

Women and Equalities Committee

Oral evidence: [Health impacts of breast implants and other cosmetic procedures](#), HC 869

Wednesday 25 June 2025

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Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Rosie Duffield; Kirith Entwistle; Natalie Fleet; Catherine Fookes; Christine Jardine; Rebecca Paul; Rachel Taylor.

Questions 76 - 117

Witnesses

[I](#): Dr Beth Daniels, Professor and Director at Centre for Appearance Research at University of the West of England (Bristol); Dr Ruth Holliday, Professor of Gender and Culture at University of Leeds; Dr Christopher Rowland Payne, Consultant Dermatologist.

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Examination of witnesses

Witnesses: Dr Beth Daniels, Dr Ruth Holliday and Dr Christopher Rowland Payne.

Chair: Good afternoon and welcome to the Women and Equalities Committee. Today we are holding an evidence session on the health impacts of breast implants and other cosmetic procedures, but primarily today looking at the mental health impacts of these procedures.

I am delighted to welcome Dr Beth Daniels, professor and director of the Centre for Appearance Research at the University of the West of England Bristol—that is a mouthful of a title, but thank you and welcome—and Dr Ruth Holliday, professor of Gender and Culture at University of Leeds, and Dr Christopher Rowland Payne, consultant dermatologist. Hello and welcome—now I am suddenly very aware that my skin care routine was not up to scratch.

Before we get going, I wanted to say that we have quite a lot of questions to get through and different sections to cover, so if there is anything that you feel that you want to go into in greater depth, please just add this in writing to us after the Committee, or follow it up with a conversation with one of the Clerks.

Q76 **Natalie Fleet:** To you all, whoever wants to respond, what do you think are the primary drivers behind the increase in demand for cosmetic procedures? Any volunteers?

Dr Holliday: I can talk a bit about breasts, if that would be a good place to start. The internet and the way it is impacting on young people is more another witness's area, but we tend to think about breasts as something sexual. Breasts get a lot of airtime on television because it is titillating and entertaining for an audience, but we also need to remember that breasts are a really important marker of being a woman. We have ideas about being a proper woman, and having breast augmentations is about feeling like a woman.

A lot of people took part in research for a big project we did on cosmetic surgery tourism; we also did a survey of women with PIP breast implants, and something that came up a lot was that not feeling like a man because you have breasts is a really big thing. It is partly about the circulation of images on the internet, but we often have a kind of stereotyped image of it being a young irresponsible girl who is getting the biggest breast augmentation that she can get, and actually it is much more complicated than that. There is a very big range of people engaging in cosmetic practises for very different reasons, and having a breast augmentation is very different from having body recontouring procedures after dramatic weight loss, for instance; they have different meanings attached to them.

Q77 **Natalie Fleet:** You are bringing me to the next question. It is a perfect time to ask whether there are certain demographic groups that are



experiencing a more rapid increase in cosmetic procedures than others.

Dr Holliday: I do not know the answer to that question, do you?

Dr Daniels: To backtrack a little, we can look to the normalisation of cosmetic procedures as being a driver, with the relative affordability and accessibility all being much greater today than in the past.

In terms of who is getting more cosmetic surgeries per se at the moment, I would probably pass that off to Christopher to comment more on that specifically, but we do need to pay attention to the vulnerable people who are presenting for cosmetic surgeries. For instance, we know that people with mental health issues—specifically, generalised anxiety disorder, people who have higher drug and alcohol use and a number of other vulnerable categories—are more likely to present for cosmetic surgery. We also know that people who diet more and people who use social media at higher rates present for cosmetic procedures more. So we have some knowledge of groups that we would want to target in terms of education efforts, but I will pass to Christopher for more.

Q78 Natalie Fleet: When you are answering the question, could you also think about whether there is any evidence that under-18s want to be able to access cosmetic procedures?

Dr Rowland Payne: First, thank you very much for asking me to come, Madam Chairman and the Committee; it is a very important area that you are studying. I have children who have gone through their teens, and it was obvious amongst their friends and my younger patients that they start to consider all these body image conditions. It has been normal for generations, or probably since mirrors were invented, for teenagers to look at their spots, so it is an extension of that, but now they feel they have the possibility of something more. But if they have a good relationship with their children, their mothers wisely hold them back, so it is not a major problem that we have to turn away teenagers in my practice.

I am a consultant dermatologist; I see patients with skin cancer, eczema and psoriasis. I am also the president of the Royal Society of Medicine Section of Aesthetic Medicine and Surgery, and I have a considerable cosmetic practice. Many of the patients who see me are from families, so I might see the mother for something, then the husband, then the mother's mother and then the child. It is not rare to see three generations, but in such families I have not often seen patients who are unwisely seeking cosmetic intervention in their teenage years.

However, there are psychologically disturbed people, and every person who is active in this area needs to be proficient not only in the skills of doing the treatments but in the diagnosis and treatment of the psychological disorders, which are, as you say, very common among this group of patients. Now, I am talking not just of teenagers but of all ages, and especially people in their 20s and 30s. People who are doing the



injections or the surgery need to be relatively expert in psychological diagnosis and treatment.

Dr Holliday: Could I just add that one of the reasons this is such a difficult question is because there are no proper statistics, so it is really hard to find out how many people are having different procedures. For instance, you can just buy some kinds of fillers on the internet to do yourself at home, and there is no way of recording that. Even more significant kinds of surgeries are only recorded by organisations like BAAPS or BAPRAS, and those only apply to their membership, which means that there are no proper records of who is having what. For that reason, that is a very difficult question to answer. Anecdotally it seems that things like lip and other kinds of fillers, Botox and so on, are increasing in use amongst younger people.

Q79 **Chair:** I just wanted to come back to one of the points that you made, Dr Holliday, around PIP. You said you have done some work with women who had PIP implants. What was the mental health impact for some of those women?

Dr Holliday: The mental health impact for those women has been huge. In 2012, when the PIP scandal in the UK came out, we were just starting our cosmetic surgery tourism project, and BAAPS immediately released a statement saying that they thought most of the PIP implants had been implanted abroad.

We did a survey to try to catch some of the people and talk to them about their experiences, and we had more than 300 responses in just one weekend from women who were incredibly anxious. The news had just broken about the dangers of PIP breast implants, and they were terrified. Many of them were already experiencing quite significant health issues such as numbness and pain even in their hands and under their arms in their lymph nodes because their body was having an immune reaction. Of course, we know that some people have since died of cancers related to PIPs. The difficulty is that these women were left; they often then tried to get in touch with their GP or clinic, but at the time some clinics did not even bother to answer their phone calls, and there was no information.

