories of catastrophe or failure. Aggrieved patients come from a variety of backgrounds and ages, for albeit the facelift was conceived as a remedy for the older woman to recover her past bloom, what is today considered as requiring an injection of youth is malleable. Not only well-known personalities or those categorised as famous may seek out plastic surgeons, nor be distressed by the outcome. Whether the distress or damage to the face—generally the most visible part of the body and that upon which human identity is so often founded—can be compensated for by monetary awards may be dependent on its level of seriousness. In the 2000s, the UK damages awards for facial scarring range from £1000 to £2200 for minor scarring, to a maximum of £62,000 for severe scarring for women (as opposed to £42,000 maximum for men). Between these ranges, scarring visible from a short distance warrants compensation in the range of £11,500–£19,500 for women (as against £6000–£11,500 for men). An alternative is to seek remedial treatment, yet this may be unable to repair or undo the damage and can even exacerbate it.

Assessments of post-surgical satisfaction are variable. Various measures are employed, with the risk of possible cultural bias in their constituent parts and in their application. The World Health Organisation Quality of Life (WHO-QoL) is an assessment method designed to measure a person’s positive satisfaction taking into account variables including socio-economic status, subjects’ cultural and political systems, objectives, expectations, standards and concerns. Physical health, psychological well-being, social relationships and environment are included. As an example of outcomes, Seyed Jaber Mousavi et al. report that cosmetic rhinoplasty ‘is believed to have a remarkable effect on a patient’s physical and mental health when investigated from an evidence-based medicine approach’, bearing in mind both objective and subjective outcomes. They found satisfaction in their Iranian patient cohort six months after the operation. At the same time, they observed that previous studies of Iranian rhinoplasty patients showed ‘a variety of outcomes ranging from positive to negative quality of life’, with one study suggesting that rhinoplasty surgery was ‘not found to have any beneficial impact on mental health’, whilst others suggested ‘a reduction in quality of life post-rhinoplasty surgery’. They quote similarly for studies conducted on patients outside Iran.
Quality of life measures cannot be limited to those who, having undergone facial surgery for aesthetic reasons, return to everyday life with what might be seen as enhanced features. As the phenomenon of seeking facial beauty or recovering youth, or simply wishing to ‘look normal’ has a global reach, it is unsurprising that stories of botched surgery or non-surgical interventions are international. Hence, the tale of the 40-year-old woman from Wales who lodged a claim for personal injury against a cosmetic surgery clinic in Belgium, listing lack of symmetry on the left side of her face. Numbness and scarring, prominent around her ears and eyes, had to be hidden by her hair which she grew long for this purpose, she said, adding that she was ‘now too embarrassed to be seen in public’. The Elyzea Cosmetic Surgery Group, with offices in Paris, Utrecht, Manchester, London and Brussels denied liability whilst considering they ‘had a moral responsibility to try to put things right’. Saying that the Surgery Group ‘provides aftercare to correct errors’, the spokesperson added that generally patients ‘are not reimbursed’. 51

In one of the more unusual cases of litigation in which complaints range from curious to the horrifying to the bizarre, an Australian woman dissatisfied with the results of facelift surgery lost her Queensland Supreme Court appeal. Litigation centred around the woman’s claim that the facelift had been substituted for a ‘tummy tuck’. Admitted to hospital for the abdomen operation, one hour before it was to take place the woman was advised by the surgeon that it could be ‘life threatening’ and he refused to do it. She claimed he then offered a ‘full cosmetic facelift and eyelift’ so long as she agreed to the new operation being undertaken for the same price as the tummy tuck, which she had prepaid, and going ahead on the original schedule. In consequence of her unhappiness with the outcome, the claim went first to the Health Quality and Complaints Commission, then to the Australian Health Practitioner Regulation Agency (AHPRA), next to the Queensland Civil and Administrative Tribunal and finally to the Supreme Court as a negligence claim for damages for personal injury. The judge dismissed the claim on the basis of delay and identified flaws in the case. 52

Meanwhile, in Taiwan, a botched facelift which ‘burned from the inside out’ left the client, in her 50s, suffering ‘horrible blisters’. She suffered second-degree burns at a Taipei clinic which employed a ‘non-invasive’ procedure, Thermage treatment. Using patented radio-frequency technology, the treatment applies heat to the skin’s deeper layers in order to smooth, tighten and contour the skin through causing existing collagen
to contract and encouraging growth of new collagen. Usually the procedure takes between 30 and 90 minutes, however after an hour the woman ‘experienced a sharp pain on her face’ then blisters appeared, growing to ‘horrific’ size. She sought hospitalised medical help. Despite treatment for the burns, her face was left ‘covered in dark scars’ from the burn wounds. Two to three months were noted as being required for the condition to settle before corrective treatment could be undertaken at another clinic.53

