CHAPTER 2

The Body Beneath the Knife

Women’s bodies
Targets
Under the surgeon’s knife
Every body part besieged by
Botox
Laser/
Liposuction
Hair extensions
False nails
Implants and fillers,
foot, face, breast and bottom

Brows brushed thick
Eyelashes extended
Labia narrowly trimmed
Neatly packed and tended
Knifed into submission, natural
Legs remoulded
Ankles narrowed, knees reshaped, toes shortened, lengthened, straightened
Hips and shoulders realigned

Remade, refashioned, redesigned
Reformed, remodelled
Whittled, carved, sculpted, shaped
Nothing sacred, not really ours
Nor really us

Plastic prevails
So

In the mirror
Who stares back?

1 The Body in the Beauty Parlour

The proposition that women’s bodies can be allowed to walk daily on the street, exist in the paid workplace or appear anywhere in public without enhancement or embellishment is becoming less and less acceptable. Just as clothing maketh the woman, with employer demands that women wear high heels to the office, renounce trousers or pants in the executive suite, behind the receptionist desk, working at a computer terminal, seated in a work cubicle or anywhere else on a business premises, so too with women’s personal attributes. Once, make-up, false eyelashes, tattooed eyeliner and false bosoms were the signature of a woman on the stage, or a signal that she haunted alleys and backstreets in hope of a paying customer, or appeared in movies labelled ‘porn’. In the twenty-first century, these are signifiers of mainstream woman. Hence, in 2011 a ‘team of scientists and psychologists’ from Harvard and Boston Universities in collaboration with the Dana-Farber Cancer Institute, disclosed data gleaned from their study that women wearing make-up are perceived as ‘more competent, attractive, likeable and trustworthy’. The study’s finding was that this follows, whether women are made-up in a ‘natural’, ‘professional’ or ‘glamorous’ style, and whether the images are flashed before the eyes of participants in the study or are viewed by them for more lengthy periods.

Funded by Procter & Gamble, a huge conglomerate making much of its money through selling cosmetics (mainly to women), the study was labelled ‘independent’. The implication? It must be believed. This, at least, was the thrust. The message to all women seeking survival or promotion in Western democracies was unmistakeable. To get on in business or succeed in professional life, women must first spend extravagantly at cosmetic counters all over the country then get out the make-up palette. Better still, make their way to the nail salon, the hairdresser,
the spa and cosmetologist for the experts to apply lotions, unguents, creams, gels, ointment, balms—and on top of all that, the make-up. Even the prospect of working from home, engaging in online conferencing and scheduling meetings via Zoom in the time of Covid-19 has its implications for beauty and beautification. The hiatus in hairdressing appointments, temporary closure of nail salons and an interruption in the activities of clinics has not inhibited the beauty industry. Achieving ‘medical-grade skincare’ is essential when Botox wears off and, ‘with everyone on home quarantine’, a woman’s business profile is threatened by ‘unflattering zoom angles’. One New York plastic surgeon relates to \textit{Forbes} that ‘without disclosing numbers’, growth in her medical-grade skin care line has ‘exceeded 500%’.

Online cosmetic sales burgeon, and even the cancellation of elective surgery has not prevented a steady stream of enquiries about aesthetic, cosmetic and plastic surgery possibilities. This spawns the advice from yet another plastic surgeon to ‘stay home, stay safe’, whilst using the time productively in ‘researching about a procedure or treatment you have always wanted’.

The creation of a woman through deft and deliberate use of cosmetic sculpting and camouflage is, however, not new. In \textit{The Spectacular Modern Woman—Feminine Visibility in the 1920s}, Liz Conor reflects on the early twentieth-century invention of the woman as spectacle. Women emerged as types, the approach driven by innovations in visual technology, particularly the cinema. Liz Conor cites Russian filmmaker Lev Kuleshov inventing cinematic techniques placing the ‘spectacle of the “new woman” before the public’. This development occurred simultaneously with the 1920s identification of women as being or becoming classified as ‘the modern woman’: the City or Business Girl, the Screen Star, the Beauty Contestant, or the Flapper. Women had for long been represented in art as body types—the full-bodied type more frequently dominant, the less pronounced endowments of others nonetheless having some prominence. Peter Paul Rubens’ (1577–1640) voluptuously configured nudes stimulated notions of desire as located in the Rubenesque model. The earlier curvaceousness of the Venus de Milo combined sleekly rounded body lines with the modesty of hand-over-pudenda, a hidden yet exposed sexuality projected through a visual image. And, earlier than that, the Venus impudica or Venus impudique (‘immodest Venus’) with her rounded abdomen and thighs supporting pendulous breasts projected passion as associated with womanly flesh. Yet Edgar Degas’ (1834–1917) slender-bodied, lithe limbed dancers swirled and twirled
into fashion alongside the vogueishness of Amedeo Modigliani’s (1884–1920) models’ elongated faces and lean bodies. Some women would have been influenced by these images. Those whose lives were led in the public eye, whether as artists’ muses themselves, actresses or ladies of the night would have been particularly susceptible to the fashion of the body.

The modern era of public transport, together with the development of department stores, released many more women into public space. Liz Conor reflects on this as setting the stage for women to reflect more critically upon their own appearance, with their appearance being subjected to more intense critique. ‘Public womanhood’, she writes, ‘gained “cultural influence” by earning academic degrees, lecturing and speaking in public, travelling alone, attending theaters and dance halls, shopping in department stores, and riding bicycles’. So, too, with the growth of office jobs, librarianship, nursing and teaching. These new avenues of paid employment led women and girls onto streets and ferries, and into omnibuses, then onto the tube as it became more acceptable. Along with this freedom of movement came subjection to the male gaze. Public exposure made women more aware of their bodies, of how they looked—and were looked at. Sitting on public buses or in railway carriages meant opening oneself up to public scrutiny. Some women relished the attention which came from being under observation. Footpaths and offices becoming ‘theaters to these types of City Girl, places where [they] distracted, displaced, and visually overpowered men’. They wanted, says Conor, ‘to be part of the scene as spectacles, reputedly shortening their skirts to excite more attention …’. One ‘smart Yankee tourist’ met with the ire of the notorious Australian daily the Truth when she appeared on one of Melbourne’s major thoroughfares parading ‘in an extra short skirt, … her stockings rolled down below the knees’. This ‘bare-legged belle’ responded to criticism with a retort that in New York City ‘everyone is wearing bare knees … rouged and tattooed’.

Beauty contests, often aimed at attracting women as competitors with the lure of a Hollywood contract, became de rigueur. Newspapers ran competitions and photographers and other professionals began to dictate women’s bodily and facial perfection. This analysis followed the pattern adopted towards the end of the preceding century by famed criminologist Caesare Lombroso in his search to identify the ‘perfect criminal’ by measuring every conceivable facial feature. Closely positioned eyes, low hanging forehead, large flapping ears, thin cruel lips signified criminality. The beauty contestant analysts selected features and their relationship to
each other arriving at the antithesis of the Lombrosian type. For them, the perfect face comprised symmetrical features with a precise distance required between wide-set eyes, a retroussé nose rather than a Roman one, forehead exact in its dimensions, lips full but not too full, upper lip proportionate, chin delicately rounded. Not only were these studies in perfection utterly different from Lombroso’s. They focused on purity in breeding. Notions of ethnic and racial superiority, albeit not necessarily stated, crept in, ordaining what was, and was not, ‘beauty’.¹⁰

Women who did not conform to the perfect type sought to do so. Despite a backlash from sections of the popular press, and protestations from feminists that beauty competitions ‘judged and measured’ each entrant ‘as though she were an animal’,¹¹ some women were caught up in striving for perfection. That they were obliged to seek out means of doing so did not discourage them. Being charged with vanity and self-obsession was no deterrent. In Australia, the Sunraysia Daily condemned ‘vain women’ who appeared ‘to be watching themselves while they speak, listening to themselves, visualising themselves’. Being ‘greedy for admiration they … [were] too engrossed in themselves’, so that even ageing did not stand in the way of self-admiration. Their vanity would ‘not allow’ the ageing woman ‘to admit that her day is over’.¹² Increasingly artificial means came to create or enhance beauty, and age did not admit of defeat. Clinging to youth or its pretence was reinforced by the growing self-help industry of dyes and potions that could be administered at home, and the increased commercialisation of the beauty industry. To quell the belief that women were self-obsessed narcissists, bodily perfection as a health goal became fashionable. Products advertised originally as magical or glamorous were converted into natural adjuncts to healthy living.¹³ Yet ‘how do I look’ continued as one of the most commonly asked questions whether by a woman of her best friend, husband or partner, or (in the tradition of fairy tales) her mirror. Women’s bodies and women’s beauty took centre stage.

The pre-eminence of one shape over another may prevail, but the message remains. The 1920s bosomless look is replaced by the Marilyn Monroe breasted hourglass, thence to the slender limbed Twiggy of the 1970s, and into the 1980s where pronounced breasts compete with the bulging bottoms of the 2000s, and budding lips expand exponentially into full-blown swellings—yet bodies and beauty remain determinative of what is a woman.
In light of this, what of demands from the 1970s and earlier struggles for entry to university, the professions and trades? Do these calls for women to be recognised as more than mannequins or ornaments for a man’s arm, dressed up dolls with little but marriage on their minds, slaves to the kitchen or to mind-numbing work in an office, a factory or field have meaning? Have we ‘come a long way, baby’, or are women inexorably enmeshed in a culture that sees artifice as more acceptable than the reality of women’s physiognomy? Are women’s real bodies ‘out’, whilst contrivances projected as ‘real’ women constitute the perfection and beauty for which (once) real women must aim?

In *Bodies*, first published in 2009, Susie Orbach observes that over the thirty years prior to her writing, ‘an obsessive cultural focus on the body’ has developed.14 Everywhere, she writes, ‘we see evidence of the search for a body’. Whether it is presented as ‘preoccupation, health concern or moral endeavour, almost everyone has a rhetoric about trying to do right by their body’. This enforces and reinforces the notion that the body is unacceptable as it is. It is ‘not at all right’. Orbach concludes that the body is now a focus for ‘our malaise, aspiration and energy’.15 In this, she is both right and wrong. In 1970 Germaine Greer’s *Female Eunuch* acknowledged the problem existing then, as it had for centuries, of women’s bodies ‘being treated as aesthetic objects without form’.16 This was so for women themselves, in regarding their own bodies, as well as for the men in whose gaze they registered their existence.17 In so doing, said Greer, both the bodies and the whole woman are deformed. The various usages of women’s bodies, whatever their shape or character, ‘are deformations of the dynamic, individual body and limitations of the possibilities of being female’.18 However, the key truth of *Bodies* is Orbach’s recognition of the crushing obsessional nature of today’s focus on the body. Young women, old and older women, indeed women of any age and often not even into puberty do not learn only that their bodies are defective. They learn constantly through social and mainstream media, advertisements, film, television series, the ubiquitous red carpet of Hollywood and Cannes that anything, any body part can be fixed.

