The neglected harms of beauty

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The Neglected Harms of Beauty: Beyond Engaging Individuals

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ABSTRACT

This paper explores the neglected 'harms-to-others' which result from increased attention to beauty, increased engagement in beauty practices and rising minimal beauty standards. In the first half of the paper I consider the dominant discourse of beauty harms – that of ethics and policy – and argue that this discourse has over-focused on the agency of, and possible harms to, recipients of beauty practices. I introduce the feminist discourse which recognises a general harm to all women and points towards an alternative understanding; although it too focuses on engaging individuals. I argue over-focusing on harms to engaging individuals is somewhat surprising especially in liberal contexts, as this harm can broadly be regarded as 'self-harm' (done by individuals to themselves, or by others employed by individuals to do so). The focus on engaging individuals has resulted in the neglect of significant and pressing harms-to-others in theory, policy and practice. In the second half of the paper I turn to actual and emerging harms-to-others. I focus on three particular harms-to-others as examples of the breadth and depth of beauty harms: first, direct harm to providers; second, indirect but specific harm to those who are 'abnormal'; and third, indirect and general harm to all. I conclude that, contrary to current discourses, harms-to-others need to be taken into account to avoid biased and partial theorising and counter-productive policy-making. I advocate recasting beauty, in a parallel way to smoking, as a matter of public health rather than individual choice.

1. INTRODUCTION

In this paper I explore the neglected harms of beauty. Some potential harms of beauty are widely recognised as issues of concern and are matters of considerable debate but others are almost wholly neglected. Primarily policy-makers, ethicists and lawyers have focused on harms to engaging individuals; cosmetic surgery recipients and beauty practices users. I argue that harms arising from such practices can largely be classified as 'self-harm'; assuming a very broad definition of self-harm is adopted. A broad definition of self-harm includes the practices that individuals do to themselves, and those which they employ others to do to them. On this definition the focus on engaging individuals rather than on harms-to-others is perplexing as, on standard liberal models, harms-to-others are considered more morally significant than harms to the self. Prohibiting self-harm is often considered troublingly paternalistic in liberal contexts and yet in the beauty debate attention has almost exclusively been on the harms to engaging individuals. My aim is to highlight and investigate this striking gap and to argue that this neglect is a significant failure of theory and policy. I argue that the increased valuing of appearance in a visual and virtual culture, coupled with rising engagement and a rise in what is required to meet minimal standards of beauty, is already harmful to others.[1] Moreover, if current trends continue and appearance continues to matter more then harms which are currently nascent are likely to become prevalent. I suggest that beauty harms should be reframed as public health concerns.

In order to make this argument, in section 2, I outline two discourses in which the harms of beauty are currently discussed; those of ethics and policy and feminist political philosophy. I do this to justify my claim that such debates have primarily focused on engaging individuals; and to consider the connection the feminist debate makes between beauty practices and a collective harm to all women. In section 3 I turn to overt harms-to-others; to harms beyond those which fall on currently en-

1. In the paper I assume that minimal beauty standards are rising. This is not a claim that all standards are everywhere the same, or that there have not been more demanding beauty standards historically, undoubtedly there have; footbinding being a classic example. Rather it is a claim that as a global beauty ideal of thinness, firmness, smoothness and youth, emerges so globally minimal standards rise and are standardised and normalised (Widdows, forthcoming 2018).

gaging individuals. I introduce a number of possible harms-to-others to indicate the breadth of potential beauty harms. In section 4 I consider three harms-to-others. Each of these harms is an example of a different type of beauty harm. I have selected these three harms in order to illustrate the range and extent of potential beauty harms and to show that in some cases clear harms are already being ignored and likely emerging harms are not being recognised and anticipated. Accordingly there are harms already occurring or emerging which merit response. The three harms I explore are: First, the direct harm to providers of beauty practices; second, the indirect but specific harm to those who are 'abnormal' and can never conform to minimal standards of beauty; and third, the indirect and general harm to all. I conclude that, contrary to current discourses, the most widespread and significant current and likely harms of beauty are not harms to engaging individuals, but to others. Accordingly theoretical work, as well as policy and practice recommendations, must pay attention to harms-to-others, as well as to engaging individuals, if they are to avoid advocating biased or counter-productive conceptions, policies and practices.

2. STANDARD BEAUTY DISCOURSES

There are two separate discourses which have focused on the harms of beauty practices. The first is that of policy-makers, ethicists and lawyers, who have focused on the harms and risks to those who engage in beauty practices. The second is feminist critiques of beauty practices as instances of gender injustice. The only exception to the dominant focus on the harms to engaging individuals has been in the ethics of non-human animals, where the testing of beauty products is an issue of concern.

2.1 Safety, information and consent

The first discourse is primarily about safety, governance, and professional duties with regard to invasive procedures. There is concern that recipients are electing to have procedures or engage in beauty practices which are unduly risky; carried out by practitioners who lack extensive training in the procedures they are administering in unregulated or under-regulated premises, using untested products and without adequate information or sufficiently robust consent procedures. Such worries are heightened by scandals and rising public concern. For instance, the Poly Implant Prosthese (PIP) scandal of 2010 arose when breast implants were made from silicone intended

for industrial rather than medical purposes (Keogh, 2012). Similar scandals attach to non-surgical processes and there are constant horror stories about injectables and fillers; and complications include infection, lumpiness, blood vessel blockages, tissue death, allergic reactions, prolonged swelling and bruising and even blindness (Keogh, 2013, 24). At the most routine end of the spectrum, there are worries about practices such as skin lightening and tanning; for example, the World Health Organisation considers skin lightening a public health risk across parts of Africa, Asia and Latin America (WHO, 2011).

Such scandals have led to numerous reports and recommendations, with particular attention being paid to the most risky practices, those of surgery and injectables. Most prominent in the UK is the Department of Health's 'Review of the Regulation of Cosmetic Interventions' chaired by Bruce Keogh; often referred to just as 'the Keogh review' (Keogh, 2013). The Keogh review recommended changes in three areas: first, in provision, calling for safe products and skilled and responsible providers; second, in care, to ensure an informed and protected public; and third, in redress. While there has not been the legislative response Keogh recommended professional bodies have taken action. For example, the General Medical Council introduced 'Guidance for Doctors who offer Cosmetic Interventions' which emphasized adequate training and experience, ensuring realistic expectations, responsible marketing and the importance of doctors consenting patients in person (GMC, 2016). This was supplemented by The Royal College of Surgeons' publication, 'Professional standards for Cosmetic Surgery', which provides detailed instructions on how to meet professional standards (RCS, 2016). In addition, in 2017 the Royal College of Surgeons launched a certification scheme for appropriately trained and experienced surgeons.[2] The goals of such initiatives are to improve the safety of procedures and to ensure that potential recipients are fully informed and that best practice consent procedures are implemented across the board. In particular, that recipients are fully informed of risks and possible complications overtime; that there are no financial inducements to pressure recipients into quick decisions; and that there is a no-penalty cooling off period.