3 Around the Eyes & Rounded Eyes ...

The eyes are the window to the soul. Banal though the saying may be, it has a universal resonance. Eyes have a special place in both the history and the present of cosmetic surgery. That women are daily subjected to ‘the male gaze’ dictates to a large extent how women are seen. This in turn has implications for how women see ourselves and the expectations this places upon a woman’s upkeep of her body. Thus, Elizabeth I maintained her standing not only because of her perceived strength in matters of state and personal life, but through adopting stratagems to preserve her appearance. This included face paint and wigs, she being ‘firmly of the belief’ that ‘the eyes of her people would not so easily discern the marks of age and the decay of natural beauty’.54 Contentions as to what is ‘natural’ and what ‘beauty’ are not only dictated by age, however. Cultural, social and economic expectations, deriving from the ethnocentric idea that ‘Western’ is ‘better’ than ‘Eastern’ mean that a considerable aesthetic element based in negative notions about the shape of eyes infuses cosmetic surgery and other beauty treatments on the eyes. Edward Said’s conceptualisation of ‘Orientalism’ as an assertion of superiority on the part of Western nations and a patronising representation by the West of the countries and cultures of the East (constituted by Asia, the Middle East and North Africa) highlights the issue generally.55 Although ‘the East’ is romanticised, with Western fashion often appropriating clothing and artefacts from China, Japan and other ‘oriental’ nations, racism and ethnophobia impact negatively on people who are genuinely from those countries or who have their familial origins there.

The eyes are the physiological feature primarily seen as signifying Eastern ethnicity. Charles Darwin’s view that the ‘obliquity of the eye … proper to the Chinese and Japanese’, was exaggerated so as to emphasise ‘Eastern’ beauty and contrast it with ‘the eye of the red-haired barbarians’56 is no longer fashionable. Rather, enthusiasm to reconstruct their
eyes so as to appear ‘Western’, or at least more so, is dominant. Gilman explains it bluntly:

The most commonly sought aesthetic procedures … are nose jobs (rhinoplasty) and eyelid surgery (blepharoplasty). Asian-American women, whose ‘blank’ look is equated in American society with ‘dullness, passivity, and lack of emoting’, have ‘their eyelids restricted, their nose bridges heightened, and the tips of their noses altered.\(^{57}\)

Gilman further observes that eyelids found in Semitic cultures are often classed stereotypically as denoting their owner as ‘tired, sleepy, relaxed or threatening’ and even ‘conspiratorial’—an anti-Semitic trope. This, too, can generate the desire to ‘Westernise’ the feature. Importantly, changing the eyes is versatile. It can ‘normalise’ the face in Western terms, can create such a subtle change that onlookers do not detect that the difference has come about through surgery, or can change the whole ‘look’ of the face. This versatility adds to the blepharoplasty statistics.

Joanna Finkelstein in *The Fashioned Self* writes of Korean housewives being a ready market for eyelid surgery, whilst Eugenia Kaw’s research, pinpointing Asian American women seeking cosmetic surgery for their eyes, records the ‘medicalisation’ of ‘racial’ features.\(^{58}\) Surgery to ‘correct’ such eyes—to Westernise or ‘Americanise’ them—involves the creation of a double eyelid, achieved by a non-incision process, although this is only one of some thirty-two procedures developed in Japan to ensure ‘a clear-cut, double eyelid fold’ mimicking Western eyes.\(^{59}\) Similarly in China plastic surgeons have addressed ‘the eye (or eyelid) problem’ using varied techniques. One process developed during the Second World War involves creating a fine scar line, by stitching along the eyelids. The scar gives an illusion of the desired ‘double eyelid’ simulating the supratarsal fold.\(^{60}\) Gilman observes that Vietnam along with Korea, Japan and China ‘reflect the globalization of standards of beauty rooted in Euro-American stereotypes’. The youth ideal is not to be ‘too Asian’. This is expressed by Asian Americans as wanting to fit into what is perceived to be the so-called acceptable American norm, so that:

… among Asian Americans in California, double-eyelid surgery has become ‘the gift that parents offer their daughters when they graduate from high school or college’.\(^{61}\)
The perception that ‘West’ is better does not mean that Western women abjure blepharoplasty. One of the highest rates of growth in plastic or cosmetic surgery is associated with drooping eyelids, hooded eyes or overhanging eyelids, or fatty deposits which give the eyes a bulbous appearance. Nor does it all focus solely upon the upper eye, or eyelid. Crows’ feet, wrinkles, lines, or bags beneath the eyes, or asymmetrical eyes, feature, too. These can be a result of ageing, or can be a consequence of genetic make-up. Saving time as well as money, some women have dark lines tattooed on their eyelids—top, bottom or both to mimic eyeliner, obviating the need to apply this cosmetic daily. Eyebrows are also manipulated—Marlene Dietrich and Greta Garbo allegedly shaved theirs, then redrew them as narrow curves. In the 1920s Clara Bow and others plucked and winnowed theirs, giving them a downward look, the angle reputedly making Bow look ‘permanently sad’. The 1950s saw a return to a more natural look, with stars such as Marilyn Monroe achieving this by modest plucking simply to tidy the line. In the 1960s it was back to more severe plucking, yet women of the 2000s are said to follow the fashion of bushy eyebrows a’la Cara Delavigne.62

Yet care must be taken even with eyebrows. Too severe plucking or threading can result in unsightly or unflattering brows, or their being so narrow as to be almost invisible. It takes four to six months for eyebrows to regrow, the length of time being affected negatively by tweezing and waxing, cuts, burns and other damage to eyebrow hair follicles caused by trauma, stress and anxiety, pregnancy, ageing, thyroid disease, harsh make-up or eczema, psoriasis or other skin conditions. Age, also, can affect regrowth and as eyebrows tend to become less distinct with ageing, artificial measures should be taken with care.63 Yet whatever can go wrong with eyebrows, it is the eyes which require most tender care. Every organ of the body is precious, yet the eyes are extremely susceptible to harm. Here, the slip of the tweezers or tattooist’s hand or equipment, or that of threaders, can cause untold damage leading to negligence claims.

Blepharoplasty is generally a day procedure, the operation on the upper eyelid taking up to an hour, that on the lower lid taking up to two hours. A blepharoplasty to correct, repair or enhance the upper eyelids requires an incision to be made along the crease of the eyelid, where the skin folds naturally. Excess muscle, skin or fat is removed surgically, then the cut is closed so as to hide the scar in the eyelid’s natural fold. As for lower eyelids, similarly cutting is required, this applied on the skin below the lower lashes or the inside of the eyelid. Small amounts of skin may
be cut away, the main target being removal of fat from bags under the eyes. Some operations require the inclusion of support for eyelid muscles and tendons, and in all cases the usual practice is for suture strips to be applied after surgery to support the eyelids. Up to one week after the procedure, these thin, sticky strips are removed. Temporary consequences include redness, bruising, light scarring and mild pain, with patients being advised to rest away from work for up to a week, wear sunglasses and avoid driving. Other temporary side effects may result, namely difficulty in closing eyes for sleeping due to numb and puffy eyelids, watery eyes which are sensitive and may suffer irritation, heavier bruising with an appearance similar to a black eye, and pink scars that do eventually fade.64

The next category of after-effects can include double or blurred vision—again temporary, and blood collecting under the skin (haematoma) which generally does not need treatment, disappearing after some weeks. More concerning are noticeable scarring and eyes being, or appearing to be, slightly asymmetrical. Just as with any operation, according to the National Health Service (NHS) there is a ‘small risk’ of an allergic reaction to the anaesthetic, infection, excessive bleeding and a blood clot developing in a vein. However, although said to be ‘rare’, more serious problems can follow. Blepharoplasty can result in eye muscle injury, drooping of the lower eyelid so that it sags away from the eye and turns outwards, or the lower eyelid being pulled down so as to show the white of the eye below the iris. In the worst cases, blindness can result although the National Health Service says this is ‘extremely rare’.65

Nevertheless, however ‘rare’, cosmetic surgery to the eyes is not immune from going wrong. The outcome may be one of disappointment because the imagined promise is not there (which can result in psychological problems and repeated trips to surgeons for corrective surgery or repairs) or it can cause lasting physical health problems. A Newcastle case illustrates the risk that side effects said to be temporary may have a greater longevity. There, the woman had undergone gastric bypass surgery, losing 58 pounds. Inevitably, some of that went from her face. Her upper eyelids worried her the most, however, the advice was that she have work done on both upper and lower lids.66 After the operation, her eyes ‘were constantly streaming’, with ‘tears pouring down [her] face when [she] was trying to go to sleep’. Her son, she said, told her she looked ‘weird’ whilst napping and it was then she realised that her eyes remained open
during her sleeping hours. Both effects are recognised as possible temporary outcomes, yet in this case they lasted longer, giving an appearance of being potentially ongoing. The surgeon and surgical practice resisted any claim, observing that over 7000 patients had undergone a ‘surgical episode’ at the practice during the relevant period (January to December 2014) and fewer than 1.9 per cent of patients ‘felt they had cause for complaint with any aspect of the service’. Only one legal claim was said to have been instituted during that same period. 67