In the 1970s, women were concerned about weight, diet, bodily appearance as exemplified by the weight (losing weight) industry already working overtime, and women’s magazines laden with fashion, recipes, how to dress (the mantra of perpendicular stripes, not horizontal), make-up and diets. Orbach herself recognised this in her early work, *Fat Is a Feminist Issue*.19 But despite this age-old malaise, the 1970s aspiration
and energy were directed towards shifting from this concern to position women substantively in the world. Women claimed a right to become and to be legitimate operators at all levels of society and in all institutions, without reliance on frippery or furbelow. Kate Millett in her own original work, *Sexual Politics*, effectively revived Simone de Beauvoir’s *Second Sex* from twenty years earlier, Millett engaging in her own critique of literature, art, culture from the perspective of an American scholar.\(^\text{20}\) Earlier Betty Friedan’s *The Feminine Mystique* contested the notion that woman’s place was in the suburbs, content with three children, cat, dog, people carrier and a husband returning from his daily effort in the city designed to keep woman, children, animals and both cars (his and hers) afloat financially.\(^\text{21}\) Schulamith Firestone in *The Dialectic of Sex* added intellectual ballast and ten years later Susan Brownmiller followed up her peon against women’s subjection to rape, *Against Her Will*, with her new book, *Femininity*.\(^\text{22}\) Robin Morgan led in the radical movement, challenging the myth of bra burning, whilst leading women together on demonstrations and sit-ins, their bodies freed from brassiere and step-in constraints.\(^\text{23}\) Jo Freeman published her vital work on the Women’s Liberation Movement’s organisational approach to securing change, *The Tyranny of Structurelessness*,\(^\text{24}\) advocating that attention be paid to power hidden under the cry for freedom from constraining organisational and hierarchical demands. Then, after doing a journalistic stint as a Playboy Bunny at Hugh Hefner’s club, Gloria Steinem wrote her expose decrying the institutionalised objectification of the woman under the Bunny ears.\(^\text{25}\)

Almost instantly, however, the 1970s saw a raft of books and articles published as an antidote to the rejection by the Women’s Movement of lipstick, bras and step-ins (a modified corset or girdle), and the replacement of stockings and suspenders with pantyhose. When American women demonstrated in Atlanta at the Miss American contest, throwing underwear (including bras) and other paraphernalia into a ‘Freedom Trash Can’, it was inevitable that the establishment would respond.\(^\text{26}\) Marabel Morgan’s *The Total Woman*, advertised as having sold more than ten million copies, was perhaps the most popular of the anti-feminist tomes of the time.\(^\text{27}\) She advocated that women enfold themselves in saran wrap—a transparent plastic used to preserve left-over food—before greeting a husband just home from work. An alternative was to spread oneself liberally in jam or honey whilst making supper for a husband lying prone on couch or carpet watching evening television. In this context, ‘wife’ was supposed to equal ‘supper’.

Although the book and her accompanying seminars had a reputedly massive audience, it is doubtful that many women went to the lengths Marabel Morgan suggested. Yet perhaps a return to her bizarre instructions for feminine enhancement would be less damaging to women than a visit to today’s beauty parlours, and—extraordinary though it may seem—even less dangerous or humiliating. And certainly, less expensive.

Australians are reputed to spend ‘a collective $AUS 1billion-plus’ on cosmetic procedures annually, calculated as coming in at 40 per cent more (per capita) than the United States. In June 2019, the *Sydney Morning Herald* reported that spending on basic beauty routines ‘is out of control’. ‘Basic’ maintenance for women in their early twenties and thirties ‘is costing [them] the equivalent of a house deposit’. At a conservative estimate, approximately $AUS 14,000 (some £8000) is spent by each woman on ‘standard’ treatments. This includes ‘six to eight-weekly haircuts and colour, regular blow waves, (preventive) Botox, non-fat fillers, professional teeth whitening, eyelash extensions and refills, microdermabrasion, SNS nails [Signature Nail Systems], pedicures and laser hair removal’. Over and above this, cash is being laid out on skin care and make-up in the privacy of a woman’s own bedroom or bathroom, plus salon facials, waxing and spray tans, as well as ‘special events’ including the racing season, the festive season and celebrations such as birthdays, weddings and Valentine’s Day. Adding these into the estimates of women’s annual expenditure would amount to ‘hundreds of thousands of [dollars] over the course of a woman’s life’. Investigating, writer Kasey Edwards asked a trader in stocks and shares to estimate how an alternative approach of investing the $AUS 14,000 would look. On the basis of ‘net returns of about seven to eight percent’, over about a decade that figure ‘could be rapidly swelling towards $AUS 250,000’ (£140,000). Even if simply left in a bank term deposit for some six years, that same $AUS 14,000 could gain a woman a six-figure sum.

Yet entering a beauty parlour is not the only way a woman can be regaled with methods and mechanisms for spending money to become beautiful. In London, venturing into a large department store in Oxford Street means being assailed on all sides by ‘product’ representatives bearing potions, lotions and pastes in tubes, jars and containers of all dimensions, or brandishing hair wands, lash curlers or body shapers of all sorts and sizes. Sauntering into shopping malls brings with it a need to avoid salespeople imploring passers-by to sample a wide variety of perfume, cosmetics and beauty treatments. American, Australian and
other major capital cities carry their own brand of cosmetic confrontation, with department store refurbishments undertaken regularly to position make-up and perfume counters at the forefront of luring the customer. In the 1980s, competition between Opium, Obsession, Tresor and Shalima was at its height. In 1983 in Melbourne and Sydney, New York and San Francisco, department stores positioned scent-bottle-atomisers at every major entryway, spraying Angel on every woman passing through their doors. The scent wafted inside between display counters, into elevators and up the escalators, filling passageways and drifting outside into the malls. Meanwhile, in the 2000s, beauty salons adopt more and more fanciful methods of pampering the body, more and more ways of ensuring that women’s pockets and purses open wide in the search for the perfect body with flawless features, and the face of beauty—according to conventional diktat. Even pop-up or home-based practitioners can be found providing such services at reduced rates.

Want puffed-up lips? This comes not by the sting of a bee, but through the injection of chemical fillers, or agitating the lips with capsicum or chilli. Collagen and more recently developed products using hyaluronic acid operate akin to scaffolding, although ‘care must be taken’ to avoid ‘creating ridges’ giving the mouth ‘an ugly edge’. Silicone implants or ‘Permalip’ last longer—though they cost twice as much: $AUS 2000 to $AUS 4000 (some £2000) as opposed to $AUS 1000 to $AUS 2000 (some £1500) for several months of a protuberant pout. Then—it’s back to the beauty (sic) parlour to be relieved of another hefty sum to refurbish the lips now threatening to droop or deflate. Worried about fading eyebrows or wanting better defined arches? Microblading at $AUS 1000 (£600) ‘is not that painful’, it’s ‘pretty quick’, and you can have high arches or straight arches or mildly curved arches tattooed into your brow. It takes anaesthetic cream, the wielding of a ‘scalpel-like instrument’ (microblade), scratching pigment into your skin, two weeks of healing, at least five applications of aftercare cream, wearing a plastic head-shade in the shower and three follow-up visits. But, hey presto, the arches are well-defined … Then again, it’s trimming, plugging, waxing or threading as usual. Still, what about an end to wrinkles? This requires a good dose of botulism or, as advertised, its commercially named Botox. Rather than the death that follows upon a botulism bout, Botox targets ageing’s most visible facial indicator, the dreaded creases, folds and furrows. Of course, this has costs, too. Yet perhaps rather than the monetary outlay, the so-called ‘side’ effects should be centre stage.
Lessening or alleviating frown-lines may cause life-threatening conditions that, once detected—even at their most mild stage—dictate an immediate call to the doctor or the nearest hospital’s emergency department. These include short-term and sometimes long-term ‘side effects’:

- Problems with swallowing, speaking or breathing, caused by weakening of facial or throat muscles;
- Loss of strength and ‘all-over muscle weakness’, as well as double or blurred vision, ‘drooping or swelling’ eyelids, dry eyes, loss of capacity to speak, hoarseness or inability to articulate clearly, loss of bladder control;
- Dry mouth, discomfort or pain at the site of injections, tiredness, neck pain, headaches;
- Allergic reactions including ‘itching, rash, red itchy welts, wheezing, asthma symptoms, dizziness or feeling faint’.  

Even so, said one Botox website in November 2011, ‘no confirmed serious case of spread of toxin effect’ has been reported from between-the-eyes Botoxing. Nonetheless, if these symptoms occur, a sufferer ought not to ‘drive a car, operate machinery, or do other dangerous activities’. Readers may wonder about unconfirmed serious cases—and what classifies as a confirmed non-serious case, but merely receives advice that the ‘potential risk of spreading viral diseases’ such as Creutzfeldt-Jakob Disease (CJD) via human albumin—present in Botox—is ‘extremely rare’: ‘no cases of viral disease or CJD’ have ‘ever’ been reported ‘in association with human serum albumin’. In 2019 the site warned that Botox ‘may cause serious side effects that can be life threatening’ advising that if ‘any of these problems’ is experienced ‘hours to weeks’ after a Botox injection, then medical help should be sought immediately. The problems listed included those relating to swallowing (which ‘may last for several months’), speaking or breathing, attributed to weakening of associated muscles. These ‘can be severe and result in loss of life’. An additional warning flagged the highest risk as present if such problems existed prior to injection.

This and other services, treatments and products provided by salons in the pursuit of women chasing beauty raise the question of legal liability. What responsibilities devolve upon those providing the products and delivering the services? Product liability is governed by negligence law
and statutory provisions. In the United Kingdom, operating alongside common law negligence, the Consumer Protection Act (‘the Act’) covers statutory liability for defective products. Similar laws exist in other jurisdictions, including the United States and Australia. This means that where defective products cause harm to the bodies of those upon whom they are used, the client or patient can sue for compensation. Strict liability is imposed on defective product manufacturers, meaning that there is no need to prove negligence. Under the Act, the onus lies on the patient or client to prove, on the balance of probabilities, that:

- The product complained of was defective; and
- The product was the most likely cause of the injury of which the client or patient complained.