Such responses only go so far. They do not address concerns about surgeons who do not fall under the auspices of UK professional bodies: recipients travel abroad to access cheaper procedures and surgeons are flown in by cosmetic companies to do

2. Members of the public can search a specialist register; however while some cosmetic surgery providers only employ registered surgeons non-registered surgeons continue to practice.

multiple operations.[3] Nor do they address the lack of regulation, governance and best practice of non-surgical procedures. For instance, while Botox requires a prescription in the UK, it can be bought from the internet, and dermal fillers are almost wholly unregulated. The Keogh review memorably puts it that "a person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen or a toothbrush" (Keogh, 2013, 5). The review continues:

> *"Dermal fillers are a particular cause for concern as anyone can set themselves up as a practitioner, with no requirement for knowledge, training or previous experience. Nor are there sufficient checks in place with regard to product quality – most dermal fillers have no more controls than a bottle of floor cleaner" (Keogh, 2013, 5).*

In terms of harms to recipients the regulation of non-surgical treatments is a pressing area for policy makers to address. Non-surgical procedures are far less regulated than surgical procedures and yet it is here where uptake is rising exponentially.[4] Although figures should be used cautiously, that these procedures are increasingly commonplace is not contested; accurate data is notoriously lacking across beauty practices and there is no systematic recording of the numbers of surgical and non-surgical procedures, outcomes, complications and side-effects.[5] Part of ensuring that products and premises are safe and the practitioners are well-trained is about protecting engaging individuals from harm-from-others. Serious physical and psychological harm can result from both surgical and non-surgical procedures.[6] Some harms are

3. So called 'fly-in-fly-out' or 'seagull' surgeons are an increasing phenomenon and the primary reason for cosmetic surgery tourism is to attain cheaper treatments (Griffiths and Mullock, 2017).

4. There is no centralised reporting of the number of such procedures and therefore estimates of the numbers of procedures carried out in the UK or globally are impossible to attain. However, that there is a rise in Botox and other non-surgical but invasive procedures (such as fillers, non-surgical face lifts and chemical peels) is undoubtedly the case. All surveys, however incomplete, suggest that Botox rises year on year. For instance, the 2016 statistics for procedures carried out in the US describes Botox as the most popular non-surgical procedure with over 4.5 million procedures carried out by registered medics in 2016 (ASAPS, 2016, 7).

5. The lack of data, particularly extensive and robust data, is a constant complaint of policy-makers in the beauty context. The frustration is evident in the Keogh review which comments that, "there is no central collection of data on the complications following cosmetic interventions and hence no information on the type or frequency of complications" (Keogh, 2013, 39). This frustration is echoed in the Nuffield Council on Bioethics Report, *The Ethics of Cosmetic Procedures* (Nuffield, 2017).

6. Physical harms include standard harms of surgery (including adverse reactions to anaesthesia, bleeding, scaring and risks of infection and complications) as well as added risks which attach to using implants (either from additional risks of infection and rejection or from harms from the sometimes toxic implants, especially when they rupture or leak). Psychological harms are more contested and some argue offset by psychological benefit, but possible psychological harms include increased attention to appearance leading to increased body image anxiety and its negative consequences.

foreseeable and intentional; for instance, that the recipients of PIP implants would be harmed was wholly foreseeable. This was a direct harm, and one the women did not do to themselves and which could not be classed as self-harm.

Protecting individuals from using unsafe products is part of protecting individuals from harm-from-others. Moreover, professional bodies are, by definition, concerned with regulating the profession, and the emphasis on safe products and procedures serves to protect the profession and the practitioners within it as well as engaging individuals. Yet, assuming that providers are acting ethically, providing services and products in good faith and informing recipients of the risks, then both practitioners and recipients are protected, and harms to engaging individuals are effectively self-harm. For example, in cases where surgery goes wrong but no one has acted wrongly harms which arise are best understood as 'self-harm'. If individuals are made aware of the risks—and there are always risks—and have fully consented then they are taking responsibility for bad outcomes which they know might occur. All surgery can have complications, even when performed by the best surgeon in the best setting. That recipients do take responsibility for bad outcomes when no one is at fault is borne out by the testimonies of women who engage.[7] Whether or not this is ethical, and whether these decisions are really as free as the consent model assumes is something I debate elsewhere (Widdows, forthcoming 2018). However, on the liberal model where individuals are permitted to engage in harmful and risky practices as long as they are fully informed, weigh the risks and benefits, and formally consent such harms are, rightly or wrongly, placed at the door of the consenting individual. Accordingly harms which befall engaging individuals can be classified in some very broad sense as 'self-harm'.

If such harm is self-harm, then the lack of attention paid to harms-to-others is perplexing. One possible explanation for focusing only on those engaging rather than others is the difficulty of tracking harm-to-others. Collecting comprehensive data on the harms to those who engage in practices may be challenging, and currently lacking, but collecting data on those who do not engage is more challenging. This is particularly true when we consider indirect harm, where there is no causal link between an action and a harmful outcome. While direct harm to others (such as that to providers which will be considered in section 4.1) is possible to evidence in a similar way to direct harm to recipients, indirect or communal harms, for instance,

7. For example 'Betty', a cosmetic surgery recipient, voices this, when she says that having had surgery "you have to stand behind the decision" (Davis, 1995, 145).

harms resulting from changing social norms and expectations, is far more difficult to track and document. Evidence of general or communal harms is never causal, but requires the tracking of patterns, trends and correlations and making informed, but always interpretive, deductions from data. Given this, claims of general, communal and group harm are harder to substantiate and are not definitive in the way which causal harm to engaging individuals is; although the harms are directly experienced by individuals in that it is individuals who feel the pressure to conform to more demanding beauty ideals and social norms. Evidencing this harm is far more complex than evidencing the harms of physical disfiguration or pain. The operation or procedure is the cause of physical disfigurement or pain; by contrast what is the cause of increased body-dissatisfaction? To be sure feeling increased pressure to engage in more beauty practices correlates with the increased use and normalisation of practices, but the exact nature of the relationship is indeterminate. Therefore, despite the significant damage done to very many, it may be that the lack of direct causal evidence is sufficient for policy makers to shy away from recognising and addressing such harms.

2.2 Inequality, inferiority and gendered harm

The second discourse about the harms of beauty practices is found in feminist political philosophy. At first glance this discourse appears to be wholly distinct from the discourse in medical ethics, law and policy. However, on investigation, it too tends to focus on the harms to women who engage but, and importantly for this paper, the feminist discourse also highlights communal or general harm to all woman.