Although a general view appears to be that blepharoplasty errors are few, on the other hand patients come forward with concerns they see as serious, despite the medical practitioners’ view that problems are rare. One surgeon acknowledges seeing an ‘unfortunate side effect … far too often with eyelid surgery’, namely ‘aggressive removal of excess skin and fat [leaving] hollows under the eyes or below the brows’. This outcome is acknowledged as ‘very aging and unnatural looking’. The remedy is grafting structural fat ‘to smooth the eye area and fill in hollows’. 68

However, as a corrective measure this puts the patient through two operations rather than the one which would have been anticipated originally. Nonetheless, and noticeably, this is not unusual. Where problems identified by patients are accepted as real, generally the surgically recommended remedy is further surgery. Thus, a patient with concerns about eyes that ‘sit too deep in the inner corner and eyelid width is uneven’ is advised that the result, Post Upper Blepharoplasty Syndrome (PUBS) ‘is all too common’. It includes ‘high upper eyelid crease, upper eyelid ptosis, lash ptosis and a compensatory eyebrow elevation’. Lash and eyelid ptosis are medical conditions constituted by ‘drooping or falling of the upper eyelid’, sometimes known as lazy eye. It can be caused by ageing, birth, injury, trauma or infection, muscle weakness, nerve damage, skin looseness above the upper eyelid or a tumour behind the eye or eyelid. In this instance, it is a consequence of surgery and, by that means, possible nerve damage or injury to the muscle during the initial operation. Fixing it would require not simply ‘revision’ but ‘an actual reconstruction’ as the patient’s upper eyelid creases were made ‘far too high’ by the surgeon doing the blepharoplasty. 69 Health message boards and blogs are replete with people complaining of what they describe as botched eye surgery, sometimes involving the corrective surgery applied as the remedy.
4 FOR BEE-STUNG LIPS, WHITER-THAN-WHITE TEETH, RECEIVING CHINS & MEASURES UNDER THE NECK

In Beauty and Misogyny, her treatise on ‘harmful cultural practices in the west’, Sheila Jeffreys writes compellingly of the contradictory role make-up plays in women’s lives. She critiques the time taken to apply it, time that might be better spent on activities not requiring the same monetary and potentially emotionally draining investment. Lipstick provides a central puzzle, in that it could be seen as a ‘very strange practice in which women smear toxic substances on their lips several times day’, taking into their bodies ‘an estimated 3 to 4.5 kilos in a lifetime’s use’. As Sheila Jeffreys observes, this tends to be regarded as a ‘natural’ activity for women, one that would better be understood as a harmful cultural practice. However, lipstick plays a relatively minor role, today, in the array of decorative and toxic procedures carried out on a woman’s lips.

Botoxing, fillers and the phenomenally enlarged lips they spawn once appeared only on Hollywood stars, starlets and celebrities. Now they are an everyday spectacle. Speculation has it that Goldie Hawn, Britt Ekland, Jennifer Garner, Nicole Kidman, Melanie Griffith, Demi Moore, Kylie Minogue and more have had this treatment, even on a regular basis for some. Indeed, as with so many treatments or procedures designed to enhance, improve, make more natural or normal, or provide women with autonomous ownership of their own bodies, ‘the look’ can be maintained only by repeated visits to the clinic, spa or salon. Yet the cupid’s bow of the 1920s, with Clara Bow promoting this lip configuration physically and by her stage name, is a precursor and has its origins even further back. The chocolate box beauty was juxtaposed against the lipstick phenomenon which was preceded in turn by the use of rouge to redden lips. This chimed with earlier centuries’ assessments of beauty associated with lips carrying an implicit sexual subtext—as illustrated in the famous Dante Gabriel Rosetti portrait of Fanny Cornforth, Bacca Baciata, now made explicit by the red dye. Eventually painted lips lost their dubious status, spreading from stage actress, where colour had been seen as racy, to women lacking pretensions to showiness or show business. Reflecting back on religious and cultural notions of women’s head hair as prompting and even promoting immorality, today prettifying women’s lips and so staving off the ageing process is advanced by some plastic surgeons as necessary from a moral, rather than immoral, perspective. Thus in Face Value: The Politics of Beauty, Robin Lakoff and Raquel Scherr remark
upon the subtext in popular media that a woman ‘has a virtual moral duty – to herself and to those who must behold her – to remove those wrinkles and bags, tuck that tummy, raise those breasts …’ and rid herself of the senility of her upper lip.  