After a while, the NHS offered to remove but not replace implants, which then left women in a very difficult situation, of course, because they did not want to lose everything they had saved up for ages to have, which they felt was self-improvement and improving their chances in employment and so on. They were faced with this dilemma, but most of all it was not knowing whether your breast implants were going to seriously damage your health, or if your poor health was caused by your implants, which was a really difficult situation to occupy and caused huge levels of anxiety. Many of the women who had them have been unable to work since: their lives have been really quite destroyed by this scandal.

Chair: Yes, that pretty much backs up what we have heard from other panellists, so thank you. I am going to hand over to Catherine now to



look at some motivators and idealised standards.

- Q80 **Catherine Fookes:** I will start with Dr Daniels, if I may. We have talked a bit about social media and how that has pushed people to have more cosmetic procedures, but what about reality TV shows like “Love Island”? How much are they driving this trend towards more and more cosmetic procedures?

Dr Daniels: There is very little research on the relationship between reality TV shows and cosmetic surgery intention. More generally, we know that watching more reality TV shows is associated with more negative body image, so we would expect to see a pretty similar pattern there. From the very limited research that has been done on reality TV shows specifically around cosmetic surgery, we know that when university-age women view those shows positively, they then report higher cosmetic surgery intention. The limited evidence we have suggests that relationship is a connection very similar to the body image literature. That is an area for more research, but initial findings are pretty indicative of the path that we would expect.

- Q81 **Catherine Fookes:** To what extent do women find themselves criticised for trying to adhere to the idealised standards set by men? I am not sure who is best placed to answer that.

Dr Daniels: Can you rephrase the question?

- Q82 **Catherine Fookes:** When women have these procedures, to what extent are they then laughed at and criticised by society at large for something that ostensibly they believe men want them to look like?

Dr Holliday: This mechanism is quite complicated. We have a situation in society where the circulation of images of women is controlled mostly by men, through film producers and directors, fashion images and so on. What this does is create certain body types as having value, so people who want to become valuable invest in their bodies to approximate these kinds of images that are circulated. The procedures that people have in order to do that are often very highly valued by the people around them who share the same embodied taste, but those tastes are often not shared by people in different social categories. For middle-class women, we know that the ideal is that less is more, and if you are going to have cosmetic surgery, it should look natural. But if you are working class, maybe letting people know that you have had cosmetic surgery shows that you are a body that is worth investing in; you have made an investment because you are worth it. It is complicated. Women are both empowered in choosing what surgery they have and when they have it, but they are approximating an image that is largely devised by a patriarchal culture.

- Q83 **Catherine Fookes:** Does the panel believe that the impact of social media on body image is more significant than that of traditional forms of media such as film, TV and magazines, and if so, why?



Dr Daniels: We know from one study that social media seems to be more powerful. We can look at that in terms of the affordances of social media platforms, which have 24/7 availability, are highly visual, and there is a peer feedback loop: the likes, sharing, retweeting and those kinds of things afford social currency to particular images. Particularly when we think about young people—including university-age students, not just teens—we need to pay attention to that peer component, because they are particularly attuned to social information. Yes, the evidence to date shows that social media seems to be a more powerful driver than traditional media in terms of body image outcomes.

Dr Rowland Payne: I would echo that.

Q84 **Chair:** This, and the level of complaints every time it goes wrong, costs the NHS a huge amount of money. We know that 98% of the complaints end up being dealt with and corrected by the NHS in some way, whether it is life-saving work that we have heard from Sasha Dean, who came to give evidence around her liquid butt lift that went horribly wrong. She ended up with sepsis, was in a coma and had life-saving treatment from the NHS. Do you think social media firms need to be held to account for what they advertise, publish or promote on their platforms that has a potentially damaging impact, predominantly on women? Dr Daniels.

Dr Daniels: Yes, and to your point about the NHS having to deal with the fallout, social media companies have chosen not to do for themselves what we would hope they would do in terms of regulation. They have the ability: at one point Instagram experimented with removing “likes” from under-18s, which would remove that peer component that drives social media engagement for young people. Once you take that piece away, their social information is limited. Instagram experimented with that for a period of time, but young people did not like it and the feedback to Meta was immediately, “Let’s put it back in”.

The social media companies are not doing things that would help to mitigate some of the mental health impacts that their platforms generate, and the idea then is that Government have to regulate, to step in and say, “We’re going to limit your capacity to just do whatever because you’re not making choices.” Not allowing clinics to advertise directly through social media influencers and not allowing them to give discounts to people to turn on to social media and then say, “This is the clinic I got my procedure at,” would be ways to limit the impact. Those are things which other countries, for instance Australia, have looked at. The quick answer is yes, there needs to be some regulation because the social media platforms are not doing it themselves.

Q85 **Chair:** Dr Rowland Payne, there is something about the trivialisation, or the popularity and ease with which these quite invasive procedures seem to be termed, “a quick fix” for some. We heard about the liquid breast lift or liquid breast augmentation basically being a lunchtime breast job. Is there something to be said that it is problematic that these are deemed as quick fixes that you could just do in your lunchtime, when actually



they are quite invasive, and have serious complications when it goes wrong?

Dr Rowland Payne: I agree with you. Cosmetic and aesthetic medicine is a branch of medicine and should be treated in exactly the same way. Ideally, patients arrive at the consultant's consulting rooms by reference from a GP. That has largely fallen down with all private sector patient referrals now, as the GP service has so altered in the last 30 years, but that would be the ideal. It was not so long ago that doctors were not allowed to advertise at all. If that was still the case, there would not be this problem on social media. It would be really a very good thing if doctors were not allowed to put pictures on social media.

Chair: This is a good point to bring in Rachel.

Q86 **Rachel Taylor:** Welcome to the panel; it is nice to see someone here from the university where I graduated. Ruth, what impact do high-pressure sales tactics such as time-limited offers, multi-procedure package deals and those sorts of things have on decision making and mental wellbeing?

Dr Holliday: For young women going for procedures, there is an incentive, is there not, to bring somebody with you if you are getting a two-for-one? I personally have not come across that. In our surgical tourism study, we had young women from Australia going to Thailand in groups to have breast augmentations arranged by an agent, but there were not any of those kinds of sales in that case.