This type of argument originates with radical second-wave feminist thinkers such as Andrea Dworkin. Dworkin introduces footbinding as an extreme but typical beauty practice. It serves to sexualise, physically constrain and physically hurt women; it establishes women "as ornaments, as sexual playthings, as sexual constructs" (Dworkin, 1974, 106). Dworkin argues that beauty practices in general serve this function: they make women 'women', by showing women are different from and subservient to men. Moreover, that they are painful is not accidental, but "teaches an important lesson: no price is too great, no process too repulsive, no operation too painful for the women who would be beautiful" (Dworkin, 1974, 115). The use of beauty practices to make women 'women' and to transform them into stereotypically sexual objects, such feminists argue, is harmful and costly for individual women, and harmful to all women.

Clare Chambers makes a similar argument, but within a liberal framework and using language which is more familiar to current debates. She argues that engagement in beauty practices, such as elective breast augmentation, is harmful because it compromises the core liberal value of equality. For Chambers, individual women are harmed as a result of conforming to patriarchal norms. While an individual woman's choice to engage may be free from the desires of any actual man, it is not, and cannot be, free from the constraint of patriarchal norms. To illustrate, she compares breast implants and knee implants highlighting their cultural meaning:

> *"Why on earth would anyone want to have surgery to insert heavy and dangerous alien objects into her body if there were not social meaning to, or social payoff from, the practice? A woman who did want to have breast implants in such a society would be like someone who wanted to have cosmetic knee implants" (Chambers, 2008, 40).*

Chambers argues that it is rational for women to choose to engage in beauty practices, but only because of the unjust context. In her analysis individual women are harmed by engaging in risky, costly and painful practices in order to conform to discriminatory and harmful social norms. She questions whether even the most informed of consents could be truly agentic as "gender inequality is so deeply entrenched in social norms that individual free choice cannot overcome it" (Chambers, 2008, 8).[8] However, for this paper what is important to note is that the feminist debate—like the policy and ethics debate—focuses on harms to engaging individuals. The ethics, law and policy debate seeks to limit harm to engaging individuals by enhancing agency. For example, the reason emphasis is placed on improving consent processes because it is assumed that individuals who have information can make autonomous and robust decisions. By contrast, the feminist debate is concerned that such decisions, which benefit men rather than women, can never be free (Jeffreys, 2005, 32). Despite these differences the focus for both is on engaging individuals.

However, the feminist debate, while focusing on engaging individuals, high-

8. Jessica Laimann is more optimistic about informed consent from a feminist perspective and suggests that: "In addition to education campaigns that raise general awareness of the discriminatory and objectifying nature of the practice of breast implants, the relevant information could be specifically communicated as part of the physician-patient-consultation, or on the medical consent form that patients are required to sign before breast implant surgery. The relevant information would not only include reference to the status harm that having breast implants might entail, but could also feature information about the harm effects breast implants might have on other women by increasing acceptance and influence of the relevant norm" (Laimann, 2015, 56).

lights one important harm-to-others; the general harm or communal harm which all women suffer. To return to Chambers, she argues that "the problem with disciplinary appearance norms is not just that they are different for men and women, and not just that they are more exacting and expensive (in both time and money) for women, but that their effect is to cast women as inferior" (Chambers, 2008, 29). This then is a general, communal or group harm which falls on all women; all women are being marked as inferior and unequal. It is a status harm. For Chambers, on liberal grounds, States should intervene as "liberal institutions ought to ensure that, wherever possible, pressures to make disadvantageous choices should not fall on a specific group or groups" (Chambers, 2008, 130). Her claim is that choices which are systematically made by one group and not another suggest disadvantage, and choices which are responses to identifiable pressures suggest undue influence. Both systematic influence and/or disadvantage are indications of injustice.[9] In Chambers argument, as in Dworkin's before her, it matters that the requirements of beauty are unequal; that they fall on women and not men. As Sandra Bartky memorably puts it, "soap and water, a shave and routine attention to hygiene may be enough for *him*; for *her* they are not" (Bartky, 1990, 71). The asymmetry or inequality marks women's status as inferior and unequal and permits gendered exploitation and/or subordination.

What I wish to take from this debate is not the gendered nature of beauty harms—an argument I critique elsewhere[10]—but rather the recognition that there might be general and communal harms to all which attach to beauty practices and norms. The status harm falls on all women; irrespective of whether they engage or not. This claim, that social communal norms can be harmful—and to many, perhaps all—is a key argument, and a model upon which I draw. Social norms, in the feminist discourse, can harm: they can impose limitations on what it is possible for individuals to be and do. I will return to communal harms of this broad type in section 4.3.

9. Chambers identifies two key indicators of injustice, the 'disadvantage factor' (choosers are harmed compared to those who choose differently) and the 'influence factor' (identifiable pressures on choosers from the group who choose differently and benefit) (Chambers, 2008, 120).

10. I argue at length that while there are significant and troubling gendered harms of beauty, for instance from hyper-sexualised norms, it is less possible to claim that *engagement* continues to be a gendered harm as the minimal demands of beauty become increasingly burdensome for men (Widdows, 2017).

3. NEGLECTED HARMS-TO-OTHERS

In the last section I claimed that the dominant discourse about the ethics of beauty practices is overwhelmingly focused on and concerned with harms to engaging individuals. This is also the case for the second discourse of feminist political philosophy, although some attention is also paid to the communal and general harm to women as a group. That the medical ethics discourse is so focused is perhaps not surprising. The concern of medical professionals is not to question wider social norms but to do their best for their particular patient within current frameworks. Nor is it surprising that they assume, despite the numerous critiques, that informed consent protects from harm, as this is a standard assumption in medical practice.[11] Yet policy-makers cannot appeal to the same defence. It is exactly the task of policy-makers to consider harms across their jurisdictions and to recognise the interaction of practices, policies and norms. The task of policy-makers, considered broadly, is to put in place governance frameworks which leave individuals space to live the lives they choose as long as they do not harm or unduly proscribe the freedom of others. Some, even liberal, models go further and argue that policy-makers should seek to provide equality of opportunity or conditions of human flourishing for those in their jurisdictions. But, endorsing these stronger claims is not necessary to claim that policy-makers should regulate to protect others from harm and/or prevent the undue restriction of others' freedom. It is exactly the harms-to-others and restriction of others' freedom deriving from increased attention to and engagement with beauty practices which is currently neglected.

While harms to individuals who engage are important and by no means yet fully addressed the harms of beauty are not limited to those which beset engaging individuals. To accurately consider the harms of beauty a broader frame is required, one which can recognise the harms-to-others which result from increasing engagement with beauty practices and the knock on effects of such engagement as engagement is normalised and minimal standards rise. Such harms fall not only on those who choose to engage in beauty practices but on those who do not engage, or who only engage enough to meet minimal standards of beauty, to be 'good enough'.[12] There

11. For instance, Neil Manson and Onora O'Neill argue that consent should not be regarded as protecting autonomy, but rather as a means to waive certain rights (Manson and O'Neill, 2007).