The receding chin and the too strong jawline, the wrinkled ‘gobbler’ neck or multiple chins also once carried connotations associated with (im)morality, as with laxity (the chin) or criminality (the jawline), or represented greed and gluttony (the chins), the dissolute sot, or witchcraft and sorcery (the irredeemably furrowed neck). This history led these bodily configurations to be regarded with a contempt propelling their owners into the hands of quacks and butchers then, with the burgeoning growth of the beauty industry, into the rooms of its companions and competitors, the plastic, cosmetic or aesthetic surgeon. Reconstruction of regressive chins was an early plastic surgery practice, aimed at making faces ‘ordinary’. The idea and ideal of normalisation was employed as the rationale for surgical intervention involving bone restructuring and grafting. Today’s practices are mostly directed towards reconfiguring jaws, jowls and necks to hide ageing—or endeavour to do so. Visual criteria identified in 1980 to ‘assess the youthfulness of the neck’ and which remain as the current measure include ‘a clear jawline … with no jowl overhang’, subhyoid depression giving ‘an appearance of a long and thin neck’, an ‘anterior border of the sternocleidomastoid muscle’ (the muscle enabling rotation of the neck) visible to the eye, and an ill-defined cervicomental angle (the angle formed by the horizontal and vertical planes of the neck). Bone enhancements using implants can address the regressive chin or jaw problem. Less drastic measures are available too. In an ‘advertorial’ published in Aesthetics, the journal published monthly ‘for medical aesthetic professionals’, solutions of a comparatively minor or non-surgical kind are described. In ‘Successful Jawline Treatment’ Heather Muir explains the use of a variety of commercial products to restore or at least improve the loss of definition in the jawline of her client. This involves injections in a bolus (a small rounded mass) ‘to lift the tissue quickly and provide structure’. That the jawline and chin comprise an animated area means that care is required in not producing a cemented or fixed appearance. The bone of the lower jaw—the mandible—is the only facial and skull bone (besides the middle ear ossicles) that is moveable. Undertaking the jaw procedure requires injecting a bolus of the product ‘deeply down to the bone’, then two further injections into the muscle. Next come deep injections ‘on each side of the pre-jowl sulcus’
(the area on either side of the chin that creates a hollow appearance as loss of volume causes the skin to sag), employing a fanning technique. Finally, ‘orange peel’ dimpling (on the thighs or upper legs known as cellulite) requires attention, as this can be ‘particularly noticeable’ when the client ‘smiles or talks’. Further injections employing the fanning technique are required. Just as with similar procedures addressing ageing, this is not a ‘one off’ operation. The particular client has been attending for some eight years.  

Wrinkles beneath the chin are more difficult to shift. In the past, loose neck skin could be pulled tight in the course of a facelift. However, this was rarely successful. Even into the 1970s, withered or sagging necks were seen by cosmetic surgeons to be beyond recovery. When the skin lost its elasticity there was so much of it that had to be shorn from the body, and the lack of pliability or springiness meant that the skin relapsed quite quickly. Relatively soon, the wrinkles of the neck had reinstated themselves, leaving patient dissatisfied and upset, and surgeon disappointed, even thwarted. Yet in the mid-1970s this changed. Bryan Mendelson’s *In Your Face* explains that a practice was developed, publicised to the profession in 1974, where the neck was contoured by ‘shaping the underlying platysma muscle layer as well as removing excess subcutaneous fat’. Although it lengthened the time of the operation considerably, the transformation appeared to be ‘miraculous’. Today, prospective patients learn that a ‘lean and tight’ neck can be achieved through ‘various injectables’, although excessive and aggressive procedures must be avoided, for this can itself lead to premature ageing. The injectables include botulinum toxin A, dermal fillers, platelet-rich plasma and platelet-rich fibrin, mesotherapy, bio-remodelling and bio-revitalising agents, thread lifting and fat-dissolving agents. Of these, botulinum toxin A appears to be the most popular, despite there being as yet no published research of long-term effects. Potential complications that are known depend upon the technique employed, but ‘typically include muscle soreness or neck discomfort, difficulty lifting the head from the pillow from a [lying] position, and headaches’. Complications said to be ‘rare’ include dry mouth, hoarseness and difficulty in swallowing, along with ‘masticatory and speech disturbances’. Whether a rash of legal actions will be precipitated once the long-term effects become known is a matter for the future. However, what is known is that ageing cannot be staved off forever. Ultimately, even if the product itself does not generate harm to the patient or client’s health, psychological risk through a lack of satisfaction with
the outcome remains real. Bearing in mind the outcome in *Zahir v Vadodaria*, namely that the measure for courtroom success lies in the medical quality of the treatment, not approval on the part of the patient, legal action is no answer. Taking the matter to court may well not avail the woman dissatisfied that multiple and continuing treatments—whether for eight years, 10 years or more—no longer provide an illusion of youth.