I have heard a lot about these two-for-ones and so on, but I have not seen it. We saw a mother and daughter travelling from China to South Korea to have blepharoplasty, which was a case of, "If you take your mum, you get her surgery half price." Because we have mostly focused on cosmetic surgery tourism, what we find is that the people who travel for surgery often spend five to 10 years making up their minds about whether they will have it. They thoroughly research their clinic and surgeon before they go, they scan the internet for any information where surgery has gone wrong or someone has got an infection or a complication. They research it very thoroughly, go for one thing that they have wanted for ages, return and that is that.

Q87 **Rachel Taylor:** You do not think that they have decided what procedure they want and are then persuaded by an advert saying, "Well, you can have Botox or fillers half-price if you're also having this"?

Dr Holliday: We had 105 people in our study and none of those were travelling for a special offer. They all thought there was something about their body that they did not like and they were travelling to get that one thing fixed. Special offers would perhaps influence slightly their choice of surgeon, but probably not, and it certainly would not influence what surgery they were having, but maybe that is a different kind of constituency than other groups.



Dr Daniels: If I can just add, if you think about what I started off saying about psychologically vulnerable people who particularly present for cosmetic surgery, those individuals are going to potentially be more affected by high-pressure tactics. So if you are arriving already with a mental health disorder, such as generalised anxiety, or you have had an adverse life event, or you are a victim of domestic or intimate partner violence, we know those women are over-represented as cosmetic surgery patients. You really need to dig into who is presenting and what vulnerabilities they may bring to this experience, which would be quite different from the group that would travel for cosmetic tourism.

Q88 **Rachel Taylor:** Moving on from that, do you think that the current advertising standards are sufficient to protect those vulnerable individuals from the idealised portrayals of procedures and outcomes?

Dr Daniels: No. You can look at a comparable dynamic, for instance where the city of London decided to limit adverts in public transits that would promote unrealistic body standards or body confidence issues, so you cannot have unrealistic bodies portrayed in advertisements on the tube. Thinking about that as a good analogy for what could happen in other spheres, existing regulatory bodies such as the ASA could enforce more stringent standards around what is permitted, as we know that these kinds of advertisements could be nudging people in the direction of cosmetic surgeries.

Q89 **Rachel Taylor:** I do not know who wants to answer this one, but what impact do you think social media algorithms have that target users with cosmetic procedure adverts? How do they impact on mental health and body image? Ruth, I do not know if you want to take that one?

Dr Holliday: I know from my students that if they start to look at anything around cosmetic surgery, that algorithm will target them with constant adverts. They are not even aware that this is happening, so they say, "Oh well, you know how you get bombarded with adverts for cosmetic surgery," and I say, "No, I only get targeted with adverts for home improvements," which is obviously a different demographic. Algorithms are really important, and the more you are exposed to this culture, the more normalised it becomes, and then that is bound to have an effect.

Dr Daniels: I would add that it is more insidious than just your active training of algorithms. There was a study that was just released about TikTok, and young women with eating disorders are receiving more eating disorder content above and beyond their own liking of that content. Those algorithms are proprietary, so as researchers we have no insight into how they are making these decisions; we are only seeing the effects of them. We want to be clear that social media platforms should have accountability for this content, because they are pushing it on to users.



Dr Rowland Payne: It all boils down to the most important thing, which is the safety of patients. We saw that in the dreadful story that was told at the last session by poor Sasha Dean whose treatment was performed by somebody without a medical qualification, as I understand, just in a room which was not anything to do with a clinical room, let alone an operating theatre. Clearly, the person would not know anything about complications and nobody was looking after her until luckily she was taken to hospital in extremis, and the wonderful national health service saved her.

The elephant in the room here is that all these treatments should be done by doctors, as they are in every other country. In Europe, Canada, the United States and Australia, only medically qualified or dentally qualified people are allowed to do these treatments. This is very sensible, as every doctor or dentist has had a five-year training including two years of anatomy and physiology, and then they have to do jobs as soon as they have qualified before they can do anything else, so everybody has clinical experience. When you are a doctor, you are constantly educated in the ethic that you are serving the patient—the safety of the patient comes first—the primary thing is, “Do no harm.” There is also a considerable element of psychiatry and psychology in the training of every doctor, and that goes on because we do continuing medical education. Why is this country the only country in Europe—and possibly Ireland—the United States and Canada that allows non-medically qualified people to do these things?

The first thing is that the sale of these treatments such as fillers and botulinum, must be limited to doctors and perhaps dentists, and the whole thing should be restricted to the medical world. Nurses acting under the supervision of a doctor is possibly an area that could be discussed, but not people who are not doctors, then you would save a lot of the problems.

Rachel Taylor: It is important, but we have strayed slightly off the topic.

Dr Holliday: Just to quickly add, I imagine that this terrible gone-wrong surgery was not legal. The fact that people can use the internet to advertise a procedure they are not qualified to give is another problem. Doing something in a hotel room tells you everything you need to know. It is really vital to educate young people so they know that they should not go anywhere near anybody offering them liquid silicone injections into their body because it is not a proper filler for their face. We really need to start educating people about false information on the internet. No matter how much you regulate the internet, you are not going to get rid of unscrupulous people selling snake oil anywhere in the world.

Q90 **Alex Brewer:** Dr Daniels, I would like to ask you about body dysmorphic disorder and pre-existing mental health conditions. How prevalent is body dysmorphic disorder among individuals seeking cosmetic procedures, and how is it typically identified?



Dr Daniels: I do not think we have that data, specifically because a psych assessment is not required before seeking cosmetic surgery. Arguably—or inarguably—there should be because in the case of BDD, a cosmetic procedure is not going to address the underlying mental health issue. We can see people pursuing multiple procedures because their underlying psychological distress is not relieved by a procedure. In addition to BDD, we definitely need to pay attention to the range of other mental health disorders that might be related to seeking cosmetic procedures: anxiety disorder, depression, eating disorders and so on.

The training that medical doctors might get around psychology is not remotely the same as what qualified psychologists receive. You need to think about bringing them into a screening process and regulating it such that people who have diagnosed mental disorders are getting identified before engaging in a cosmetic procedure.

I cannot really answer your question because I do not think we have the data, but there are a range of issues that we need to think about besides just BDD.

Dr Rowland Payne: If I may add, there is some literature on this. The prevalence of BDD in the general population is about 2%, and the prevalence in dermatology outpatients—which includes people with eczema, vitiligo and so on—is 10%, and in cosmetic it is about 15%. There are many studies. The figures vary by 5% either way, but that is roughly how it goes. BDD patients have five times the rate of seeking cosmetic procedures and 10 times the rate of suicide of the average person. As you were saying, these BDD patients often have underlying anxiety, depression, OCD and even psychosis.