12. For discussion on the ethical similarity and dissimilarity between the explanatory and justifying narratives for *engagement* of 'to be normal', 'to be good enough', 'to be better' and 'to be perfect', see last section of chapter 5, "Perfectly Normal", of *Perfect Me* (Widdows, forthcoming 2018).

are numerous possible —direct, indirect, individual, group, communal and general— harms which might attach to the rising demands of beauty.[13] In section 4 I will focus on three distinct, actual or likely, harms-to-others which follow from increased engagement with beauty practices. However, these harms are by no means exhaustive of harms-to-others which attach to beauty practices considered broadly, but rather they have been selected to exemplify different types of harm and so show the range and extent of possible beauty harms. Other harms-to-others I could have considered are very general harms of discrimination, harms of unequal distribution of beauty, intergenerational harms, gendered harms from hyper-sexualised beauty norms, and harms to particular racial or ethnic groups. Before I detail three specific harms, let me briefly comment on discrimination and the potential distributive justice harms, as these are increasingly discussed in certain quarters and are indicative of the breadth of possible beauty harms.

Appearance discrimination, 'lookism', has been increasingly discussed and has been compared with sexism and racism (Etcoff, 1999; Swami and Furnham, 2008). Appearance discrimination is a broad category which encompasses a number of possible harms. For example, in some forms it could be considered a general communal harm in that a society which discriminates on appearance grounds creates a toxic environment in which appearance matters more than other goods (a parallel claim is made in normalisation arguments).[14] Alternatively appearance discrimination can be considered group harm; limited to a specific group which is singled out and discriminated against on appearance grounds. Finally—and this is the focus of much of the emerging literature—appearance discrimination can be an individual harm; experienced by individuals who are denied employment or other goods on appearance grounds.

When it comes to individual harm the evidence is contested with regard to the extent to which appearance impacts upon employment and other opportunities. Evidence suggests that there is a small but clear advantage to good looks and a small but clear disadvantage to being classed as unattractive; and such advantages and

13. In this paper I do not distinguish in detail between different types of general, communal and group harms. The reason for this is that my aim is to show that harms beyond engaging individuals must be recognised, hence the purpose is to show that all of these non-individual harms are important, rather than to distinguish between them.

14. This argument underpins the claims in sections 4.3 that rising minimal standards impact on all. For a detailed account of the process of normalisation see chapter 5 of *Perfect Me*, "Perfectly Normal" (Widdows, forthcoming 2018)

disadvantages apply across domains.[15] Yet some argue that such advantages are over-estimated, and are outweighed by the harms which attach to over-valuing appearance: particularly with regard to self-esteem (which has significant knock on effects for confidence and activity in other areas).[16] Given the current lack of consensus, laws to prevent lookism may be premature: the evidence is contested and legislation might further embed a view that appearance is important and be counter-productive. Moreover, some claim that anti-discrimination laws would be unworkable as it would be difficult to determine those who could be classed as 'unattractive' and thus be subject to such discrimination.[17] In addition, once appearance discrimination was illegal, employers would be unlikely to give appearance as a reason for not appointing, making appearance discrimination particularly hard to prove.

Nonetheless if appearance continues to become ever more valuable and valued in a visual and virtual culture then calls to extend discrimination laws to appearance may increase. Moreover even if legislation on discrimination grounds is not appropriate other beauty harms may require mitigation or redress. For instance, if beauty is regarded as an important good—relevantly similar to health or education—then the distribution of beauty, opportunities to access beauty, or compensation for a lack of beauty, are issues of distributive justice. Beauty is already functioning as such a good in some contexts. For example, women report having surgery in order to ensure continued employment, and professional longevity is increasingly a reason for beauty engagement (Gimlin, 2012). Moreover, some go as far as to argue for a 'right to beauty'; a dominant discourse in Brazil where cosmetic surgery, *plástica*, is widely available in public hospitals (Edmonds, 2007; 2010). In this context Ivo Pitanguy, a famous plastic surgeon, has asserted that "the poor have a right to be beautiful too" (Edmonds, 2010,

15. For instance, Daniel Hamermesh, draws on numerous studies to show that when it comes to earnings there is a 'beauty premium' and an 'ugly penalty' of approximately 15% (Hamermesh, 2011, 46). Similarly in other domains; the more attractive are more likely to marry (Etcoff, 2011, 65) and to be assumed to have positive personality traits, such as friendliness, competence and intelligence (Eagly et al., 1991).

16. For example, those who are considered beautiful may experience anxiety and insecurity as a result of heavy investment in their looks (Vantarian, 2009).

17. Most problematic is who would be protected. William Corbett suggests that because there is not a clearly identified group deciding who would be covered by such legislation would likely dominate any litigation (Corbett, 2007). Moreover, Daniel Hamermesh points out that obesity discrimination cases have been brought on the grounds that obesity is a disability (Hamermesh, 2011, 155). For obvious reasons bringing cases on disability rather than lookist grounds might be preferable for plaintiffs.

14).[18] While the argument in Brazil for a 'right to beauty' is very contextual and connected to wider issues (not least as Brazil's position as a hub for training many of the world's cosmetic surgeons (Edmonds, 2010, 93)), if it is the case that beauty is a significant enabling good, then a lack of beauty, or a lack of access to beauty, is an instance of injustice.

I raise the harms of discrimination and unjust distribution of goods or opportunity, not to draw conclusions (not least as the extent of the harms attached are contested and indeterminate) but to show the possible extent of the harms that might attach to beauty. The harms I wish to focus on in detail in the next section are less contested and more determinant. The harms have been selected to illustrate different types of harm which might attach to beauty; to suggest that different harms fall on different groups, in different ways with various impact; and to show the possible extent of such harms. Thus I seek to highlight both the breadth and depth of potential beauty harms. To this end, I focus on one direct and two indirect harms which are already occurring, emerging and probable. The direct harm is to easily identifiable others; the indirect harm is in one case to identifiable others and in the other it is a general or communal harm which potentially affects all.

4. THREE BEAUTY HARMS-TO-OTHERS

4.1 Direct harm to providers

As discussed in section 2 the ethics of beauty practices has largely been concerned with the medical or pseudo-medical practices of cosmetic surgery and the duties of medical professionals. But, while there has been significant attention to the harms to recipients, there has been very little attention on harms to providers. Given that this is a direct harm, where evidence and causal data should not be difficult to find, this omission is particularly glaring.