Action can be taken against the manufacturer of the product or of a component part of the product and/or against any party responsible for any essential characteristic of the product resulting from an industrial or other process. An injured person can also include, in their action, a respondent party with their name or trademark attached to the product and so holding itself out as the producer. Action is also available against a respondent party who imported the product into the European Community.\(^4\) As the Act provides, product safety encompasses:

- Monitoring the safety of products;
- Providing consumers with information enabling them to understand risks,
- Warning consumers of potential risks; and
- Taking action where a safety problem is detected.

A key issue is ‘what is a defect’ or ‘what is defective’. In Wilkes v DePuy\(^4\) the court determined the question by reference to an objective test, based on what the public at large are entitled to expect of the product. The case involved not a cosmetic or cream or similar beauty product, but a metal hip replacement implanted for mobility (not aesthetic or cosmetic) reasons. However, the principle applies to product liability generally, including cosmetics, hair and eyelash extensions, false nails and other products of the hair salon and beauty parlour.
In *Wilkes v DePuy*, suffering from osteoporosis, Mr Wilkes had a C-Stem implant inserted into the hollow of his thighbone. Some three years after the operation, the stem fractured, with some metal debris shed at the joint. This required insertion of replacement parts. Five years later, a further fracture necessitated further revision, sending Mr Wilkes back to the operating theatre, from which he emerged sporting a replacement model of a different type. Mr Wilkes sued DePuy International Limited, manufacturer of the metal components making up the artificial hip.

In assessing how the public’s ‘expectation’ of the product should be measured, the court referred to an earlier case *A v National Blood Authority*. There it was held that the requirement of safety does not mean ‘an absolute level of safety, nor an absolute liability for any harm caused by a harmful characteristic’. Rather, the question is, ‘is the safety or the degree or level of safety or safeness which persons generally are entitled to expect’. In assessing the question, that means it is the public at large or persons generally whose expectation should be measured, not that of the individual claimant. This is particularly relevant to claims involving beauty products, whether cosmetics or breast implants or other prosthetics, fillers or inserts, for individual expectations may be unrealistic, going beyond that of the public at large or persons generally.

Furthermore, safety is not measured by what the public at large actually expect, but what they are entitled to expect. Summing up this aspect, the court in *Wilkes v DePuy* concluded that in considering whether a product suffered from a defect:

> ... the court must assess the appropriate level of safety, exercising its judgment, and taking into account the information and the circumstances before it, whether or not an actual or notional patient or patients, or indeed other members of the public, would in fact have considered each of those factors and all of that information.

Again where beauty product claims arise, this analysis resonates, for client or patient expectations and wishes of transformation may be so high or wilfully exaggerated as to pass over proper consideration of information dispensed or fail to consider factors relevant to the product’s application. Referring to *Wilkes v DePuy*, in *A Practical Guide to Cosmetic Surgery Claims*, Victoria Handley lists the circumstances a court will take into account, whether or not a claimant considered them:
All aspects of the marketing of the product;
The use of any mark in relation to the product;
Instructions and warnings;
What might reasonably be expected to be done with the product at
the time the product was supplied.\textsuperscript{50}

If damage suffered by the client or patient is caused in whole or in part by
the defect, then the product’s producer is liable. The client or patient is
obliged to prove on the balance of probabilities that there is a causal link
between the damage and the product defect, but is not obliged to prove
what caused the lack of safety or why the product failed.\textsuperscript{51} But what must
be borne in mind, as the court in \textit{Ide v ATB Sales Limited}\textsuperscript{52} pointed out,
is that no medicinal product, ‘if effective, can be absolutely safe’. This
applies, too, to cosmetics and beauty treatments generally, and each case
must be considered on its own merits.

Claimants must remember that time limits apply to claims under
consumer legislation such as the \textit{Consumer Protection Act}. This means
that if action is not launched within the time limit running from when
the damage occurred or when the client or patient became aware of the
damage, then the claim will be dismissed automatically. Some cosmetic
surgery or even beauty treatments may not show immediate damage,
coming to light years after the application of a particular product. This
may apply, for example, with breast implants and liposuction, where
ruptures or circulation of fat deposits to other parts of the body may
occur long after the patient or client has left the surgery or salon. In this
case, to come within the three-year limitation period the argument has to
be made that action was taken immediately the damage came to light, or
within three years after it did so. The three-year limitation can run from
that date, rather than the date of the operation or procedure itself.

Defences of contributory negligence and \textit{volenti non fit injuria} are
particularly cogent in claims relating to cosmetic and beauty treatments.
As for contributory negligence, this could occur where the product is used
at home and some misstep in its application is made, contributing to the
damage. The person using the product without regard to the instructions,
or varying its application by missing out steps or ignoring some require-
ments whilst following others, who suffers damage could then be seen
as having some responsibility for contributing to the harm. Any claim
for compensation will be cut down accordingly. The second defence of
\textit{volenti non fit injuria} encompasses the willing acceptance of risk—which
may well apply to clients eager to transform their body or some feature of it. The literal translation of the Latin is ‘to a willing person, injury is not done’. Theorists who argue that women exercise agency in undergoing aesthetic, cosmetic and plastic surgery, even when it is known to be risky—even highly risky—need to be aware that they are advocating for complete responsibility where women are harmed or even seriously damaged by the procedures to which they submit. Their argument of ‘agency’ undercuts the legal rights of women to compensation for harm and damage.

Other defences include the argument that the product was defective by reason of its having been required to comply with a legal requirement, or that the product is not genuine, but a copy of the manufacturer’s own product. Just as copying is a feature of the fashion industry, it can be prevalent in the pharmaceutical and cosmetic industries. Yet not only copying is a problem. ‘Puffing’ through false or exaggerated advertising of a manufacturer’s own products can persuade women that their hopes for a new life through bodily transformation can be realised. What about such representations or misrepresentations made to women undergoing treatments or procedures delivered to beautify: are these to be accepted simply as within the bounds of beauty advocacy, or is there a liability in the cosmetic or other company that makes extravagant claims? What of client autonomy and issues of consent? These issues arise not only in the beauty parlour, but in the clinic, the surgery and the hospital setting.

2 The Body on the Operating Table

Consent is at the heart of bodily touching, whether it’s a question of medically required treatment, cosmetic enhancement or surgical augmentation. Various levels of assault and battery apply to intentional touching of another person’s body without consent. As Lord Lane CJ held in *Faulkner v Talbot*, proof of hostility, rudeness or aggression is not required and, because the actual damage is constituted by interference with bodily integrity, nor is there any need to prove physical or economic harm for a claim to succeed. As was said in *Collins v Wilcock*:

The law cannot draw the line between different degrees of violence, and therefore prohibits the first and lowest stage of it; every man’s person being sacred, and no other having the right to meddle with it, in even the slightest manner.
The reason surgeons and other medical practitioners can carry out their work legally is that the touching—whether causing damage such as bruising, wounding or serious or grievous bodily harm—is consented to by the patient or patient’s parent, guardian or other appropriate person, and it is for the patient’s benefit. For those whose work requires it, including cosmetologists, hairdressers, beauty specialists, manicurists, podiatrists, pedicurists, eyebrow threaders and microbladers, waxes and razorblade welders, dentists, therapists and the like, the same principles apply. Similarly with licenced tattooists and body artists, although ‘extreme body art’ is a problematic field. The second question is the standard of care that is to be expected from the practitioner.

When medical operations go wrong, questions arise as to the professionalism of the practitioner and the care they have taken not only in conducting the operation but in discussion with the patient. This includes the issue of risk and quality of information conveyed to the patient. How much risk and explanation of it is required to be given by doctor to patient so that the patient’s consent qualifies as ‘informed’ at a level sufficient to satisfy the courts? If a case is brought in battery, Chatterton v Gerson held the question to be ‘was the patient informed in “broad terms” of the nature of the procedure proposed?’ This sets a high threshold for claimants which, as Jo Samanta and Ash Samanta say in Medical Law, generally makes it difficult for an action in battery based on ‘want of disclosure’ to succeed. However, successful claims are possible, as in Schweizer v Central Hospital and Cull v Royal Surrey County Hospital, where patients sued for trespass to the person. In one, consent had been given by Mrs Cull to an abortion, but the end result was hysterectomy. In the other, Mr Schweizer gave consent to a toe operation, only to be presented with a completed back operation. Hence, to configure it starkly, were a woman consenting to a rhinoplasty to wake from a general anaesthetic to find her ears pinned back, whilst her original nose remained, she should succeed in an action against the surgeon and hospital for trespass. More problematic is the situation where consent is given to a breast augmentation, the woman consenting to a DD breast size, the resultant operation producing breasts of greater or lesser dimensions. Here, negligence is the more likely line of pursuit.

In negligence cases brought by patients who, having been operated on, are harmed by or dissatisfied with the outcome, courts grapple with paternalism, autonomy, medical knowledge and expertise. The principal legal cases addressing these questions and setting down the principles do
not involve plastic surgery or cosmetic procedures. However, because they set the standards, decisions in these cases are key in determining whether a plastic surgeon or cosmetic specialist is likely to be held liable when injury or harm occur, or when patient dissatisfaction surfaces.

A US case fixes the cardinal principle of medical treatment. In 1914, in *Schloendorff v Society of New York Hospital*, Justice Cardozo said that every human being ‘of adult years and sound mind’:

> ... has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient’s consent commits an assault. 60

This principle or its equivalent is followed in the United Kingdom and other common law countries like Canada, Australia and Aotearoa/New Zealand. But when Justice Cardozo talks of consent what is actually meant? The notion of ‘informed consent’ emerges into the surgery and operating theatre, spa and salon or pop-up practice, and thence, when ‘things go wrong’, into the courtroom. Considered on the most basic level, when a patient makes an appointment with a doctor and attends at the surgery to present the doctor with their concerns, the assumption arises that the patient has come for a discussion and potentially an examination. If the examination is routine, say a blood pressure test or taking blood for tests to be conducted by a pathologist, the assumption is generally that the patient gives an implied consent. The practitioner (nurse or doctor) takes out the blood pressure equipment when asking the patient to roll up a sleeve or remove a jacket or shirt to ensure that the band is wrapped firmly around the upper arm. Inserting a needle to extract blood, the practitioner warns ‘it may sting’ or ‘hurt’ and the patient can withdraw, but generally the needle goes in, the blood is taken, a plaster is affixed to the spot of needle entry and the patient departs, knowing that the results will be conveyed when available.