As for double chins and plump necks, the extensive adoption of the practice of liposuction opened up possibilities for the area under the chin and jaw. Invented to address deposits of fat collecting on buttocks, hips, thighs and abdomen, surgeons with an eye to making the best of facelifts introduced it as a part of this process. Fat that refuses to disappear despite a healthy diet and exercise is sucked out. This enables the body to take on a more fashionably contoured shape. Conforming to a lifestyle that enables the patient to maintain a healthy weight means that the operation can meet with a lasting success. However, it is more likely to have a positive result if the skin is tight, with a positive elasticity. This means that it is not an answer to the scraggy, wrinkled and withered neck. Bryan Mendelson observes that some other neck conditions are unable to be improved by the process—where, for example, there is little or no definition between chin and throat, and despite the introduction of fat-melting injections for double chins, ‘neck rejuvenation’ remains ‘a key topic’ for plastic surgeons today.

Meanwhile, dentists are in great demand, offering services that include ‘smile makeovers’, crowns, teeth whitening, periodontal treatment, veneers, dentures, bridges, implants, orthodontics and treating ‘an incorrect bite’. As explained in *The Million Dollar Smile*, a failure to smile ‘can be perceived as sadness, anger, or pain [and] also as a cover-up … the inclination or need to hide imperfections or to simply hide anything’. Women smile more than men, and a smiling woman is evaluated more highly than an unsmiling one. Smiling is also more prevalent when power relations are involved: the less powerful smile more than the powerful. Research indicates that this is even more pronounced with the Covid-19 uptake of online conferencing via Zoom, which is ‘causing us to reassess our smiles’. Faced with a presumed potential for improving social interactions and employment prospects, women may therefore be even more drawn to undergoing expensive, even dangerous, dental surgery.

In their ‘ordinary’ guise, dentists are important to oral health. Oral hygiene is important, and a failure to care for one’s teeth can lead to
severe health problems including periodontal disease, recession of gums, loss of teeth, continuing bone loss affecting the jaws and thence changes to the entire structure of the mouth. Reconstruction is not, therefore, isolated to those who simply want ‘whiter than white’ teeth to be shown off in mouth splitting smiles. In the past, lost or disfigured teeth could be replaced by dentures or bridges or partial dentures (an alignment of a small number of ‘lost’ teeth, like dentures to be fitted into the mouth in the morning and removed at night). Then came crowns or caps—artificial teeth fitted over chiselled down ‘real’ teeth used as a base for each permanent white-enamelled or porcelain (sometimes gold) cap, or (now more likely) zirconium or ceramic crowns. Veneers, being porcelain shells that fit over the front and edges of teeth, each shell being bonded to an individual tooth, are generally employed ‘to alleviate flaws on a patient’s teeth’. Veneers are used where patients ‘are not satisfied with the colour or shape of their teeth’ or to correct gaps, cracked or chipped teeth. Sometimes they are used to address what clients see as ‘too long’ or ‘too short’ teeth: the original teeth are ‘adjusted’, with veneers ‘applied to correct that issue’. They are sometimes adopted by patients as a better option than teeth whitening.

Advances in dentistry have led to the introduction of dental implants, which replace lost teeth or teeth that require removal. Missing teeth affect the ability to chew food, where the digestive process begins. Beyond this practical consequence of the everyday, missing teeth ‘eventually cause … facial muscles to deteriorate’ and this alters facial appearance. The procedure for dental implants is not simple, requiring a three-step process. First, a titanium screw is inserted into the jaw, replacing and imitating the tooth root. This is left to heal so that it becomes a part of the jawbone. Next, a post or ‘implant abutment’ is attached to the ‘root’, jutting from the gum and into the mouth. Finally, a crown is applied to the abutment, so that it replaces the tooth—root and ‘cap’ or crown. So long as there remains sufficient bone in the jaw, an implant can replace all the teeth, one tooth or the front teeth so as to enhance the smile and enable good chewing of food. The conclusion of proponents is that implants are ‘the best option in terms of preventing bone loss and restoring the bite and smile to what it needs to be and to what patients would like it to be’.