Harms to providers tend to be in non-medical settings. Very many beauty practices (including invasive practices) are not carried out in medical settings or by

18. Arguments for a 'right to beauty' in Brazil are taking place in a very distinct discourse in which surgery is regarded as treating the mind and addressing multiple needs, and where surgeons believe that "plástica is a form of 'public health' to which the poor should have access" (Edmonds, 2007, 367). Given the 'right to beauty' is being asserted in a context where human rights are generally hard to access and there is little social mobility it may be that this discourse serves other purposes and provides "a popular form of hope" (Edmonds, 2007, 378) or an "imaginary vehicle of ascent" (Edmonds, 2010, 20) when other opportunities are lacking.

medical professionals. If we think, as I argue we should, that cosmetic surgery is better conceived of as a beauty practice rather than a medical practice then we can posit a continuum of beauty practices. At one end of the continuum is minimal grooming (practices such as hair-styling and the routine and often daily application of lotions and potions) at the other end is the most risky type of beauty practice, that of surgery (recognising that surgery too is on a continuum; some is routine, frequent, with quick recovery times and low complication rates and some is complex, novel, has long recovery times and high risks of complication).[19] Conceptualised in this way there is no clear line between procedures which are routine beauty practices, invasive or surgical, nor is there a clear line between who carries out what practices in what settings.[20] The middle of the continuum is particularly opaque and very many beauty practices are not provided by highly trained, privileged and protected medical professionals. Even when they are carried out by medical professionals the professional in question may not have training in the specific procedure.[21] Some beauty practices carry little risk, either to the recipient or to the provider, and others are highly risky to either the recipient or the provider. However while there is significant work on the harms to recipients there is little on the risks to providers of procedures.[22]

The first direct harm to others is to providers who work largely in non-medical settings at the less-invasive end of the beauty practice continuum; hairdressers, nail technicians and beauticians. Beauty practitioners are not highly skilled, or at least their skill-base is not regarded as 'expert' in a way which is equivalent to or approximates with the medical professionals' skill base; although in many instances significant training and accreditation is required to use particular lines of products or equipment. Beauty practitioners are much less likely to be regarded as professionals than medics and are classed as low-end service-providers; similar to retail workers they are

19. Breast implants are now relatively routine with low complication rates (BAPPS, 2008). By contrast buttock lifts are far more risky (Widdows, forthcoming 2018). Moreover, some fairly frequently carried out surgeries, have startling high risks of serious complications. For example, as many as a quarter of those who have abdominoplasties (tummy tucks) require further surgery (Stewart et al., 2006).

20. For example, fillers could be carried out at home, in a salon or in a medical setting.

21. Non-surgical procedures promoted as being carried out by medical professionals may be done by dentists or GPs rather than experts in cosmetic work, likewise surgeons may not be specialised or experienced in the surgeries they are undertaking.

22. Glen Jankowski makes a parallel argument with regard to fashion. He argues that while there has been lots of attention on the need of the fashion industry to address the rise in body image worries by using more diverse models and images, there has been very little attention to the injustices perpetrated on those who work in the 250 million sweatshops providing the clothes of the fashion industry (Jankowski, 2016).

regarded as selling a product and a service. They are not generally regarded as part of the professional classes. This is significant with regard to the power dynamics of the relationship between provider and recipient. The cosmetic surgeon is powerful, can suggest, explain, delimit and ultimately refuse to provide surgery. By contrast the beauty practitioner is expected to deliver what the client wishes, and while they can advise and suggest, ultimately it is the client's wishes which largely prevail. The power rests with the consumer, the providers' role is to meet the recipients' desires, making it hard for providers to control what they do; including the extent to which they work with and administer risky products.[23] There are of course exceptions and counter examples; celebrity hair-dressers are in high demand and they can charge significant amounts of money and dictate their clients' hairstyles. Likewise, surgeons can be in vulnerable positions (for example, surgeons from lower-income countries, contracted to cosmetic surgery companies who fly them in to perform a series of operations in a short period of time).[24] In such scenarios the surgeons do not meet with recipients in advance and therefore have little control over who they operate on or the operations they do. Moreover, even the most expert and professional surgeon might feel under pressure to deliver, or try to deliver, what the recipient asks for.[25] A frequent comment from cosmetic surgeons is that if they do not agree to operate the recipient will simply find another surgeon who will operate; and the implication is that this would be worse for the recipient. This said, for the most part, those who work as beauty professionals at the more routine, less medicalised, end of the spectrum have less power relative to the recipient, less control about what they deliver to a particular client, and less social and economic capital. Given the relatively low value placed on such beauty work, such workers often find themselves in highly competitive environments, vulnerable to being priced out of the market or replaced, especially given the relatively low barriers to entering the profession. As such they are low-paid and low-status workers vulnerable to exploitation. They are unable to ask for, or to provide for themselves, better pay and less harmful and risky working con-

23. Debra Gimlin captures this difference between surgeons as powerful service providers, whose judgements are regarded as expert and who chose what they will and will not do, and hairdressers who seek to advise but are not treated as experts and ultimately do what the client wishes (Gimlin, 2002).

24. The so called 'seagull surgeons' discussed in footnote 3.

25. The narrative of seeking to provide what the recipient wants and yet being aware that some of those who seek cosmetic surgery and/or beauty interventions are looking for impossible transformations, is a prevalent discourse of both surgeons and beauticians. This arguably adds a further emotional pressure on providers.

ditions if they wish to keep their jobs or remain competitive. To illustrate, consider the harms which are regularly suffered by nail technicians.

Nail technicians suffer physical harm from working with toxic chemicals on a daily basis and from inhaling the dust produced by filing acrylic nails. The *New York Times* ran an expose of the conditions of nail technicians working in New York in the summer of 2015 (Nir, 2015a; Nir 2015b). These articles documented the experience of the women who work in nail bars and their experiences of illnesses caused by the chemicals and materials involved in providing acrylic nails and gel polish. The harms which the women reported either experiencing or being aware of included miscarriage, cancers, skin irritations and respiratory problems. They also reported that children are frequently born with health issues and learning difficulties. Of course such reports are not evidence-based. These conditions, which women either experienced or knew women who had experienced, were not verified, nor could their causes be directly equated to their working conditions (at least not without further research). However, "some of the chemicals in nail products are known to cause cancer; others have been linked to abnormal fetal development, miscarriages and other harm to reproductive health" (Nir 2005b), making this work *prima facie* risky. Such harms are not limited to nail technicians and there is evidence to suggest that hairdressers also run risks from frequent exposure to toxic chemicals (Takkouche, 2009).