On a similarly basic level, this applies with beauty salon treatments. Defending against bad hair days, the client makes an appointment, stipulating what is required—say shampoo, semi-permanent colour, blow dry. Upon arrival, the assumption is that they (and the salon) know what is intended—colour selected in a consultation between client and hairdresser or colourist, colour mixed then applied to hair, the client advised that the colour will remain for (say) 20 minutes or half an hour. Then comes a move to the basin, water, shampoo and conditioner. Next, back
to the original chair, a question about ‘product’ such as mousse and a ‘yes’ (consent) or ‘no’ (no consent) from the client. A hairdryer is turned on, the hairdresser completing the blow dry. If she had not had colour applied at that salon previously, a colour test should have been undertaken 24 or 48 hours earlier, colour applied behind the client’s ear to guard against a negative reaction when the whole head is covered. Without the test, and the client suffers an allergic reaction to the colour, the salon is open to legal challenge. One Marine Agency Insurance company in listing the ‘Top 9 Reasons’ for a lawsuit against a hairdresser’s salon does not include allergic reaction to dye, effectively confirming that salons generally do test. Nonetheless, failures occur, and a business support service lists this as a potential claim. As to content of the products used, the client rarely asks and is rarely advised. The assumption is that, as a professional with the (presumed) requisite training, the hairdresser or colourist uses products containing hair- and body-friendly ingredients, sound and without defects. Sometimes, these assumptions are misplaced, giving rise to injury, complaints and legal action. So, too, in the doctor’s surgery: if equipment is faulty or products are contaminated or produce allergic reactions, lawsuits may arise from injuries sustained. So long as European regulatory regimes are maintained in the United Kingdom, medical devices and diagnostic kits and delivery systems for drugs are subject to strict regulation. Failure to comply underpins legal liability. Regimes and regulations may differ in Australia, Canada, Aotearoa/New Zealand and the United States, but generally product and equipment defects and mishandling come within statutory guidance and control. If the United Kingdom renounces the EU standards, it can be expected to adopt a regulatory regime generally consistent with the standards existing in these countries.

As to principles of legal liability governing medical practitioners and clinicians, dentists or beauty industry professionals, sometimes claims may be brought under contract law between a private practitioner and patient (though not for procedures on the National Health Service [NHS]). In Canada a contractual claim against a plastic surgeon succeeded where, preceding the operation, the doctor told the patient: ‘There will be no problem. You will be very happy’. There was a problem. The patient was not very happy. This was deemed an express contractual warranty binding on the surgeon, making the surgeon liable in contract. Generally, however, claims are pursued in tort, a civil wrong. The claimant bears the
burden of proof ‘on the balance of probabilities’, relying upon the negligence of the practitioner. The patient must establish that the defendant (surgeon, hairdresser, therapist, manicurist, masseuse …) owed them a duty of care, that the duty of care was breached and that the damage was caused by the defendant’s failure. The duty arises from the relationship between the parties, patient or client and doctor or practitioner or hairdresser … A claim may also be brought against the medical practice or the beauty salon itself, or the spa owner/operator or management. Once the duty of care is established, the onus is on the claimant or litigant to show that the duty was breached. This is proven by evidence that the standard of treatment given by the defendant to the claimant ‘fell below the standard expected of [the defendant] by the law’. The standard expected is that which relates to the type of practice or procedure the defendant holds her or himself out to provide. This is illustrated by a case involving a skin complaint treated by a practitioner trained in and applying Chinese herbal medicine. In *Shakoor v Situ (T/A Eternal Health Co)* the patient had consulted the Chinese herbal medicine specialist, knowing that that was his speciality. Following the therapy, the patient suffered acute liver failure and died. The court dismissed the claim, basing its decision on the fact that the defendant had applied the treatment consistent with the traditional practices of Chinese medicine, in which he was trained. He had not held himself out to be a medical practitioner so, said the court, he could not be judged by the standards applied to competent medical practitioners.

Finally, where substandard treatment is found, for the claim to succeed the court must decide whether it is because of this substandard treatment that the claimant suffered a legally recognised harm. In other words, did the defendant’s acts or omissions cause the harm? Harm that is recognised by the law as actionable and compensable or warranting damages includes physical injury or psychiatric illness. For claims of psychiatric damage to succeed, an identifiable psychiatric or psychological condition or illness must be proven. Stress or distress can be a symptom or sign of such condition or illness. But without evidence before the court of psychiatric illness or a psychological condition the claim fails.

Two further matters must be borne in mind. Just as is so under consumer legislation, limitation periods apply in negligence claims. First, the *Limitation Act 1980* requires that a claim for negligence must be lodged with the court by filing a statement of claim within three years of the conduct causing the damage complained of. This rule can be varied,
but in circumscribed circumstances. Say the damage is not discovered immediately. As with the application of the limitation period principle under consumer legislation, this can happen with implants whether breast, or tooth and gum, fillers or other substances imported into the body by aesthetic, cosmetic or plastic surgeons, or other practitioners. Once the damage is known, or the claimant ought reasonably to have known of it, then the three-year limitation period begins running. If the time runs out before an action is instituted, then that puts an end to the claim. Secondly, a question of contributory negligence might arise. When a claim is lodged, the defendant may institute a counterclaim for contributory negligence, averring that the claimant herself contributed to the damage. Say that the claimant undergoes liposuction or implant surgery. She is told by the practitioner not to exercise for several weeks, or to stick to gentle walks or slow, rhythmic movements that do not engage that part of the body which underwent the procedure. Contrary to advice, she begins back at the gym almost immediately, working out with dumbbells in a vigorous routine because she believes that exercise will help to reduce any prospect of fat, suctioned away by liposuction, returning. Or she attends a bootcamp, taking part in long, strenuous walks and deep breathing exercises, showing off her new contours. If her claim is accepted by the court, namely that there was a breach of duty owed by the defendant, that the defendant breached it, and that damage was caused thereby, the court may also find that the whole of the damage was not a result of the defendant’s conduct alone. Rather, the cause of the damage lies with both the defendant and the claimant. Compensation calculated as due to the claimant will therefore be cut down by the claimant’s contributory negligence. If the compensation is calculated at, say, £30,000, and the claimant’s contributory negligence is calculated at one-half or fifty per cent, the defendant will be ordered to pay her £15,000 only. The case of Karen Turner v Mr Nigel Carver, decided in 2016, has some similarity with these facts, as Ms Turner did not follow the post-operation advice of the surgeon, Mr Carver. Her claim foundered on the failure to prove negligence. However, had she succeeded in establishing negligence, her damages would have been reduced because of her ignoring the surgeon’s post-operative advice.70

Returning then to beauty treatments, spas and hairdresser and beauty salons are ripe for investigation of how the law applies. Take the hairdresser example. A regular at the salon, the client has a standard appointment including a permanent or semi-permanent colour. Throughout her
time as a client, the woman’s hair has been coloured with a particular product. The salon decides to try a new hair dye, fails to do a test on the client, and the client experiences an allergic reaction to the dye. Suffering a fainting fit, she is sent home in a taxi at the salon’s expense. Overnight, a severe rash breaks out all over her body, her scalp develops suppurating boils, her hair falls limp and lifeless. The injury is caused by the hair dye, the salon owes the client a duty of care arising from the relationship between the client and the salon. The breach of duty lies in the failure to test the new product on the client 24 or 48 hours ahead of the appointment and using the new product without this caution. Had the test been done, the danger would have been evident and disaster averted. Failure to test opened the client to suffering physical injury. As long as the connection can be made between the dye and the reaction, the claim is likely to succeed. Or say the appointment was to fix the client’s hair for a special night out. She displays proudly a temporary black henna tattoo fixed on her left shoulder and one on her right forearm, done to impress her friends. She asks the hairdresser to select a contrasting dye for her hair. The dye is applied from existing stock, and just as she leaves the salon and later at home, she suffers fainting, boils, rash, and hair limp and lifeless. She misses the party, her condition worsens overnight, an ambulance rushes her to hospital where, having suffered a serious anaphylactic reaction, she is bedridden for days. The breach of duty of care lies in the salon’s applying the hair dye having failed to ask whether the tattoo was ‘black henna’. This is crucial, for black henna carries illegally high levels of PPD or paraphenylenediamine, a chemical in hair dye at maximum levels controlled by law. PPD levels in black henna tattoos can render a person highly sensitive to PPD in hair colour, despite the hair dye having been used safely on the client previously. The case rests on the salon knowing, or that it should have known of the potential impact of exposure to PPD through black henna tattoos, and the legal level of PPD in the salon’s shampoo. The NHS warns specifically of this risk, publicising the death of a woman whose black henna tattoo had been applied five years before she suffered a serious anaphylactic reaction to dye when colouring her hair.71

In a cosmetic or plastic surgery setting, the duty of care lies in the doctor– or practitioner–patient relationship. For example, the patient undergoes one of the most popular body-changing procedures, liposuction. She complains of dimpled thighs or cellulite. She wants her thighs made smooth and believes liposuction will effect this by removing the
fat that forms the lumps. Excitedly she hears the doctor will use laser liposuction, a new procedure he says is less invasive than the traditional method. Telling her she may well see the results as soon as the procedure is complete, he says nothing about the risks of third-degree burns, charring, scarring or infection, or that she may need to return to the surgery for revision. Nor does he say this is the first time he’s used the equipment, and he’s had no training on it. At the same clinic, another patient undergoes traditional liposuction, this time with liposuction removing adipose tissue from her buttocks (too fat, she thinks) and into her thighs (too thin). This liposuction fat transfer she believes will make her bottom perky, her thighs smoothly contoured. There is some risk the doctor says, but only about 0.3 per cent of patients suffer complications. The first patient emerges from the tiny operating theatre with smooth thighs and is thrilled, her husband admiring. She imagines wearing short skirts again, even daring short-shorts. Her thighs are tingling, there’s a burning sensation, but she’s been told this is normal and will pass. It doesn’t. She develops serious burns, undergoes treatment for what seems like weeks on end, and emerges with serious scarring. The second patient returns home delighted. She’s hoping the bathing costume she wore so desirably in years past has retained its elasticity, to match the taut curves beneath her bottom. As she reaches into the smartly built-in wardrobe, moving gently for yes, there is some pain, she suddenly collapses and dies before the ambulance or medics can reach her. The verdict? Cause of death pulmonary fat embolism. An independent senior consultant tells the inquest that the risk of fat embolism is a known risk of liposuction, whether performed with or without fat transfer. If the operation does involve fat transfer, there is a risk of its disrupting blood vessels with resultant fat embolism.  