Not only is it dangerous for the patient with BDD to be treated with a physical rather than a psychological treatment, it is unlikely to satisfy the patient. In the extreme, there have actually been at least six cosmetic surgeons in America who have been murdered by BDD patients, so there is also danger for the doctor

Dr Daniels: Getting back to Ruth's earlier point, having comprehensive data around who is getting procedures and what kinds of mental health issues are involved is really vital.

Q91 **Alex Brewer:** More across the board, thank you. Do you think there is currently adequate support for people suffering with BDD? If someone presents to your clinic, where would you refer them to?

Dr Rowland Payne: First, it is very important that the person they are coming to seek the treatment from should be able to identify them, which is sometimes very difficult, because they have perceived their psychological problem in terms of whatever the symptom is—"My nose is too big" or whatever it is. If you say no, then they will go somewhere else; they will not seek psychological help. If you refer them to a



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psychologist or a psychiatrist, they usually will not go, so it is incumbent on the person who sees them to do some of this treatment themselves.

I worked with a psychiatrist in my clinic for seven years. I had one with me once a week in a white coat with the patient sitting next to me, and the patients were quite happy to talk to this person. My knowledge of psychiatry is more than the average dermatologist, but the BDD patients require treatment at the place where they present, which is another reason why it must be a doctor who sees them if they are to have any hope at all.

Dr Daniels: The clinical assessment part is key to focus on as well because a voluntary screener that a patient might do online, for example, before coming to an appointment—

Dr Rowland Payne: Hopeless.

Dr Daniels:—will not produce anything like you have described, which sounds quite effective.

Q92 **Alex Brewer:** Yes, there is no critical analysis in that situation. What impact is the normalisation and accessibility of cosmetic procedures having on the prevalence of BDD, given that there is an absence of data?

Dr Daniels: Sorry, can you repeat that one more time?

Alex Brewer: My question is, are we increasing the prevalence of BDD by normalising cosmetic procedures?

Dr Daniels: I do not know that I have the answer to that.

Dr Holliday: One of the things that I would say about this is that certainly there are people with BDD out there, but for a lot of people it is a very rational decision. We know that people who are better looking earn higher salaries and get on better in life.

Sometimes I worry that we over-psychologise cosmetic patients a bit, especially because many are women. For instance, last year in the United States, 24,000 men had breast reductions because breast tissue in men is very common, but we do not say, "Oh, do they need a psychological consult before they have their breast tissue removed?" We just say, "Well, they are men and it is unthinkable that men should have breasts, so of course they have to have it." When we have women that are completely flat-chested, for instance—sorry to keep going back to breasts—we then say, "Oh well, she might have an AA-cup and she might say she does not feel like a woman, but is that because she has body dysmorphic disorder?" I worry that there is sometimes this idea that women are easily led by advertising and that they are more susceptible to a kind of madness around this. I am not saying that there are not people with mental health problems, of course, who feel like this is the cure, but we said 15% max, so there are a lot of people who are doing this with very rational reasons in mind.



Q93 **Alex Brewer:** That is really interesting, thank you. Is there any evidence at all around—I don't necessarily want to say an addictive behaviour, but a kind of, "Oh, I'll just have a little more; and now I've done this and it went okay, I'll try that"? Do you get a lot of repeat custom, or is it, like you said, that very rational "I have decided that I would like this and that is it, and I am done"?

Dr Holliday: These are different constituencies of people. For instance, if you have had weight loss surgery and then you have skin that sort of hangs off your body, then you want to get that fixed, and if that is fixed, that might be it. But if it is a tweak with facial filler here and there, or you are ageing so you need to maintain your upkeep, that is different. We often tend to think about cosmetic surgery that it is all the same people and the same reasons, but different surgeries have very different drivers.

Dr Daniels: Yes, that is absolutely right. Thinking about one patient as representing the group is impossible. Of course that makes it difficult at your end to legislate, but it is complicated to consider these different motivations.

Regardless of whether a patient is, as you have described, someone who is autonomously making this informed decision and going forward to have a procedure and the extent to which they go forth and have that done, versus the large number of people who have a disadvantage and may not know very much about the outcomes or the risks and may have a mental health condition that makes them more likely to pursue a cosmetic surgery or may have a life circumstance, why do we not increase the regulation around these procedures, including the training for psychological assessments and making these procedures safer? That would benefit the wide range of people with different motivations for pursuing cosmetic surgeries.

Dr Rowland Payne: I agree with both my colleagues that the majority of patients who come have quite rational reasons. It is natural for a person to want to be their best self and have a good appearance, and people seek these treatments for rational reasons. It is a small proportion that are seeking them irrationally—perhaps 10% or 15% of body dysmorphic people—and then people who have other diagnoses, where perhaps the psychological side might be treated as well. I very often find the body dysmorphic disorder is an extreme. What we see are natural anxieties that we all have with work, job and family, which is a sort of hinterland between the perfectly rational decision and the body dysmorphic one. There is this range in between where judgment is required. It does not necessarily have to be done by a psychologist; it can be done by the clinician who has the proper training, which would only be a doctor, I think.

Q94 **Chair:** Just quickly before we go to David, with body dysmorphic disorder is there a sliding scale, or is it that you have BDD or you do not? When we look in the mirror, there are always things that we look at ourselves



and think, "I would love this," or, "I wouldn't want this" or, "I like this and I don't like this about myself." We are all highly critical of ourselves, whether it is because we spend too much time on social media or even if we do not. Throughout time, we have always wanted to perfect or reach a beauty standard, whether it was a Victorian tiny corset waist or perfect, wrinkle-free faces. Is there a possibility that some of these procedures are actually tipping people over the edge to BDD, or is there a sliding scale? How does one get diagnosed with BDD in that respect?

Dr Rowland Payne: The people who murdered their doctors must be a very rare group, even within BDD. So yes, it is a sliding scale. We have all looked at a spot in the mirror. If I go to a conference and stay in a hotel and they have a big magnifying mirror, I think, "Don't do it, don't do it, don't do it." I do not have those mirrors in my own house. We are all body dysmorphic to a certain extent, but the point at which we need to identify the patients and not treat them is when it becomes irrational. I might give some patients a psychological treatment and a cosmetic treatment; many patients have many things that I can help them with.