The harm to providers of engagement in at least some beauty practices is direct and rarely mentioned. There are numerous reasons for this. Not least, the focus on cosmetic surgery in isolation from other beauty practices, means that often the providers are assumed to be relatively powerful and privileged surgeons; although less privileged medical professionals such as nurses are key deliverers of non-surgical practices. For obvious reasons surgeons are far less vulnerable to harm than hairdressers or nail technicians who come from poorer and more vulnerable demographics. Yet the harms to providers are direct and almost wholly missing from discussions about the consequences of the increasing value placed on appearance, the increased engagement in beauty practices, and the rise of minimal standards of beauty. If manicured nails become, as hair dye already is, part of the minimal requirement of beauty then the numbers of those being directly harmed will dramatically increase, as will the need for urgent action to address such direct harm.

4.2 Indirect, specific harms to those who are 'abnormal'

The second harm to others is indirect, but falls on a particular group of identifiable individuals; although exactly who falls into this group is open to discussion. The group in question is those who do not, and cannot conform to minimal beauty norms. This group is made up of individuals who fall significantly outside what is considered to be 'normal', or 'just good enough' when it comes to meeting beauty ideals. Those in this group obviously fail to meet beauty standards and in ways which will not be experienced by most individuals. For instance, they are not failing to measure up because they are old, overweight or hairy (all of which might be failing to meet appearance standards, but either in ways which can be addressed or in ways which are commonly, 'normally', experienced). Those in this group obviously, uncontroversially and perhaps permanently fall outside the normal range. Those in this group a can be termed 'abnormal'. I use the terms normal and abnormal reluctantly but knowingly and deliberately as if they are clear categories. My reason for doing so is to highlight the significance of the potential harm, and to show the serious nature of the risks which attach to the narrowing of normal in a context where appearance is increasingly valued.

Those who fall into the abnormal group are those who are disfigured at birth or by accident or have physical features which fall dramatically outside the normal range. What matters is that for this group there is no possibility of attaining minimal standards of normal and this is obviously and strikingly the case. To put it simply the individuals who fall in this group are clearly abnormal to the observer in a way which means that they fail to meet at least some aspect of minimal beauty norms; although they may, of course, meet other features of beauty norms.[26] My claim is that those who fall a long way outside the normal range will become more visible—and so more vulnerable—as beauty becomes more important and as minimal standards of beauty rise. As we 'fix' what can be fixed, the gap between what is normal and what is abnormal grows and the widening of this gap may harm those who fall into the abnormal category. The harms which such a group might suffer, taken broadly and indicatively, are: harms with regard to self-conception and identity (including lower self-esteem and increased feelings of shame and anxiety); harms of increased stigma and discrimination; and harms of exclusion. As appearance increasingly matters for presentation and communication in an increasingly visual and virtual world social exclusion is

26. For example, smooth and unblemished skin may be attainable for an individual who cannot attain beauty norms of thinness and height and conversely someone with disfigured skin (for example as a result of acid attack) may attain thinness, and so on.

a real risk for those who cannot meet the appearance norms of the digital world or who are uncomfortable with communication which is primarily image- rather than text-based. Indeed, as participation in, and being 'liked' on virtual image-based platforms grow, meeting appearance thresholds might become an effective precondition of social interaction.

Both of these claims—first that this group will be more different and visible and second that they will be harmed as a result of increased difference and visibility—are open to critique, and in part empirical critique. In this paper it is not possible to definitively claim that this group are (or will be) harmed by increasing minimal standards of beauty, but it is possible to argue for their increased visibility and to suggest that this makes harm a real and reasonable possibility. To be clear, the widening of the gap between normal and abnormal does not necessarily result in harm, but it does make it possible for harm to occur in comparison to a scenario where the gap between what is normal and abnormal is narrower or indecipherable or where measuring up to normal appearance ideas is not regarded as socially or culturally valuable. I will consider first the narrowing of normal and extending the distance between normal and abnormal and second why this might result in harm for this group.

First, the narrowing of normal. That more is required to attain minimal standards of beauty, to be 'good enough' or to 'be normal' is an argument I make in depth and at some length elsewhere. In brief I argue that increasingly more is required of more of us to attain minimal standards of beauty and that this is happening incrementally and in some instances what is required to meet minimal standards has risen dramatically over a short period of time and with little critique.[27] Examples at the routine end of the spectrum include body-hair removal, where in a generation visible body hair has gone from acceptable—and even sexy—to unacceptable and shameful. Another practice which was once occasional or optional but is now required to meet minimal standards of beauty (particularly for women, but increasingly for men) is hair dye; most women over a certain age, dye their hair. Further, the increase in nail bars suggests that manicures might be the next practice to tip into the required category.[28] In some contexts and among some demographics minimal standards go well beyond these. Already, in some circles Botox and fillers fall into the required category and it is the untreated and aging face which is abnormal (Kay, 2015). Moreover, while

27. I argue that this is globally the case and that this matters for the normalising claim as there are less competitor norms (Widdows, forthcoming 2018).

28. I make this argument in detail in chapter 4, "Routine maintenance, Treats and Extremes", of *Perfect Me* (Widdows, forthcoming 2018).

cosmetic surgery is still exceptional in most groups and contexts it is increasingly desired and normalised.

The gradual escalation of minimal standards, coupled with increased pressure to engage beyond what is minimal and towards what is maximal, results in a narrowing of the normal range. As those who can engage to attain ever more demanding minimal standards the group I am concerned with become increasingly differentiated from the norm; more visible and more different. In addition, those in this group may also become rarer, again making them more visible. As those things which can be 'fixed' are fixed in order to attain as near an approximation to normal as possible those who cannot be 'fixed' stand out more. There are numerous examples of 'fixing' features routinely, often for supposed health reasons, even though health functioning is not affected. To illustrate, sticky-out ears are routinely 'pinned back' for appearance reasons even though hearing and other health functioning is not affected, likewise birthmarks and other disfigurements are removed. Similarly, if affordable, teeth are routinely straightened, and while some of this work is for functioning reasons, for instance, to reduce overbite or/and to reduce plaque build-up, much teeth straightening is for appearance reasons.

In addition to fixing abnormalities, it is also increasingly the case that appearance is regarded as a reason for pre-natal selection (whether by Pre-Implantation Genetic Diagnosis or pre-natal testing followed by termination). For instance, while the numbers of abortions to avoid a child with a cleft lip or palate are small (McHale and Jones, 2012), and smaller than the hype would have us believe, such terminations do occur and presumably the reasons for such choices are appearance based. While the functioning of a cleft palate or lip can usually be corrected by surgery often the tell-tale signs remain. Such features are disfigurements and as appearance matters more they are becoming regarded as significant; and significant enough to justify selection against. This suggests that appearance is a factor in decisions about selection and perhaps to the extent where a flawed appearance, irrespective of functioning, is regarded as a significant impartment. Selection on appearance grounds is likely to extend, for example, it has been claimed that were the technology available 11 percent of couples would abort a foetus predisposed to obesity (Rhode, 2010, 26). I do not wish to enter discussions about whether or not those who are selected against are harmed, but I do wish to argue that increased selection makes those in the abnormal category rarer, more visible and as a result makes them more open to harm. In addi-

tion such judgements contribute to the belief that appearance is highly valuable and accordingly that failure to succeed in attaining beauty goods is significant.