In each case, the patient must establish breach of the duty of care. Where the patient died, duty of care is breached if the doctor has failed to meet the standard of care the law expects in delivering the treatment. As the potential for pulmonary embolism is a known risk of liposuction, the doctor is obliged to exercise care taking this into account. If it could be shown that the doctor failed to bear this potential in mind, this failure causing the death, then the doctor would be liable. What if the doctor injected more fat into the woman’s thighs at a more rapid rate than clinically advised, then that could breach the standard. Alternatively, perhaps the woman suffered an underlying condition making her vulnerable to pulmonary embolism. If this could and should have been known to the
practitioner by proper diligence in examining the patient and taking her history before embarking on the procedure, that could underpin liability. Another argument could be that the patient should have been warned by the practitioner of this particular risk, with advice of steps she could take in exercising care to guard against that outcome. As to the laser liposuction case, the question is whether the burns and scarring were caused by the doctor’s conduct in carrying out the procedure. Lack of training would be relevant. Although burns can happen, they may be the result of the doctor’s inability to use the equipment to the standard of a properly competent medical practitioner—likely because of that training deficit. A breach could lie in a failure to advise the patient how to read post-operative signs of burns early, so as to seek medical care and attention immediately. A breach could also arise in that knowing that burns can be an outcome, the doctor failed to advise the patient as to post-operative care that would lessen the possibility of scarring. Additionally, being a relatively new therapy may affect the standard required. This is particularly germane to the beautifying bodies field, because new procedures and new products come onto the market at a seemingly rapid rate.

The original test for determining the standard of care owed to patients by medical professionals was set in *Bolam v Friern Hospital Management Committee*. The House of Lords held that the professional would not be in breach of their duty of care if acting in a manner that accorded with practices accepted as proper by a responsible body of medical professionals with expertise in the same field. There could be disagreement between groups of these professionals, however, that did not mean that the doctor would be liable. So long as there was a group which considered the professional’s conduct ‘proper’, then the doctor would be considered to have met the required standard. This test was disputed on the ground that it allowed medical practitioners to set their own standard. In *Bolitho v Hackney Health Authority* it was held that if a body of opinion says that the doctor’s standard is a proper one, the court must be satisfied that the opinion rests on a logical basis. This can be regarded at least to some extent as applying an increased critical perspective to the work of professionals such as medical practitioners, yet there remains a substantial reliance on, effectively, doctors’ self-assessment of what is an acceptable standard. More recently, *Montgomery v Lanarkshire Health Board* set a standard relating to patient autonomy. Before addressing this principle, however, it is important to consider against whom a patient or client can take action.
What if the doctor, hairdresser or beauty practitioner does breach their duty of care, yet holding them liable gains the damaged patient or client nothing beyond emotional satisfaction, if that? Although individual professionals are likely to be insured if they are prudent, and some professions require practitioners to take out their own insurance against potential errors, people injured or suffering pain or serious damage will be advantaged if the salon, clinic, hospital or hospital trust carries insurance. If the party suffering from a botched procedure wants financial recompense, wisdom lies in suing the party with the greatest likelihood of paying out a damages claim, most likely to be an institution or business. Here, vicarious liability is the key.

Vicarious liability is the legal term given to circumstances where one party engages in wrongdoing, and a second party is held liable. Sometimes, the second party has some ‘primary liability’—that is, has engaged in some form of wrongdoing, too, so is equally to blame or has some blameworthiness. Sometimes, however, the second party has no primary liability—having engaged in no blameworthy conduct at all. At first glance, this may seem unfair. However, public policy comes into play, balancing rights and responsibilities. So here it is that public policy governs the field, and public policy dictates, effectively, whether vicarious liability applies. This can be particularly important where errors occur in procedures involving beauty treatments or cosmetic surgery, plastic surgery or less intrusive measures such as cutting and shaping hair, affixing acrylic nails, straightening corkscrew curls or frizzy hair, applying permanent waving lotion, gels and hairspray, or whitening or tanning skin. Does the business bear responsibility and hence liability for compensation? Or does liability lie solely with the practitioner who applies the lotion or adhesive, colouring agent or dye, wields the scissors or hairdryer, wraps the body in mud packs or guides the client into a chair and positions her head under an all-enveloping dryer?

Originally, vicarious liability covered the employer/employee relationship only. This meant liability lay in the claimant establishing, on the balance of probabilities, that:

- The wrongdoer—errant hairdresser, slapdash beauty practitioner, less-than-professional medical practitioner or surgeon—was an employee; and (that being so)
- The wrongdoing was done in the course of employment.
Advances in the law of vicarious liability mean that today it can apply to situations beyond employer/employee (a contract for service). Considering changes in the industrial world, this is particularly important. Employers have sought to escape responsibility for employee on-costs including holiday pay, superannuation or national insurance, sick leave pay, maternity and parental leave, and similar work-related benefits as well as avoiding payroll and other taxes by classifying workers as independent contractors (a contract for services). This development is pronounced in hairdressing and the beauty industry as a whole, where workers are asked to supply their own equipment and even to hire the chair allocated to the clients whom they beautify. Now, rather than simply look at the stated contractual terms between the parties or whether a worker is ‘part and parcel of the organisation’ (a test developed by Lord Denning) courts consider the parties’ relationship as a whole. As well, if the relationship is ‘akin to employment’ then vicarious liability may apply.

In Lee Ting Sang v Chung Chi-Keung, a case involving a worker injured on a construction site, the court listed a number of factors to be taken into account in determining the working relationship, including whether the worker:

- Is closely supervised—although if the worker is skilled, the impact of this factor is lessened;
- Is an integral part of the organisation or business;
- Provides their own equipment and/or hires their own workers;
- Bears a financial risk as a part of the working relationship and/or profits from their good management of the work done;
- Determines their own working hours or has their working hours set by the organisation or business;
- Works for the organisation or business as their ‘boss’ or manager, or is in business on their own account.

In Various Claimants v Catholic Child Welfare Society (the Christian Brothers case) the court listed factors which make it fair, just and reasonable for vicarious liability to be imposed on an organisation or business as a matter of public policy. Although insurance is not a sole reason for determining liability, it is a matter to be taken into account. This follows, because the employer is more likely to be able to compensate a client or patient suffering damage and generally will be insured against the
risk. Further, the business or organisation will have created the risk by having the activity carried out as a part of the business activity. Whether to a greater or lesser extent, the party doing the damage or causing the injury will be operating under the control of the business or organisation. Finally, the damage or injury will have been caused as a consequence of activity carried out on behalf of the business or organisation. These principles were set down by reference to the employee/employer relationship. However, the court went on to say that in the absence of an employment contract, where the relationship has like incidents as employment, then it ‘can properly give rise to vicarious liability on the ground that it is “akin to that between an employer and employee”’. 82

This is not the whole answer, however, because liability also is governed by whether the employer, organisation or business has authorised the doing of the act which led to or caused the injury or damage, or if the employee was off ‘on a frolic of his own’. 83 Was the employee ‘engaged on her or his employer’s business’? 84 Employers have been held liable where an employee drove contrary to the employer’s instructions, driving negligently in rushing through the factory gates to clock in on time, or paid a minor to carry out work tasks, despite the employer’s prohibition. 85 Hospitals have been held vicariously liable for the negligence of doctors in their employ or in a relationship akin to that of employer/employee, just as have local authorities for negligent acts by their teachers. 86 The principle can be extrapolated to hairdressers or beauticians, eyebrow threaders or waxers, microbladers and manicurists taking shortcuts or leaving creams or dyes or other products on the client beyond the allotted time, or clients under hairdryers for longer than usual.

Even where an employee’s acts are not negligent but intentionally harmful and so subject to criminal action, an employer can be held liable. The rule governing this is whether acts or conduct, albeit not authorised, ‘are so connected with acts that [the employer] has authorised that they may rightly be regarded as modes – although improper modes – of doing them’. 87 An employer will not be vicariously liable, however, if the intentional or criminal conduct was ‘so divergent from the employment so as to be plainly alien to and wholly distinguishable from the employment’. In Harrison v Michelin Tyre Co 88 the court held that this question must be determined by reference to the reasonable man (or person). Finding for or against employer liability rested upon ‘whether a reasonable man looking at all the circumstances would think that the incident was part and parcel of the employment’. 89
At the same time, attention must be paid to the client or patient and their role in the process. Ultimately, cases may turn directly on the question of consent. This is particularly problematic in the case of aesthetic or cosmetic or plastic surgery, where women consent to surgical operations and cosmetic procedures as well as non-surgical or ‘non-invasive’ measures that are not designed to save life, nor to improve health as conventionally understood. Yet the risks can be high, some would say disproportionately so. Susie Orbach in *Bodies* posits that the very existence of surgical and non-surgical means for ‘transforming the body’ generates a craving to make use of all these measures to remake our bodies. Indeed, it becomes an obligation, even a moral duty, to act. The fact that we ‘can transform the body’, says Orbach, ‘makes it a site of dissatisfaction which can be overcome’. Since the means of overcoming this sense of dissatisfaction is so readily available, the point is reached where failing to do so is not to be tolerated. Women are accustomed to hearing exhortations such as ‘why on earth doesn’t she do something about her hair’. Nowadays, sotto voce exclamations as to a woman’s failure to ‘do something’ about her wrinkles, her grey hairs, her untidy eyebrows, her sagging bosom … are not uncommon. Hence, ‘the overcoming of dissatisfaction [with our bodies] has … come to take centre stage’. Plastic surgery and plastic surgeons, cosmetic surgery and cosmetic surgeons, beauticians and personal trainers represent to us, whether through advertisements or the internet, or popular magazines or upmarket publications, that we can change everything about our bodies. This leads women to enter into agreements to have their bodies altered, whatever the price. So the woman wanting smooth thighs puts her body into the hands of the surgeon, ready to subject herself to a procedure he tells her is new. Rather than enquiring about potential dangers, her focus is on ‘new’ as in ‘good’ and getting rid of the cellulite that plagues her days. Instead of pausing to reflect that it may be unorthodox to go under anaesthetic to have fat sucked from her thighs or transposed from one part of her body to another, or that an operation is serious, and not to be submitted to lightly, she thinks only of lithe legs and gently curved hips, and reviving past bathing costume glories.