Q95 **David Burton-Sampson:** Christopher, my questions are mainly for you, but Beth and Ruth, please feel free to join in. We have explored some of this already, but I would like to look a little more at pre-existing mental health conditions. As a clinician, what safeguards are in place to ensure that individuals with pre-existing mental health conditions are appropriately assessed before they undergo procedures?

Dr Rowland Payne: I am president of the new section of the Royal Society of Medicine. My mission is to increase identification of mental health concerns, and the best way to do that is a consultation. If a new patient is considering anything cosmetic or, indeed, any condition, I give them an hour. In that time, we talk about the reason they have come and their past medical history. I ask them a lot of questions to find out how they are feeling, how they are in their lives, and how they sleep. This is how I discover whether they are anxious, depressed or even body dysmorphic. Anxiety and depression are extremely prevalent, and this is a holistic approach. If you simply give a questionnaire to people who are unqualified, for example, the BBL fabricator, to hand to the patient and the patient knows that if they tick these boxes they will not get the treatment, that will not help anybody.

Q96 **David Burton-Sampson:** From the work you have done, do you think psychological screening should be mandatory before cosmetic surgery, including non-surgical procedures?

Dr Rowland Payne: Yes, but this should be done in the form of a consultation by the doctor who is doing the treatment. It does not necessarily mean that they should see somebody else as most patients are rational and normal. It is sometimes difficult, but generally speaking, the doctor can identify patients who are not suited to benefit from the procedure. Patient selection is something that we are always talking about at medical conferences; it is very important.



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Q97 David Burton-Sampson: You mentioned the hour-long consultation as being perhaps one way. Are there any other ways that could be implemented, for example, a cooling-off period before the procedure is actually done? I will let Christopher answer first, and then I will come to you.

Dr Rowland Payne: In one of the reports I read prior to coming here, it talked about a two-week period before major surgery, or 48 hours before some procedures. It is a shame to put rules in like that, but it is sensible not to do major procedures on a person you have only just met. Usually, that is not a wise thing to do. I would not like to say never, but on the whole, it is a bad policy.

Q98 David Burton-Sampson: Thank you. Ruth, do you want to come back on that?

Dr Holliday: What Christopher is saying is absolutely right: consultations should be with the surgeon who is doing the surgery. We interviewed around 50 surgeons for our project, and on the whole, they are very keen not to operate on people who are not going to be satisfied with their result because then the patients put that all over social media and it is bad for the surgeon. However, when you think about lots of the budget clinics in the UK doing this stuff, it is not the surgeon doing the surgery who is going to have a consultation with them; it will be a sales agent who is going to sit and talk to them for maybe 10 minutes.

Christopher is talking about best practice. This is not what happened when people were implanted with PIP breast implants, which were all done by doctors and sold by sales agents. Some surgeons were receiving bonuses for doing a breast augmentation every 20 minutes, for reaching their target, or getting fined for not reaching their target. The other thing we need to recognise is that many doctors are very mobile; they move a lot across national borders. Making doctors accountable is quite difficult because if something goes wrong, you go back to the doctor, but the doctor is no longer in the country, and then it is almost impossible to sue across national borders.

Q99 David Burton-Sampson: Interesting—a very interesting challenge actually. Christopher, can you take us through how a practitioner might assess whether a specific procedure is in the patient's best interests?

Dr Rowland Payne: Again, it is the medical history, examination and diagnosis, and it should be done by the person who will do the treatment. It should not be a junior person doing the consultation, like an agent that you were talking about. If anything, the senior person should do the initial consultation and maybe then delegate it to somebody else. For example, I might see a patient who had hair on her lips and I might ask my nurse to do the laser, but I would not expect my nurse to do the consultation and then a patient turn up for me to do some treatment. In those types of clinics they are doing it the wrong way round, and that sort of practice ought to be discouraged. Also, do not forget that a patient



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like Sasha Dean, the poor lady who was here, has no recourse either. Not only was she treated by somebody who had no training and knowledge of complications of treatment, she has no way of going to the General Medical Council. All doctors have indemnity; she has none of these benefits.

Q100 David Burton-Sampson: If you were meeting with a patient during a consultation and you identified that the procedure might be harmful to their mental health, what additional support would you maybe access for that patient before you decide to proceed with that procedure?

Dr Rowland Payne: For example, if a patient is depressed but I still think that the choice of treatment is rational and will be helpful, then I would treat the depression first. I would talk to the patient; I might possibly prescribe something and then see her again in a month or so. It is much better to treat the psychological aspect before the physical. We also know that patients will be happier with the outcome when they are happy before surgery. If they are still sad before surgery, they will not like the outcome. That is the likely explanation, but a doctor always puts patient safety first. We are thinking about what is the best treatment. We are not thinking about trying to reach a target or what is the most expensive thing we can do. We are trying to think about how we can help this patient in all possible ways who has been thinking about the whole thing since they were 18 years old. As a doctor, that is what is happening all the time.

Q101 David Burton-Sampson: As we mentioned earlier, if you deny somebody a procedure, they are likely to just go somewhere else. Is it a high possibility that people will go somewhere else if you deny a procedure? You are all nodding.

Dr Rowland Payne: It is a very high possibility, and if the reason they are seeking the procedure is a psychological one, it is incumbent on the person who sees that person to try to help them. Only that person can do so because the next person they go to will not be a psychiatrist or a psychologist; it will possibly be someone unqualified who is prepared to do the injections.

Q102 David Burton-Sampson: That is interesting, because we have mentioned the commercial nature, budget companies and so on. Does that commercial nature maybe disincentivise practitioners from exercising the level of caution that they maybe would for other medical procedures?

Dr Rowland Payne: I want to answer that again. I do not believe it would disincentivise a doctor, but it would if you think of these things as a shop. I am going into the sweet shop: "I'm going to have some bullseyes and some filler; please do it for me." That is not the right arrangement. If somebody says, "I'm worried about this. How can you help me?", we think about it. It is just coming at it from the wrong angle, and it is a danger.

Q103 David Burton-Sampson: Beth or Ruth, do you have anything to add?



Dr Holliday: I just want to add something on the cooling-off period. In our study, people thought about having their surgery for a long time, but once they decided they wanted it, they wanted it really quickly because waiting for surgery is a very anxious time for obvious reasons. A cooling-off period was something that was being talked about in 2012 around the PIP scandal. That is something that I talked to lots of patients about, and they were saying no because they would be so anxious waiting for the surgery.

Dr Rowland Payne: You are right.

Q104 **Kirith Entwistle:** My first question is for Dr Rowland Payne. Do you believe current UK regulation of cosmetic procedures, both surgical and non-surgical, adequately protects individuals, especially those from vulnerable groups? If not, what improvements would you recommend?