Given these trends it is not unreasonable to think that those who fall outside the normal range will indeed become rarer and as a consequence more visible. Yet being visible or rare, even to the point of abnormality, is not necessarily a harm, which brings me to the second argument. To argue that such individuals are, or will be, more open to being harmed requires an additional, and more difficult, argument. It requires empirical evidence which is simply not available with regard to current harm. However, while the evidence is not yet sufficient to prove assertions of current harm, that harms are possible, perhaps likely, is sufficient reason for policy makers to be alert to the possibility and to seek to establish whether such harm is occurring.

Looking forward it is possible that increased rarity and visibility of this group might result in increased vulnerability and harm, but the opposite may also prove to be true. On the one hand it is the case, at least in very many places, that those who are very visibly disfigured or abnormal are in far better situations than they were in previous generations; following disability rights activism and regulation of the last half-century (Shakespeare, 2006). It is not just the case that there is less discrimination permitted in certain sectors, for example, in terms of employment opportunities, but also that successful activism has resulted in cultural change with regard to those who are visibly disfigured; in the terminology of this paper abnormal. Certain types of harm—most obviously discrimination, but also stigma and shaming—are not just illegal but unacceptable. This is clearly evident in terms of acceptable language and behaviour. This tolerance may mean that even if there is increased discrimination on appearance grounds this group may not suffer from it; because discrimination of the obviously physically disabled or disfigured is unacceptable. Indeed it might be the case that those who fall a long way outside the normal range might prove less vulnerable to harm than those who fall nearer to it. The impossibility of attaining normal might protect those in the abnormal group from pressures to attain appearance norms all together. On the other hand it is reasonable to think that as appearance matters more, the suffering of those who do not make the appearance grade will increase. If meeting beauty ideals becomes an increasingly valued aspect of personal identity and a key factor is self-esteem then not being able to meet these criteria will be increasingly costly with regard to identity and self-conception, as well as carry costs with regard to being valued in the public sphere and able to access other goods, such as employment. Exactly how such harms might accrue and be constituted is not

clear and the extent to which harms will in fact manifest requires further evidence. However, that this group are more visible is clear and, given this, it is not unreasonable to think this makes them open to suffering a number of possible harms. This deserves both recognition and attention.

4.3 Indirect, general harms to all

The third harm is the indirect harm to all of rising standards of beauty and increased engagement with beauty practices. As more is required to meet minimum standards more of us fall short and fail. Arguably this leads to an increasingly toxic environment which constitutes a general harm to all. In the last section I argued that rising minimal standards of beauty make those who fall a long way from the normal range more visible and different and potentially open to harm. In this section I argue that rising minimal standards not only harm those who are abnormal, who can never meet the increasing demands of beauty, but also those who can. As more engage so non-engagement stands out and becomes unusual and eventually abnormal; in the words of Susan Bordo "the ordinary body becomes the defective body" (Bordo, 1997). For example, it is the hairy body and non-coloured hair which are now abnormal. Beauty requirements are enforced by social norms and expectations, rather than by coercion, but nonetheless the list of beauty practices which are regarded as required is increasingly extensive and demanding. Rising minimal standards of beauty eventually fall on all who are able to conform, as not conforming becomes unacceptable; a failure to minimally groom connotes lack of respect for the self or others and signals illness or distress. Over time the choices of some to engage eventually mean that all have less choice not to engage. Thus the choices of some gradually reduce the choices of all.

This argument has parallels with the feminist argument discussed in 2.2; and in a similar manner seeks to suggest that social norms harm those who do not engage and potentially all. However, while there are some similarities—most importantly that the choices of individuals should not be considered as isolated or discrete—my claim is substantively different. The feminist arguments focus on the harms which arise from gender injustice; whether to individual women or to women as a group. Key to these claims is the asymmetrical and hierarchical relations between men and women and the difference between men and women's engagement in beauty practices. These arguments are not primarily concerned that beauty standards are increasingly demand-

ing, although this is part of the critique, but that they are demanded of women and not of men. According to such theories the purpose of beauty practices is to mark women out, to trivialise and sexualise and to embed unequal and inferior status. My target is not gender disparity or inequality, but the harms which accompany the increasing valuing of appearance in a visual and virtual culture and the harms which follow from increasing engagement in beauty practices and the accompanying rise in minimal standards of beauty. Such rising engagement is required of all, irrespective of gender.

There are of course valid arguments about the gendered harms of beauty, but the harms which follow from rising minimal standards are not necessarily gendered, nor do they derive from asymmetry between men and women. Elsewhere I have argued in detail that the asymmetry, or inequality to use the more familiar language of moral and political philosophy, between genders with regard to body work is breaking down. Men, particularly young men, increasingly do body work and engage in beauty practices to attain normal or minimal standards. They also increasingly suffer, as women long have, from body image anxiety, and experience pressure to attain body ideals which require significant time and effort and often chemical and/or surgical intervention.[29] Accordingly, for all, irrespective of gender, what is required to attain minimal standards of beauty, to be just good enough, to be normal, is growing. Beauty requirements are more demanding, and there is more pressure to attain minimal standards, and more pressure to engage beyond the minimum for both men and women. Moreover, and crucially for this paper, more harms attach if one fails to attain such minimum standards, or believes that one has failed. The types of harms which attach to failing in the appearance stakes, or simply to over-focusing on appearance, are myriad. They include harms to individuals as anxiety about body image and appearance increases and increasingly beauty failure is regarded as failure more generally. In addition there are shared and communal harms as time, effort and money is devoted to beauty goods in preference to other goods. This harm is a standard justice harm of opportunity cost: what could we do if we did not do this? Given the size of the beauty industry, taking into account the use of global resources, as well

29. To clarify, I argue that the inequality between men and women with regard to beauty is breaking down in four key ways: first, men increasingly value (male) appearance; second men increasingly worrying about body image; third men increasingly engage in body work; and fourth male beauty ideals, like female beauty ideals, are increasingly demanding and require intervention (Widdows, forthcoming 2018). However, significant gender differences – and harms from such gender differences – remain.

as expertise (for instance, R&D devoted to beauty which could be devoted to health), the collective opportunity cost is extensive.

However, while it is the case that the harms from an increasingly toxic environment are potentially devastating to individuals and communities it is not the case that these harms track directly to engagement of some in beauty practices. My claim is not that those who engage in beauty practices are wholly responsible for the rising minimal standards of beauty, nor am I arguing that those who engage should be blamed or prohibited from engagement.[30] Rather, I argue that it is reasonable to infer that rising engagement in beauty practices is one factor which contributes to a culture in which beauty standards will continue to rise, and in which normal will be harder to attain, and in which beauty will be increasingly valued. The harms of this are not, or not only, to those who engage, but to others who currently do not engage or who only engage to reach the most minimal standards of acceptable grooming.