Here, in the laser liposuction and traditional liposuction examples, each patient put her life and well-being at risk, yearning to improve bodily features by remaking those that existed naturally. Wanting this, each sought out the clinic, secured the surgeon, and acquiesced in the treatment. In the first case, it was consent to undergo laser liposuction. In
the second, consent was to submit to the traditional procedure. Yet was this consent in the legally required sense, that is, informed consent? In neither case was the patient informed of the risk associated with liposuction, and in the first the patient was denied knowledge of the doctor’s lack of competence in using the equipment, through lack of training and lack of experience. Turning, then, to negligence cases setting the parameters of informed consent, originally the Bolam case set the leading test.93

The basic principle in Bolam’s case for consent to medical treatment is that general risks must be disclosed to the adult patient with the capacity to make decisions for treatment.94 According to Bolam, a duty lies on the practitioner to inform the patient of risks of an operation or a procedure. However, this does not mean there is an obligation to advise of every possible risk. If a practitioner fails to disclose a minor risk, and the patient having consented without that information suffers injury or harm because that risk ensues, is the doctor liable in negligence? The principle established by Bolam’s case is that so long as there is a body of professionals in the same field who would not have disclosed that minor risk, then liability does not accrue. As with the legal standard of medical care and treatment, it does not matter that another body of professionals in that field would hold otherwise. This principle has been criticised as paternalistic. Nonetheless, it was followed by the courts until the decision in Montgomery v Lanarkshire Health Board.95

The Montgomery case instated the principle of autonomy in patient–doctor decision-making. Applying this in the context of negligence, the patient’s case is that first, the doctor did not disclose the risk. Therefore, the patient ‘consented’ to the operation or procedure without knowing that the risk was present. When the risk happens in the course of or as a consequence of the operation or procedure, the patient then argues that, had the risk been disclosed, she or he would not have gone ahead with the operation. That is, would not have consented. Hence, the argument runs that secondly, the doctor has failed in her or his duty of care and thirdly that the injury or harm has been sustained as a result. For a claimant to win a negligence claim on the ‘lack of informed consent’ basis, the court must be satisfied, on the balance of probabilities, that the patient’s injury was caused by the practitioner’s failure to obtain the patient’s valid consent. The argument relating to informed consent was formulated in the United States in 1957, in Salgo v Leland Stanford Junior University Board of Trustees, when it was said that a duty lies on the medical practitioner to inform the patient of ‘any facts which are necessary to form the
basis of an intelligent consent by the patient to the proposed treatment’. The court went on to refer to ‘informed consent’:

In discussing the element of risk, a certain amount of discretion must be employed consistent with full disclosure of facts necessary to an informed consent.

In *Law and Medical Ethics*, GT Laurie, SHE Harmon and G. Porter observe that in the United Kingdom, following *Montgomery’s case*, a person ‘should not be exposed to risk of harm unless he has agreed to that risk and he or she cannot properly agree to – or, equally importantly, make a choice between – risks in the absence of factual information’. The issue then becomes one of ‘to what extent must or should particular details be divulged’ and the overarching question of ‘by what general standard should the information be judged?’ In *Montgomery* it was held that practitioners have a duty to take reasonable care to ensure that patients are aware of ‘material risks’. What is ‘adequate information’ about ‘material risks’ is judged in the particular case from the perspective of a reasonable person in the patient’s position.

Returning then to the women undergoing liposuction, whether each gave an informed consent must be judged by the *Montgomery* standard. First, did the practitioner using laser liposuction discharge his duty to take reasonable care to ensure that his patient was aware of material risks? Was adequate information about the material risks imparted to the patient, judging this by reference to a reasonable person in the patient’s position. The information that could have been imparted was (a) the lack of training and experience of the practitioner; and (b) the possible risk of suffering burns from the laser treatment. If she had been provided with that information, would the patient have consented? An assessment would have to be made from the material in the particular case, including the woman’s evidence. Would she have withdrawn consent if told of the inadequacies in training and experience of the practitioner? This highlights a difficulty with surgery aimed at making the body beautiful. There is a trend for women to take enormous risks with their bodies. Sarah Marsh in ‘Botched cosmetic surgery …’ reports that the ‘alarming’ rise in reports of ‘botched cosmetic procedures in the UK has prompted doctors and campaigners to call for better legislation to protect against rogue practitioners’. Marsh reports that in 2017, some 72 per cent of all complaints were from patients who had used social media to locate
a practitioner. She includes a case study where the complainant booked an appointment with a woman who was running the business from her home. The procedure involved lip fillers and the treatment was ‘incredibly painful’ as well as taking an extraordinarily long time.\textsuperscript{101} After some weeks, the filler began leaking from a hole at the side of the woman’s mouth. Swelling began to subside, but the filler remaining was lumpy and her lips were uneven. Seeking professional help, she discovered that the filler was inserted wrongly, and was not positioned as it should have been. This story is not isolated. Save Face, an accredited practitioners register having government approval and cited by Marsh, attributes the rise in demand for body enhancing (or harming) procedures to reality stars and celebrities who trumpet their body modifications on social media, television, and any other available publicity forum. This self-promotion in turn promotes desire in the audience for the publicised changes, although it is most likely that photoshopping and other media manipulation is projecting a double falsehood: first, the false corporal body manufactured by fillers, Botox, microblading, liposuction, waxing, laser treatment, facials, eyelash extensions, full body baths; and secondly, the false ‘imagined body’, the one shaped and reshaped by digital editing and promoted as if it is the real thing.

As for the risk of laser burns in the one case and the pulmonary fat embolism in the other, is there any certainty that being informed of these risks and their potential harm would have made the woman draw back? Perhaps the risk of death might give pause, yet even there the hankering after what Naomi Wolf termed the beauty myth might overrule natural caution.\textsuperscript{102} Indeed, the Final Report—Review of Regulation of Cosmetic Interventions, commissioned by the UK Department of Health and published in 2013, pointed out that those considering cosmetic surgery ‘have a natural tendency to focus on outcome’.\textsuperscript{103} Doing so means that they can pay insufficient attention to risks and limitations, and may need guidance to reorientate their focus. A distinction could be drawn, the Report said, between cosmetic procedures and surgery generally. In the latter, ‘patients may have no knowledge of the procedure but are acutely aware of, and alert to, the risks’. With aesthetic procedures, people actively seeking them out ‘may have a tendency to underplay the risk’. This contrasts sharply with ‘the apprehensive patient required to undergo a significant (general) medical procedure’.\textsuperscript{104} Perhaps a crucial distinction is that patients in the latter category are set to undergo operations to save their lives, to repair their bodies following
motor collisions, workplace machinery accidents or other such mishaps, or to relieve disease or bodily malfunction. In the former category, the aim is to boost or enhance a well-functioning body, so that there is little thought of the damage that an operation or procedure aimed at augmentation might do. Alternatively, the seeker after the perfect body accepts that there can be no pain without gain. Just as a prize athlete works out relentlessly, driving their body to new and greater heights, the plastic surgery aficionado sees the operation or procedure as their way of gaining a better body through the effort of going under the knife. That in the end the expectation may exceed the outcome, or the outcome may actually damage rather than improve the body, much less raise its appearance to greater heights, raises a crucial question about medical operations, consent and the criminal law.

3 THE CRIMINAL BODY AND THE BODY IN CRIME

In 1934, Mr Donovan took a young woman of seventeen years into his garage to strike her repeatedly with a cane. His aim, it appears, was his own sexual gratification. The young woman, he said, consented. She nevertheless having suffered bruising, the transaction came to police attention. Donovan was prosecuted for indecent assault and causing actual bodily harm. Possibly taking a dim view of unorthodox sexual activity occurring in a domestic garage, the court gave short shift to the proposition that as the young woman had consented, there was no crime. Justice Swift in *R v Donovan* said that where a person intends to inflict bodily harm, that is ‘... any hurt or injury calculated to interfere with the health or comfort’ of the victim …’ so long as it is ‘not transient or trifling’, the victim’s consent cannot render otherwise unlawful conduct lawful. Donovan was convicted. Similarly where Mr Emmett tied a plastic bag around his partner’s head and neck, and on another occasion dripped lighter fluid onto her abdomen, then set it alight. His claim that she consented as part of a sexual game designed to gain both parties sexual gratification held no force when the matter came to trial. In *R v Emmett*, he, too, was found guilty. Clearly, though, this rule is not absolute. Otherwise, surgeons would be prosecuted daily for carrying out their work. So would beauticians conducting procedures that require breaking of the skin or result in bruising, such as Botox, fillers, derma blading ...
A surgeon’s intention in cutting into a patient’s body when conducting a medical operation is to ‘inflict bodily harm’. The ultimate proposition is that in so doing, the surgeon will effect a positive outcome, although this aim cannot always be assured. But from the law’s perspective, the initial intention and the infliction of bodily harm amount to common law battery, actual bodily harm, unlawful wounding or grievous or serious bodily harm, depending upon the magnitude of the damage. What renders this otherwise criminal conduct lawful is that the surgeon operates with the requisite professional skill and care, the patient consents, and the operation is for the patient’s benefit. Where the law gets into difficulty, however, is in the area of body embellishment and adornment. This begins to slide into the territory, or some of the territory, occupied by plastic, cosmetic and aesthetic surgeons and other professionals working in body augmentation. For example, so long as a tattooist or piercing specialist is registered with a licence renewed annually and carries out the job with care and skill to the standard set down, now, by Montgomery they are acting lawfully. Although their time is spent inflicting actual bodily harm or unlawful wounding (by breaking both layers of the skin to complete ear piercing, for example), they do their job lawfully, piercing their clients’ skin and body parts (ears, tongue, navel and so on) with instruments designed for the purpose. Similarly with tattooing: the licenced tattooist pierces the skin of the client and injects coloured fluid to ensure the design is visible and permanent. What, however, of a licenced body artist operating from registered premises who advertises tattooing, acupuncture, electrolysis, semi-permanent skin colouring, ear piercing and ‘other’ skin piercing, including more radical services such as bifurcating tongues, piercing labia, nipple and penis, cutting off ears, or placing objects under the skin? Some of these services are similar to those conducted in plastic, cosmetic and aesthetic surgery, or in beauty parlours, such as embedding fillers in lips and cheeks, injecting Botox, microblading, removing body hair by wax, electrolysis or other means, and the like. Does the law class all of them legal because consent is obtained and the work is of a good standard, or do the courts enforce actual bodily harm and similar laws, rendering the activity criminal? This question arose in 2018 in Regina v BM.