Yet dentistry, like medicine, is not infallible. In addition, unqualified ‘practitioners’ entering the field cause damage and harm, and do so illegally. As the National Health Service points out, despite more and more people ‘paying for brighter, whiter teeth’, bleaching cannot make
teeth brilliant white although it ‘can lighten the existing colour by several shades’.

This process should be carried out by regulated dental professionals such as dental therapists or hygienists on a dentist’s prescription, or by dentists themselves. More than one visit is required, with a mouthguard taken from an impression of the patient’s teeth and provided to the patient so that they apply bleaching gel regularly over two to four weeks. Beauty salons offer teeth whitening illegally unless a qualified dental professional is present, and clients’ oral health can be placed at risk. A quicker process is laser whitening, but patients need to be advised of the risks associate with laser treatments.

Risks accompany bleaching teeth at home, even when under the care of a dentist. A mouthguard must be made specifically to the fit of the patient’s mouth, otherwise the bleaching gel can leak. This can be a feature of home kits, because the guard will not have been made to the measure of the user’s mouth. Leaking gel can cause blisters, and sensitivity of gums can arise from the process even when carried out by a dentist or other dental professional.

Dental implants, crowns and caps carry risks, too. One dental site lists the risks for dental implants as relating to the surgery itself or occurring in the first six months after implantation, or long-term complications and risks. Because the implant process involves surgery, it carries the general risks of surgery, although dentist George Ghidraj observes that risks of complications ‘is considered to be very low – less than 5 percent according to current statistics’. Problems that do occur are ‘usually minor and easily treated’. Complications can include bleeding, even severe bleeding if mistakes are made, requiring compression, vasoconstrictive medication, cautery or artery ligation. Ghidraj notes that generally ‘bleeding is kept under control’. Next, he lists infection, a common surgical risk amounting in present times to ‘less than 1%, … most being minor’. Accidental nerve damage is said to be ‘the most common issue’, causing ‘lingering pain, tingling and numbness in the teeth, gums and lips (mostly the lower lip) or chin’ for an indeterminate time. Patients ‘will recover’ after a period, in the instance of minor nerve damage. Problems with sinuses and instability of the implants are possible risks.

Complications within the first six months involve a failure for the implant to integrate, arising out of existing health conditions, poor oral hygiene, accidents during the surgery, or the consequence of heavy smoking or high alcohol consumption. Referring to the most recent research, Ghidraj notes the ‘most important factor’ as ‘primary implant
stability’ arising from lack of a healthy quantity of bone in the jaws.\textsuperscript{100} Long-term complications can arise from ‘an improper design of the prosthetic restoration or inappropriate care and maintenance. Ultimately, implants fail as a consequence of ‘loss of bone around them or mechanical failure of the implant’. Implants can also chip, break or fail to satisfy the patient. Such complications, whether in surgery or within six months or long-term, potentially arise if the procedure is carried out by an untrained person illegally, so that both civil and criminal action can ensue.

Victoria Handley in \textit{A Practical Guide to Cosmetic Surgery Claims} lists risks of cosmetic dental implant surgery as ‘infection at the implant site, injury or damage to surrounding structures, such as other teeth or blood vessels, nerve damage … and sinus problems ….’. Sinus problems occur, she advises, ‘when dental implants placed in the upper jaw protrude’ into a sinus cavity. Nerve damage ‘can cause pain, numbness or tingling’ in natural teeth, the gums, the lips or the chin’.\textsuperscript{101} Michael Hill, a barrister working in medical and dental negligence, reports on dealing with dental negligence claims including ‘implant failures, lingual nerve injuries, restorative failures, consent failures, inappropriate restorative materials, poor infection control, systemic infection, prescription errors, and inferior alveolar nerve injuries’ (damage to a branch of the mandibula nerve), amongst others.\textsuperscript{102} Not all will be associated with cosmetic dentistry performed on those seeking the ‘million dollar smile’. However, some may be.