Dr Rowland Payne: I think you know what I am going to say.

Kirith Entwistle: Yes, I think I do.

Dr Rowland Payne: First, patient safety is not properly protected, and we should think of these people as patients, not clients or customers. The safety of the patient is not paramount; at the moment, the main driver for all these things is commercial, driven by industry that makes the products and machines, and runs the clinics. This is the driver for the majority. If we were to restrict these things to the medical and dental world—in line with all other European countries, Canada, the United States, and Australia—you would have far fewer of these problems. They would not be completely absent, because people would still illicitly access fillers and so on, but it would reduce the problems enormously—Sasha, for example.

Q97 **Kirith Entwistle:** What would you recommend in terms of practitioner qualifications, informed consent, and aftercare, just taking the medical perspective?

Dr Rowland Payne: All you need to say is medical or dental practitioner who is registered with the GMC or the GDC, and you can assume the rest. Doctors are regulated enormously heavily. All our clinics are CQC and we have appraisal and revalidation. If anything, there is actually a burden of regulation on doctors, but we can see that as a protection for patients. So, this is the way, and the patients are then protected further. If something goes wrong, there is indemnity. The national health service is protected by the indemnity. If a doctor makes some mistake, the insurance company will pay for the mistake and not the NHS.

Dr Daniels: I would just add that there was a report issued by the Nuffield Council on Bioethics in 2017 that does a nice job of laying out a lot of recommendations that are in line with what Christopher has mentioned.

Q98 **Kirith Entwistle:** That is good to know, thank you. Dr Holliday, do you



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want to add anything?

Dr Holliday: Just to say that after the PIP scandal, 47,000 women were left totally stranded because their clinics just declared themselves bankrupt and opened the following day under the same name with the same phone number. It does not feel like patients have redress. I know it is great if you have indemnity insurance as a doctor, but those clinics were totally able to evade that. There are people who are highly professional, who really want their patients to have the absolute best surgery that they can have, but there are others who do not want that. What we need to be thinking about is how to regulate the clinics that are not doing a good job, not taking care of their patients, and not putting things right when they have gone wrong.

Dr Daniels: The remit of the CQC does not include these clinics.

Dr Rowland Payne: No.

Dr Daniels: Broadening the remit so that they are within those regulations is another area of regulation that is needed.

Q99 **Kirith Entwistle:** I want to touch a little on education. Do we need further work on educating the public on the potential harms and risks of cosmetic procedures? If so, what would this look like? Dr Holliday, I will start with you if that is all right?

Dr Holliday: Perhaps the riskiest time is for younger people because they do not have so much of a sense of risk, of what might or might not be dangerous. In terms of educating, this is something that probably needs to be on the school curriculum. We need to start educating young people about risks and harms, and it is very easy to do. If you see somebody who has had a breast augmentation that has become infected, the skin has gone necrotic, and there are no breasts left there any more, then you can say this is the kind of risk that you are taking. That is a message that could get through, but it will have to be done by expert people who really know what they are doing in that educational setting. You need to get in there early and talk about the things that can happen; things do not always go in the way they are planned.

Dr Daniels: A good example of this is a study done in Australia, specifically around genital surgery, trying to educate younger women about the range of anatomical variation. The researchers found that most young women actually do not know about the range of anatomical variation around labia, for example, and so what they are seeing through porn in particular is a very narrow example. These researchers did a psychoeducational module for young people to educate them about the range of anatomical variation. When young people were informed, they were then less likely to be interested in pursuing a labioplasty. There are some good examples out there.

Q100 **Chair:** Young is different for everybody. How young are we talking about for young women?



Dr Daniels: Late teens.

Q101 **Chair:** Late teens are being educated in Australia?

Dr Daniels: Yes.

Q102 **Chair:** Is there evidence that late teens are looking for cosmetic surgery for their vaginas?

Dr Daniels: I do not know the statistics around labiaplasty in particular, but there was enough interest to drive these researchers to develop this intervention.

Q103 **Kirith Entwistle:** In 2019, the Department of Health and Social Care launched an awareness campaign aiming to better educate people on the potential risks of cosmetic procedures called Clued Up on Cosmetic Procedures. Do you have any awareness about this campaign? Do you have good things to say about it? Are there things that we can improve on that?

Dr Daniels: I am not familiar with it.

Kirith Entwistle: I just wanted to reference that. Thank you.

Chair: Sorry, I am still reeling.

Q104 **Christine Jardine:** We have talked a lot so far about the motivations and mental health issues with people coming to surgery, but what about the mental health implications of outcomes and complications? Dr Daniels, what are the known short and long-term mental health outcomes of undergoing cosmetic procedures?

Dr Daniels: My colleagues at the Centre for Appearance Research recently published a systematic review of the literature. Much of the research that has been done is of low quality; we do not have high-quality studies to draw on which is a significant limitation. From those more robust studies, we do not have any indication of benefit to psychological wellbeing over time. Most studies do not follow up more than a year maximum. There was one older study that followed people for 11 years. At the 11-year mark, the people who had had a cosmetics procedure actually showed worse mental health compared to people who did not. We are in a perfect storm of very little research in the area and not very high-quality research. For instance, studies conducted with people who have a conflict of interest with the cosmetic surgery industry, a lack of control within the study, or a number of design flaws. Then, from what we know, there can be some temporary increases in body part satisfaction. For instance, if you are having a breast augmentation, evidence shows that is likely to increase your satisfaction with that particular body part. But again, we do not have long-term evidence.

The other finding, again from a very small set of studies, is that there appears to be an increase in self-esteem, but we do not have a long-term pattern. From the available evidence, our team concluded that there is no



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solid compelling conclusion about a benefit to psychological wellbeing of having a cosmetic procedure.

- Q105 **Christine Jardine:** This might be completely wide of the mark, but you talked earlier about the drivers and it being commercial rather than medical. Would that explain why there is so little research—because it does not sit within the medical and the academic profession, therefore we do not have the research that we would have otherwise?

Dr Daniels: I do not necessarily think that is an issue that social scientists and health psychologists would be broadly interested in. It speaks to whether funding bodies are supporting research in this area, but I do not think that commercial piece is necessarily the link.

- Q106 **Christine Jardine:** Dr Holliday, how significant do you feel the mental health impact can be on patients who maybe experience complications following a procedure or are unhappy with the outcome?