BM was charged under section 18 of the Offences Against the Person Act 1861 with three counts of wounding with intent to do grievous bodily harm. The counts related to, first, an allegation that BM had removed a customer’s ear; secondly, that he had removed a customer’s
nipple; and thirdly, that he had cut a customer’s tongue, dividing it to create a reptilian appearance. BM did not dispute doing these acts. His defence was that each of the three customers had consented. Two other matters were potentially open to prosecution, but no charges had at that time been laid. One was the insertion of transdermal implants into a customer’s scalp. The other was inserting an object (which appeared to be a large metal ‘eye’) under the skin of another customer’s hand. Insofar as all these operations or procedures necessarily involved cutting, with associated bleeding and bruising, the issue was squarely that which was before the court back in 1934 in Donovan. The only difference was that rather than undertaking the work surreptitiously in the family garage, BM had professional premises operated lawfully as a tattoo and body piercing parlour under the Local Government (Miscellaneous Provisions) Act 1982. The lawfulness related to his licenced work of tattooing and body piercing. ‘Body modification’, accepted as describing the wounding constituting the three counts on which BM was to be tried, is unregulated and anyone can assume the role of body modifier. BM’s premises were not licenced for the activities the subject of his criminal prosecution, and the question was whether in assuming the role of body modifier BM’s practice had entered an unlawful realm.

The three procedures were conducted without anaesthetic. Signed consent forms were produced in evidence for two. An ear, nose and throat specialist and a consultant plastic surgeon gave evidence as to the pain and damage caused by removal of an ear, both in the operation itself and as to future harm. The plastic surgeon gave evidence relating to the nipple removal and tongue splitting. He spoke of the pain and continuing health consequences, saying that the procedures would ‘never be done by a reputable surgeon for aesthetic purposes or … any other purpose’. 111

The court referred to cases defining the meaning of ‘actual bodily harm’, ‘wounding’ and ‘infliction of grievous bodily harm’. Actual bodily harm is accepted as meaning any injury ‘calculated to interfere with the health and comfort’ of the victim, but must be ‘more than transient or trifling’. 112 A wound is constituted by breaking of the whole of the skin—dermis and epidermis, and includes inner skin within cheek, lip and urethra. Infliction of grievous bodily harm means really serious bodily harm. Cases including Donovan were considered, where convictions were upheld for inflicting various levels of harm and damage ‘not transient or trifling’ despite the victims’ consent. The court also set out situations where harm and damage were caused but not considered to breach the
law. These included properly conducted games or sports, lawful chastisement or correction, dangerous exhibitions or jostling in a crowd.\(^{113}\) Reference was made to surgical procedures, with no particularly definitive basis being set for its being lawful rather than breaching the criminal law as battery, actual bodily or grievous bodily harm or wounding:

Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability. Actual consent, or the substitute for consent deemed by the law to exist where an emergency creates a need for action, is an essential element in this immunity; but it cannot be a direct explanation for it, since much of the bodily invasion involved in surgery lies well above any point at which consent should even arguably be regarded as furnishing a defence. Why is this so? The answer must in my opinion be that proper medical treatment, for which actual or deemed consent is a prerequisite is in a category of its own.\(^{114}\)

BM’s defence counsel submitted in the consent argument that the procedures should be accepted as producing results ‘akin to body adornment … widely accepted in British culture and other cultures’, and that a customer’s autonomy to request and consent to the procedures should be respected.\(^{115}\) The prosecutor argued that the procedures carried out by BM were ‘in truth, medical, amounting to cosmetic surgery’. As ‘serious irreversible procedures not warranted medically’ they should be held to be contrary to the criminal law.\(^ {116}\) The court agreed, saying that it could see ‘no proper analogy between body modification, which involves the removal of parts of the body or mutilation as seen in tongue splitting, and tattooing, piercing or other body adornment’. The court added that what was done for reward was ‘a series of medical procedures performed for no medical reason’.\(^ {117}\)

The case of *R v Brown*\(^ {118}\) is cited as a touchstone for determining that consent to actual or serious bodily harm is no defence to a prosecution for those crimes. *R v Brown* has been subjected to critical analysis, being seen as problematic in that the practices leading to the charges were sado-masochistic acts carried out by men on one another in neither a garage nor a tattoo parlour, but a private club. The activities included penis piercing and what outsiders might class as anal abuses. However, none of the men complained and none apparently sought medical treatment. There appears to be some currency in the critique alleging that the triggering factor in the prosecution and conviction was the homosexual
status of the men involved, for the outcome contrasts with *R v Wilson*.\(^{119}\)

There, Mr Wilson carved his initials into his wife’s buttocks. The carving festered, Mrs Wilson sought medical assistance, and the doctor’s concern resulted in police action. However, the prosecution foundered on the proposition that Mrs Wilson was said to have consented and the injury was a consequence of a procedure akin to tattooing. This is a poor argument, for apart from anything else Mr Wilson was not a licenced tattooist and the conduct was not carried out on licenced premises. Furthermore, cutting with a knife into flesh is hardly comparable to practised employment of a tattooist’s needle. That the parties were married was added by the court as what might be seen as an afterthought, or it could have held a significance in the decision. As well, as the court saw it, there was no sexual imperative present. Further, unlike *R v Brown*, where the potential vulnerability of young men to be inveigled into the sado-masochistic club culture (as the court envisaged) was referred to, in *R v Wilson* there was no acknowledgement of the vulnerability of a wife to her husband’s possessory expression of marital ownership through violence.

On the other hand, *R v Emmett* involved sado-masochism within a heterosexual (though unlike *R v Wilson* unmarried) relationship, and Mr Emmett was convicted. Perhaps the better approach is to focus on the principle established by *R v Brown* and *R v Emmett*, putting *R v Wilson* to one side as wrongly decided. This would focus on the policy question of whether the law should deny the relevance of consent to bodily harm where this is carried out for purposes not allied to surgical interventions for health reasons. This then raises an issue of the level of bodily harm that eliminates consent as an exculpatory factor. *R v Donovan* is, in this regard, rightly open to challenge, for Mr Donovan was convicted of assault and indecent assault. Both are low on the scale of harm according to existing law. An argument might be made that such low-level harm should be able to be consented to by willing adults. As for *R v Brown*, there the level of harm was in issue. Although the majority held that actual bodily harm should not be able to be consented to (leaving medical reasons to one side), in dissent it was said that the level should be set higher. That is, dissenting authority said that actual bodily harm should be able to be consented to lawfully in non-medical circumstances (just as consent is lawful to that level of surgical harm). However, ran the dissent, where the level of harm is ‘serious’ or ‘grievous’, consent should be irrelevant unless the purpose is health-related in the regulated circumstances of hospitals, clinics and surgeries, and qualified and licenced medical or
health personnel. This distinction about consent and level of harm does have some persuasiveness, for there are other circumstances such as sport where the assumption is that players consent to low-level violence—pushing and shoving, banging into one another and so on. At the same time, the traditional acceptance of lawful infliction of serious or grievous bodily harm consented to for medical reasons could be distinguished from its infliction where there are no medical reasons. Clearly an argument can be made that as a matter of public policy the law should not countenance consent as a justification for or defence to the infliction of serious or grievous bodily harm in circumstances other than those involving surgery or medical treatment taken for health reasons.

There is unlikely to be universal agreement on such a policy, however, for it brings into sharp focus the conduct determined by the court to be unlawful in Regina v BM. The issue becomes one of whether as a matter of policy consent can or cannot be a defence to body modifications done for aesthetic reasons (in the eyes of the party requesting them or by reason of group culture). Then, if so, should a licencing system for practitioners and a health certificate for premises be introduced (as exists in some jurisdictions) for those trained and qualified in body arts to carry out these procedures? If body modification practices beyond tattooing and piercing of ears and navels, for example, are to remain unlawful, how does this sit with some of the practices carried out by beauticians, aesthetic and cosmetic surgeons and plastic surgeons which have no discernible or at least immediately obvious health purpose or rationale.

It is here that questions arise as to the nature and status in law of some of the body modifications being carried out on women in pursuit of beauty. Some onlookers may reel away in revulsion or consternation when a person with a bifurcated tongue comes into view. Certainly it is different from prominently pouting lips, however, these too can engender revulsion or consternation. Are false nails, exaggeratedly projecting from finger tips, so distinguishable from a serpent’s tongue or a missing ear? Are size DD breasts or breasts that appear like two peaches on a wash-board to ‘pass’, whilst ‘body modifications’ condemned by the court as breaching the criminal law do not? Critiquing Regina v BM, Samantha Pegg makes the point that the way the court has sought to delineate what will offend against the criminal law, albeit consented to, and what will not, is unsatisfactory. That some body modifications lacking medical value are seen by the court as acceptable because of religious endorsement, yet BM’s handiwork is criminalised despite a subculture that accepts
it, may be open to challenge. The proposition that BM’s customers may be suffering from body dysmorphia or body dysmorphic disorder (BDD), removing their capacity for full, free consent, sits oddly, when the criminal law does not take that view in the case of extravagant or overstated body modifications conducted by beauticians, plastic surgeons or cosmetic and aesthetic surgeons.