A dental negligence claim for £125,000,\textsuperscript{103} with damage that could be replicated in other surgeries, reportedly ended in an out of court settlement for £60,000 for pain, suffering and loss of amenity (PSLA). \textit{Clamp v K} lists the patient’s injuries as resulting in symptoms including ‘prolonged pain, difficulty eating and speaking for four-and-a-half years, numbness to her lips, sinusitis, and an adjustment disorder’.\textsuperscript{104} The claim was that the defendant had assessed and planned the treatment inadequately and therefore negligently, that the surgery employed ‘poor surgical skills’ in placement of the crowns and bridgework, and that the crowns and bridgework were ‘of an unacceptable standard’. The adjustment disorder was met with advice that the patient should undergo cognitive behavioural treatment, and it was accepted that she would require treatment in the future.\textsuperscript{105}
5 Plastic Faces or ‘The New Normal’?

The move away from traditional surgery to what are perceived to be less invasive methods has led to even greater dependence on professionals whose job it is to help people, particularly women, feel better about themselves and their bodies. Some of these new treatments can be applied by practitioners lacking formal qualifications and, sometimes as it proves, skill. Botox and collagen are possibly pre-eminent in the panoply of purportedly non- or less invasive procedures and their use extends from ridding the face of wrinkles and thence of all expression, and turning lips into pouts, in their worst guise sometimes described as a ‘trout pout’. One, collagen, is a filler, so is used to smooth out blemishes and wrinkles. Collagen stimulators are employed to stimulate the body to make collagen itself, adding body to the lips, making them plumper or smooth. Botox is a toxin, derived from Botulinum Toxin type A, working primarily to paralyse muscles, ironing out wrinkles or smoothing them. Yet even when women undergoing these treatments get what they want—plump lips and fewer or no wrinkles—their sacrifice in time and money is not rewarded by public acclaim or admiration. Too often, onlookers remark upon the loss of expression that comes with Botoxing wrinkles out of existence, and the all-too-plump pouting of overblown lips. These problems tend to be par for the course: what the client wants, the client gets. Problems also arise from faulty application of the treatments, product defects, flaws or shortcomings in the work, or dangerous encouragement to self-application.‘I want to look normal’ is a mantra frequently heard when researchers undertake studies of women going through procedures designed to ‘enhance’ their looks or ‘stop’ the ageing process. As with cosmetic, plastic or aesthetic surgery, women emerge from clinics, salons and spas convinced that the faces they now sport are ‘normal’. Yet as Suzanne Fraser questions in Cosmetic Surgery—Gender and Culture, what is normal? what is natural? Sheila Jeffreys in Beauty and Misogyny questions the ‘natural’ and ‘normal’ proposition in a world permeated by misogyny. Liz Conor’s The Spectacular Modern Woman illustrates how quickly women became acculturated to 1920s notions of bodily ‘perfection’ transmitted through the film industry, beauty competitions and the imperatives of fashion. Facial proportions and symmetry, prompted by the work of Leonardo Da Vinci, generated a striving for conformity to notions of beauty and perfection measured by facial composition of...
women promoted as ‘the most beautiful’. Yet women displaying the exact measurements were relatively few, if they truly existed in every particular at all, and all were Caucasian or, like the famous 1930s Hollywood actress Merle Oberon (1911–1979) (who claimed she was from Australia (Tasmania) rather than acknowledge her Indian heritage),112 presented themselves as such.

The amount of time and money that go into creating the appearance of ‘normal’ or ‘natural’ belies the contention that what emerges is in fact either normal or natural. The pain suffered and sometimes short-term or long-term damage in creating plastic perfection contradicts the mantra, too. Nevertheless, not all actors, supermodels or celebrities embrace the move towards ‘designer bodies’ and their parts. This should spell caution to ‘ordinary’ women seeking to emulate them. Not only the risk of harm and damage puts them on the alert. Some adopt the ‘growing older gracefully’ model of ageing along the lines expressed by Kate Beckinsale. Speaking of the way her 65-year-old actress mother, Judy Loe, has resisted treatments or surgical intervention, Beckinsale says that her mother was ‘always very, very beautiful’ and ‘still is, in her sixties’. She is sure, says Beckinsale, that her mother feels: “Wouldn’t it be nice if my neck did this?” but not to the degree of cutting parts of herself off and dragging them behind the ears’. Saying that she is of a similar view, Beckinsale concludes that her preference is for her mother’s looks, rather than the ‘wind-tunnel faces’ seen in Los Angeles. To be enjoyed when one has it, beauty is a bounty, ‘a gift’ to be handed on to one’s daughter and, then, ‘you enjoy the fact that she has it …’.113

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