Dr Holliday: The first thing to say about our big cosmetic surgery tourism project is that 97% of the patients were happy and would recommend their surgeon to a friend. That was one of our findings. That must be one of those bad studies. I guess this is a group of people who had wanted that for a long time and then fixed the thing that they felt was wrong, so that was that. Obviously, in our other study of women with PIP breast implants, it can be really devastating when things go wrong. That is then compounded by feelings of injustice when it is not recognised, compensated or put right, or when there is worry or uncertainty about whether you have a toxic implant or not. There is a lot of qualitative evidence. For instance, there have been studies in Brazil with people who have had cosmetic surgery where they are very happy with the results. It is just when there seems to be some sort of medical malpractice or something like that that it can completely ruin lives.

- Q107 **Christine Jardine:** Dr Rowland Payne, is there adequate long-term psychological support or follow-up care for individuals who might experience regret, complications or worsening mental health after a procedure?

Dr Rowland Payne: I have many patients who come back year after year. I am going to hold a party soon for those who have seen me since the last century. They come every six months for some sort of injection. They are rational people who have feelings. Sometimes they are unhappy and I might treat them for that. They may have a skin cancer, all these things. If you do a lot of surgery, you will occasionally have a complication. The only doctors who do not have complications are those who do not see patients. When that happens, you need to be as sympathetic and helpful to the patient as you possibly can. Those patients tend to keep coming to see you because they understand that you are caring for them and you are interested in their health. That is the ideal; it is the gold standard. That is what we would like to see as best practice, where there is that type of relationship with the doctor. But if



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you have a clinic, or a shop in the high street or someone in a back street, or the patient found it on the internet, how can you possibly have what I have just described? It is impossible. The best practice is as I have described, and as we have tried to project.

I would just like to say a word about botulinum, Botox. When we treat people, for example for a scowl, a frown line between the eyebrows, they notice that the world behaves differently towards them. We were all busy earlier, but if we had been less busy, chatting and laughing and you came into the room with a scowl, it would be slightly different than if you came in without a scowl because we would carry on laughing and joking. The patients notice this. They go into a shop and are treated differently by the shopkeeper because the scowl has gone. This idea stimulated studies, which have been repeated several times: patients with therapy-resistant depression who had resisted all the best efforts of psychologists and drugs were treated with botulinum and their depression improved. This is not just 25 patients; this is several studies. If you smile, the world will smile with you; and if you scowl, the reverse. We are helping people; we are contributing to wellbeing because if you look good, you feel good. This is true for the majority of patients, not the poor undiagnosed BDD patients or the terrible story we heard the other day. Does that answer the question a little?

Q108 Christine Jardine: You have referred to that story a few times today; it has made an impression on us all. That was the specific circumstance I was thinking about: someone who has that sort of experience and surgery goes wrong. At the moment, do you think that the long-term care is there for them afterwards? Is it sufficient or insufficient, and what role should the NHS maybe have in providing any sort of mental health service?

Dr Rowland Payne: I am sure it falls back on the NHS. You could argue that if the Government do not accept the recommendation, which I hope you will put to them, that it should be restricted to doctors and dentists, then you have to do something about these places where there are no medically-qualified people. You really ought to ban it, because there is no chance of the patient having any of that type of support afterwards, and there is no chance of them escaping needing the services of the NHS.

Q109 Rosie Duffield: Dr Daniels, we have been talking about the mental health of people who have surgery, but what about the mental health of people who are just shown these perfect, idealised images all the time? It is interesting what Dr Rowland Payne was saying about it improving their happiness, but is there some sort of cycle of loathing and then a hit and then you want more to try to achieve something ideal?

Dr Daniels: Ideal images are everywhere in our media environment today. There is no unedited image any longer, at least commercially produced. Everything is edited. Even individuals are putting more and more edited images in their own social media. We are sort of in an arms race, if you will, in terms of these idealised images being pervasive, and



they tend to promote dissatisfaction in viewers. The key issue is really addressing the specific ways in which those images are amplified. For instance, on social media we know that likes and shares, particularly when we look at images of sexual objectification, get more traffic. Young women who post images where they are demonstrating a sexualised self-presentation tend to attract a lot of traffic and attention. The social media platforms are then amplifying it through, for example, the quantification of likes. There are ways in which we can think about limiting that impact through social media accountability with the companies themselves being forced to address some ways in which these practices are happening on their platforms. As Ruth mentioned, we can also do a better job of educating young people. There are social media literacy programmes that have been shown to be effective. There are body image curricula out there that need to be in schools as well. We really need to disrupt the broader environment that values and overvalues these idealised images. Is that what you are getting at?

Q110 Rosie Duffield: That is a really good answer; thank you. Dr Holliday, do you want to add anything to that?

Dr Holliday: There is a lot of evidence to show that social media makes people feel bad, and that negative comparison is not good for you. Getting somebody who is a real expert on social media is really important for this because people are advertising and circulating images through social media and I do not know how that could be controlled, but someone might know.

Rosie Duffield: Have social media companies ever consulted any of you?

Dr Daniels: No.

Q111 Rosie Duffield: Do you think they would if you wrote to them and said, "We know what we are talking about. Are you listening?"? Do you think you would get any engagement from them?

Dr Daniels: A colleague of mine at the Centre for Appearance Research has done research looking at corporate social responsibility, doing interviews with industry leaders in the UK specifically, and trying to understand how they think about these issues. They tend to be more narrowly focused on patients rather than whether they hold responsibility for beauty standards more broadly in society. The expectation that industry will self-regulate is a fool's errand really, so they have chosen not to do so. To this point, as I mentioned earlier, the study on TikTok where we know that content is being directed at vulnerable young people who have eating disorders further illustrates that industry is not going to do the job of government regulation to limit their ability to pump this information out.

Q112 Rosie Duffield: What if they made it very obvious that these things were filtered? Everyone knows they use them, but might it help if there was, say, a red light or a green light in the corner of a photo to show this has



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been done with a filter?

Dr Daniels: We know from research on labelling that whether an image is edited or not does not inhibit social comparison with that idealised image. We have seen this in study after study. Those warning labels that have sometimes been required in different countries are actually not protective. We need to think about this a bit more because it also puts the responsibility on the user instead of the company that is actually generating profit and creating the content.

Dr Holliday: This is another reason why the mechanisms by which people use images are really important. It is not that people see these images and think, "Oh, I'm going to take this picture to a cosmetic surgeon and they can turn me into this image." It is just that these are the ideal, and if people can move a little towards that ideal, they are going to have more value in society. It is a really common sense mechanism. This is what the most beautiful people look like; you could borrow a bit of this and become a bit more beautiful than you are now. It is not that people think they all have to be that person or like that person, but it is just a standard that they can go some way to approximating.