This conundrum of what is acceptable and what not arose recently in three instances where police considered prosecuting plastic surgeons for conducting labia reductions or modifications carried out on women. The question arose as to whether these procedures should be prosecuted under the Female Genital Mutilation Act 2003. The Act provides that it is an offence to ‘excise, infibulate or otherwise mutilate the whole or any part of a girl’s labia majora, labia minora or clitoris’. The Act further states that no offence is committed if an ‘approved person’ performs a surgical operation on a girl which is necessary for her physical or mental health. Approved persons for the purposes of this provision include registered medical practitioners. Reactions to these proposed prosecutions were mixed. At the time, activist women from the organisation Object were demonstrating in Harley Street against ‘designer vaginas’ and protesting against removing naturally growing hair from women’s pubic areas. Kat Cooke, in ‘Why is Labiaplasty being compared to FGM?’ quotes a consultant cosmetic and reconstructive surgeon and a consultant plastic surgeon, each of whom carry out labiaplasty procedures. Both averred that patients had the labia reduction procedure for medical reasons. One said his patients found fault with their inability to exercise because ‘the labia is so large’, complained that they were restricted in the clothing they could wear and the exercise in which they could engage, as well as being unhappy about sexual intimacy. This triggered their desire for the operation. He would not, said this surgeon, ‘operate purely for cosmetic reasons’, adding that a ‘functional component’ was necessary. The other surgeon said ‘very few’ of his clinic’s patients had the surgery for cosmetic reasons, over 95% doing so ‘for physical symptoms or because of psychosexual symptoms’. It was ‘very insulting’, he declared, for them to be compared to female genital mutilation (FGM) victims ‘taken at a young age to an often-unknown individual’ to have their genitalia ‘completely mutilated’. Many of those victims attended at his clinic for reconstructive surgery, he said, and comparing their initial subjection to cutting, to women who consented to the procedure was, he said, ‘just degrading’. Yet as Camille Nurka points out in Female Genital Cosmetic
Surgery, female genital cosmetic surgery ‘refers to a range of surgical procedures that are performed on the vagina and vulva when there is no indication of gynaecological disease’. These ‘aesthetic and restorative’ procedures ‘aim to make the genitals look appropriately feminine, to reduce physical and mental discomfort, and to enhance sexual feeling’. Some argue that the reduction of physical and mental discomfort does have a health component, thus making the procedures legitimate in medico-legal terms. This may also be said about the enhancement of sexual feeling: if every human being is entitled to a ‘good’ sex life, then the improvement of this component of human existence can be classed as an improvement to health and healthy living. Where a woman’s genitals have been ravaged through culturally imposed female genital mutilation (FGM) reconstruction could certainly qualify as rightly capable of lawful consent, the operation or procedure being aimed at restoring what ought never to have been removed and denied to any woman.

Yet Camille Nurka’s assessment, in focusing on the notion that a woman’s genitals must be ‘worked on’ surgically so as to ‘look appropriately feminine’ raises a raft of questions. These include ‘the male gaze’ and women’s striving for bodily perfection which is dictated by external demands that equate plastic manipulation of women’s body parts so as to conform to a false vision of genital flawlessness and bodily excellence or rightness. Women seeking body modifications of the increasingly standard type performed by physicians, surgeons and beauty practitioners often say they simply wish their bodies to be ‘natural’ or ‘normal’. As Nurka says, claims published in 2007 in the Australian Cosmetic Surgery Magazine that ‘in the majority of women, the labia minora are covered by the labia majora (outer lips) and are seen only with the legs separated’ are no longer a part of professional discourse. Rather, she observes, advertising language now ‘reflects an acknowledgement of genital diversity’. This she attributes to ‘demands from feminist gynaecologists, urologists and psychologists for evidence based claims’. Normal and natural are not what proponents of cosmetic surgery claim, when they seek to impose upon women and women’s bodies conformity to standards set by reference to the images portrayed in Liz Conor’s work on the history of The Spectacular Modern Woman or twenty-first-century images of celebrities’ bodies photoshopped into an externally imposed orthodoxy of ‘what a woman’s body looks like’—really meaning ‘what a woman’s body should look like’.
4 THE CRIMINAL, THE CIVIL AND THE ROLE OF THE LAW

It is difficult to leave aside the criminal law without further reflection. Stories do surface of mothers taking their young daughters to plastic, cosmetic or aesthetic surgeons for breast augmentation and for labia surgery.\(^{130}\) Young women’s bodies are only just developing. To interfere with the delicate structure of the breasts when they are at the growing stage is questionable.\(^{131}\) Surgery can interfere with growth of milk ducts and impair breast-feeding capacity as an adult, or impair the breasts’ sexual sensitivity. Bad enough if this happens to an adult woman, but for a growing adolescent who needs time to consider her future, interference seems wrong. Promoting the idea that an adolescent’s genitals require correction and beautification is dubious at minimum.

This raises questions, too, about capacity to consent. If mothers are consenting for their daughters, this surely encroaches on their autonomy and capacity to make their own decisions. In *Gillick v. West Norfolk and Wisbech Health Authority*\(^{132}\) it was held that consent for medical treatment where the subject is a child lies with the parents, except that if and when the child achieves a significant understanding and intelligence to enable him or her to understand fully what is proposed, then the child has the right to consent without parental intrusion. This is a determination to be made on the facts of the individual case and with medical treatment it is the doctor who, generally, makes the assessment. Additionally, s. 8(1) of the *Family Law Reform Act 1969* gives a minor of 16–18 years powers of consent to medical and surgical treatment equivalent to those of an adult.

The *Gillick case* is taken as a general guide in Australia, too. In the United States the law is similar in that the age of majority and minority applies so that those under the age of 18 years cannot consent to surgery, but ‘adolescents between the ages of 12–17 years may be found to be capable of giving “assent”’ along similar lines.\(^{133}\) Cosmetic surgery where minors are the subject raises particular issues, however. In the United States, restrictions are set by the Food and Drug Administration agency (FDA) on breast implants. With saline-filled breast implants for breast augmentation, the FDA has approved them for women aged 18 years and above only, whilst approving them for breast reconstruction in women of any age. Saline-filled implants are also used for ‘revision surgeries’, that is, correction or improvement of results of an original surgery.\(^{134}\) Silicone
gel-filled breast implants are ‘approved for breast augmentation in women age 22 or older’. For breast reconstruction, FDA approval extends to women of any age. Silicone gel-filled breast implants, too, are used in revision surgeries for ‘correction or improvement’ of an original surgery. In the United Kingdom, as was observed in Regina v BM, restrictions on minors’ capacity exist in various circumstances. Tattooing is one of them, restricted by the Tattooing of Minors Act 1969. Should such limits apply to cosmetic surgery?

Recognition of body dysmorphia (BDD) also requires consideration, even if only in reflection, although arguably the problem may be more needing of consideration. Regina v BM saw it as a possibility with the three procedures there in question: bifurcated tongue, outer ear removal, and removal of a nipple. In Bodies Susie Orbach speculates on the dysmorphia phenomenon. Yet labelling as dysmorphic women attending the wide range of professionals now providing body-changing procedures and amateurs setting up as body beauty makers, is questionable. Doing so is simply to label them all over again, when they are seeking to escape from the strictures of a world where women remain lower paid, continue to be clustered in traditional women’s fields, are less represented in political and legal institutions, and whilst present in educational institutions in more proportionate numbers, still occupy the lower rungs. At the same time, the desperation women must experience deep down, in seeking to have their bodies made over so invasively, surely is counterproductive. To be so unhappy with one’s body that radical surgery is seen as the answer, or to be so determined to improve oneself, that altering one’s body is pursued as the solution, seems counterintuitive. Ultimately the same woman is very likely to be internally demanding recognition as a whole woman without the intervention of body shapers.

Neither civil law nor criminal law has been kind to women. Almost one hundred years ago, for the first time, a common law court acknowledged women as persons. Not being recognised in law as persons deprived women of identity, economic independence, access to ‘male’ trades and professions, political representation, and legal status. Women were classed together with children and persons lacking mental capacity. Our bodies existed, yet our minds were denied. Today, the body shaping industry relentlessly drives women back into a space where our bodies are not ourselves. Women are being distanced from our bodies as if the body were a palette to be drawn upon, a clay to be moulded into what is projected as the perfect woman. Yet physical perfection is always out of reach,
because there is always a new product, a new procedure, a new shape
to be pursued. Women’s bodies are sites of manipulation into conformity
with a shape that is dictated from outside ourselves. Historical treatises on
body changing illustrate how women’s bodies have ever been controlled,
with race and physical superiority related to class and criminality, inti-
mately linked to surgical and like interventions, including tanning or skin
whitening, puffing up our bosoms or toning them down, grasping after
larger bottoms, or hankering after boyish hips.

When women’s condition is considered, on every level consent is in
issue. With the bodily intrusions now being forced upon us and into our
mind-space by an ever-growing multi-million-dollar industry designed to
falsify women’s bodies, women confront yet again the mind–body separ-
rations. However much it may be said that women are the masters of
our souls, the captains of our destiny, the reality insofar as the domi-
nant culture is concerned is that our bodies take centre stage. Pervasive
is the view, expressed through the media and prominent in the fact that
women’s brains are not valued in the same way as men’s, that body image
is women’s prime goal. If this were not so, if women’s brains were valued
equally, it would not be that in the United States only ever have four
women taken a key role on the presidential ticket of a major political
party: Geraldine Ferraro, VP candidate to Walter Mondale (Democrat);
Sarah Palin, VP candidate to John McCain (Republican), Hillary Clinton,
Presidential nominee (Democrat); Kamala Harris, VP candidate to Joe
Biden (Democrat). Nor would it be that the United Kingdom has ever
had two women Prime Ministers only—Margaret Thatcher (Conserva-
tive) and Theresa May (Conservative), or that Australia has only ever
had one female Prime Minister (Julia Gillard), although women have
featured more prominently as Premiers or Chief Ministers of Canberra,
ACT (Labor and Liberal), Western Australia (Labor), Northern Terri-
tory (Labor), Victoria (Labor), Queensland (Labor), New South Wales
(Labor and Liberal) and Tasmania (Labor). Or that major companies and
boards do not feature equal numbers of women and men as directors
or chief executive officers, female professors are fewer than their male
counterparts, factories more often feature foremen than forewomen and,
despite women now being entitled to sit equally with men on juries, juries
continue more often to elect men as foremen.139 The list goes on …

When they seek justice for redress for harm and damage, women and
their bodies enter a legal system shaped by men as judges, advocates,
barristers, solicitors and attorneys, with women taking these roles at the
beginning of the twentieth century, not before, and with appointments to senior positions in law firms and as magistrates and judges occurring far more recently. Nor do women in positions of power dominate the industry that creates the damage and harm bringing women into the legal system for reparation. Women’s bodies feature publicly as if they are the central focus of our lives, denying our humanity as whole human beings. From our foreheads to our toes, from our collar bones to our finger tips, from the crowns of our heads to the intimacy of our vulva, women’s bodies are sites to be shaped by forces outside our control. Divided into body parts, swathed in the plastic of performance, women continue to be denied personhood.

As Elizabeth Cady Stanton and Susan B. Anthony said in The Revolution, way back on 18 November 1869, ‘no class of citizens’, no man or woman, ‘can ever feel a proper self-respect’, can ever experience themselves as entitled or worthy, ‘until their political equality – their citizenship – be fully recognised’.\textsuperscript{140} The law and the way it regards women, its capacity for encompassing women as equal whether as litigants or lawyers, is integral to the question of body, image and citizenship. Women must demand our full citizenship, incorporating ourselves as wholly human. Just as men’s citizenship is constituted not by brawn or body, or brain alone, but by the whole person, women too must be recognised beyond the body, as more than our parts. Forsaking plastic, that we are ourselves entire.

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