Q113 **Chair:** I know that question was about the impact on young people, but I have to say, even the most self-assured mature person will still be highly susceptible to that level of comparison online. We have talked about education. What about education for people who have not always grown up with the internet? Is there work to be done with some of our generations that are perhaps being targeted with adverts about how to hold back the tide of time?

Dr Holliday: A really good example might be that we all think women shaving their legs is bad. Why should women have to shave their legs and men do not? We might experiment with not shaving our legs, and then we might always wear trousers. There is this sort of knowing that the image is wrong, and then there is the impossibility of actually doing it, of just rejecting all social norms and doing something different. It is extremely hard. Education is part of the solution, but it is not everything; we are being pushed by these industries into doing these things.

Q114 **Chair:** There is also a counter industry to this, which I see very much on social media. I have personal social media which is private with a lot of food, cleaning hacks, and dogs. My public social media is, if you like, the flip side to that. It will have body positivity all over it. I will also get influencers that I follow because I love programmes such as "Below Deck" and "Married at First Sight" and all those things. Social media companies would probably argue that they promote body positivity as much as they do the other side of it, but have you seen that that is not having the impact it should have?

Dr Daniels: There is research that shows that exposure to body positive content can have a positive effect on body image, but it is the relative



proportion of that content out there that is far smaller than the “normal” content which is mainly these idealised images. Arguably, there is a bit of an unrealistic expectation that we love our bodies regardless, so the research is actually moving more in the direction of promoting more body neutrality. In that realm, it is just de-emphasising the priority of the body. Historically, we can look back and see that a woman’s appearance has always had outsized emphasis in society; women have been judged on it forever. It is trying to shift that, especially as we see women in the public sphere in higher rates than ever before, because women are still held to these really dated notions that appearance is the primary indicator of their worth.

Q115 Chair: I had a comment recently that called me a fat Labour munter, which was lovely, and it was not from my mum.

The question I want to ask is around what more they can do—you said that Instagram had taken off likes for young people, but then they really wanted it. I am seeing other platforms—Pinterest, for example—where they did not have it before, but you can search by body type. Is there anything we can do to promote that body positivity we are seeing less of to shift that balance more? Is there anything we can do around that?

Dr Daniels: That would be very challenging, especially because these algorithms are proprietary. Honestly, I do not know that researchers can answer that question, but there are these affordances of social media platforms such as the videos that continuously hop into the next video that tend to indefinitely suck in young people especially. Those kinds of things can be targeted for regulation. Even something such as the likes is technically a very easy thing for an engineer to implement, but social scientists need to be directing these companies to the affordances and to the changes that might be useful. Obviously, the algorithm would be the holy grail of trying to get a better sense of an algorithm with a more balanced set of content, but social media companies have not opened up to that at all.

Q116 Chair: If anything, from what we have heard from other inquiries we are doing, around community cohesion in particular, they have gone backwards around moderation and checking. If we reach the gold standard that Dr Rowland Payne has talked about, which is that only medically-trained people are can carry out both non-surgical and surgical cosmetic procedures, we are going to see an increase in cost and probably a decrease in the availability and affordability for some people—which, if I am honest, will go down like a lead balloon because of the popularity of some procedures. If we had started off with the regulations, perhaps we would not be in the same position. Dr Holliday, would this potentially drive more people to seek cheaper alternatives overseas, and would we see cosmetic tourism levels increase? What can we do to improve that? This has to have an international solution, but how do we improve that?



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Dr Holliday: I always find it funny that, in the wake of the PIP scandal, the argument is that we should put all medical procedures back in the hands of doctors, when it was doctors who implanted toxic implants in the first place. I am not totally convinced that, for instance, we should not be letting beauticians do this, when tend to stay on the high street, so you can go back to them and say, "I don't like this. I need this dissolving. Can you move it somewhere else?" I am not sure that argument holds up.

I guess people are not going to go to Poland for something like fillers because it is too expensive relative to the cost. But for other medical procedures, the higher the cost, the more people go abroad. The thing I want to be really clear about, though, is that there is no evidence that people who go abroad have a worse experience than people who have cosmetic surgery in the UK. The only evidence comes from UK surgeons' organisations that, in a way, have this vested interest in keeping people in the UK. In places like Poland and Turkey there are also doctors with extensive training. The clinics that patients from the UK travel to are upmarket clinics that they can afford because of different currency rates. The higher the cost of anything in the UK, the more likely it is to drive people abroad. The problem with that is that you are at a distance from your surgeon, so if something goes wrong, it is difficult to go back for follow-up.

There are medical tourism insurance companies that provide insurance, but mostly those insurance policies only last for one year. When you have surgery, there are two risks. Similar to having your kitchen done, you have a cooker and kitchen cabinets, but do the doors open and does the cooker work? Also, the tiles that arrive might not be the shade you ordered, so it does not match across. So, you have an aesthetic risk and a medical risk, and dissatisfaction can happen across both those areas. Surgeons will often say they cannot tell what the ultimate aesthetic result will be until a year after because it needs a year to settle down. By that time, the insurance policy has run out. That is another sort of problem. Again, it is not that all surgeons abroad are worse than surgeons in the UK. In fact, surgeons are moving from country to country all the time. The risk is the follow-up care and how to get that.

Q117 **Chair:** Dr Rowland Payne, do you want to come in on that point?

Dr Rowland Payne: Yes, please. When they go to clinics abroad, they are seeing doctors and that is probably why they have very good results. They are not going to the places that we heard about. We are thinking about patients and protection. If you are thinking about cost, then there are plenty of nurses who can work with doctors, and the costs would stay the same as they are now. Don't think that by limiting it to doctors and dentists with the assistance of nurses under supervision that that would make it more expensive; it would not. It would relieve many of the problems that you are worried about with the national health having to pick up the pieces. It would also bring us into line with the rest of the



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civilised world. When I go to conferences on these subjects, it is embarrassing when I have to explain that it is the wild west in this country. Anybody can get anything from the internet and inject one another without any training; it is crazy.

Chair: Absolutely. When we heard the testimony from Sasha, it is beyond belief that the person who did that to her is still practising on the high street. Had the damage that Sasha received to her body and her health been caused by a baseball bat instead of a needle, that person would be behind bars. What you have outlined today is incredibly useful. On behalf of the Committee, I am really grateful for your time and expertise. That brings our session to a close.