Tracking the causes of social and communal harm is notoriously difficult and verges on the impossible. Undoubtedly increased engagement by some is only part of the picture. What is driving the increasing demands of beauty is complex and there are myriad reasons for increasing engagement, rising minimal standards and the increased value placed on appearance. Reasons include the rise of a virtual and therefore visual culture, technological advances which make new interventions possible, the increased democratisation of beauty as practices become affordable and accessible, and the dominance of consumer culture which values work on the self and prioritises body-projects as cites of self-expression and realisation (Jones, 2008; Gimlin, 2002; Lazar, 2011; Tincknell, 2011). While all agree that there is an exponential rise in anxiety about body image and increased valuing of appearance attributing causes is complex. Yet for whatever reason body image is cited as the third largest and most harmful challenge facing young people in the UK (after lack of employment opportunities and failing to succeed within the education system) (YMCA, 2016). The literature on which factors are most important in feeding this rise in body image anxiety is large, contested and indeterminate.[31] But, while it is not possible to track the extent to which each factor contributes, it is the case that appearance increas-

30. On the contrary, I argue that rejecting beauty practices is divisive, counter-productive and is a failed response to the growing demands of beauty (Widdows, forthcoming 2018).

31. For example, some focus on the media, arguing that the link between idealised thinness in the media and body images issues is now demonstrated in many studies (Ghaznavi and Taylor, 2015). While others deny media influence and argue that it is the influence of family and friends which is primary (Stice et al., 2001).

ingly matters, particularly to the young, and, as tracking changes in beauty practices shows what is required to attain minimal standards is more demanding than previously. Undoubtedly then, "the high prevalence of negative body image is a significant public health concern due to its negative physical and psychological health outcomes" (Diedrichs et al., 2011).[32] Overall the rise in attention to beauty, engagement in beauty practices and rising minimal standards results in significant communal or general harm which falls on all. We are harmed by the creation of a toxic environment in which appearance is dominant, cosmetic surgery is normalised, and beauty is key to personal identity and denotes individual success and failure.

To argue that an increasingly toxic environment is emerging and that this harms others (all others), is not to suggest that all are harmed in the same way or to the same extent and some individuals may be virtually unscathed. Individuals will respond differently to different types of stimuli and negotiate and critique such pressures differently and some will be unaffected. Yet the impossibility of determining causal links or of tracking direct impact should not mean we do not pay attention to patterns and the potential harmful consequences of changing social norms and contexts. Communal harms matter not in an abstract way but precisely because they impact on all by shaping and limiting what is possible for individuals to be and do.

5. CONCLUSION

In this paper I have argued for a shift in framework in order to recognise currently neglected harms of beauty. I have argued that current discourses, especially those of policy-makers, ethicists and lawyers, have largely ignored harms-to-others. They have focused almost exclusively on the harms to those who engage beyond minimal standards of beauty. I argued that this is strange given the liberal assumption that harms-to-others should be addressed in preference to addressing harms to the self; as interference in self-harm is deemed wrongly paternalistic. I then turned to the harms-to-others which are currently omitted from the discourse surrounding beauty practices and I focused on three harms-to-others to illustrate the range of harms and the extent of such harms. The extent to which these harms-to-others are attributable and can be tracked differs. The first harm, to providers of beauty practices, is a direct

32. Negative effects which have been suggested result from body image anxiety include (amongst others) lower self-esteem, disordered eating behaviours and eating disorders, impaired social and occupation functioning and well as poorer day-to-day interactions and increased problems with sexual functioning (Cash and Smolak, 2011).

harm, the second two are indirect and the extent to which engagement is causal and the extent of the harm is more difficult to evidence, but nonetheless such harms should be taken into account when considering the costs and harms of engagement in beauty practices.

The significance of the harm, rather than type of harm, should determine the extent to which policy-makers seek to intervene. The current prevalence of body image anxiety experienced, particularly but not only, by young people and its negative effects (increased anxiety, low self-esteem, reduced physical activity, and lower social and educational involvement) is of epidemic proportions.[33] If these effects could be tracked to a physical cause, for instance the taking of a recreational drug, or as a side-effect of a pollutant, then such causes would immediately be targeted. How harms are recognised and the construction of harms fundamentally shapes policy responses. The classic example is the shift in the construction of the harms of smoking; once regarded a matter of individual freedom and choice and now regarded as a public health issue. A currently contested example which is increasingly regarded as a public health issue is obesity; although there is still significant debate about the extent of justified State and policy intervention. If the same reframing happened with beauty, and the harm of a toxic environment which has created an epidemic of body image anxiety, was reframed as a public health issue, rather than a matter of individual choice, policy would be transformed. No longer would this be regarded as something individuals should be left to choose to do or not do, but harm reduction would be introduced. A host of interventions are possible, including prohibiting some practices (at least for some groups), regulating advertising, providing education, making social media accountable and so on. How effective such interventions are likely to be requires further research, but what intervention will work matters less than recognising that we should intervene. Recasting beauty harms as public health concerns provides a reason, even a duty, to intervene. It reveals the harms which focusing only on engaging individuals obscures. Admittedly targeting social causes and addressing communal harms is far more difficult than regulating individual choices, however difficulty in addressing harms should not prevent harms from being recog-

33. There is numerous evidence to support this claim, including the YMCA report (2016) and the annual Girlguiding survey (2016). A few statistics from the Girlguding survey are indicative: 47 percent of girls aged 11-21 say the way they look holds them back; 40 percent of girls between 7 and 10 think feel they should lose weight sometimes or most of the time and this rises to 80 percent of girls between 17 and 21; 53 percent of girls.

nised. Policy should focus on addressing the most significant harms not those which are easiest to address. Focusing on engaging others results in a skewed picture which makes significant and potentially devastating harms of beauty invisible.

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REFERENCES

ASAPS (American Society for Aesthetic Plastic Surgery) (2016). "Cosmetic Surgery National Data Bank Statistics." Available from http://www.surgery.org/sites/default/files/ASAPS-Stats2016.pdf [Accessed 28 April 2017].

BAAPS (British Associaiton of Aesthectic and Plastic Surgeons) (2008). "Surgeons reveal UK's largest-ever Breast Augmentation survey." Available from http://baaps.org.uk/about-us/press-releases/404-surgeons-reveal-uks-largest-ever-breast-augmentation-surve. [Accessed 9 April 2017].

Bartky, Sandra Lee. (1990). *Femininity and Domination: Studies in the Phenomenology of Oppression*. New York and London: Routledge.

Blum,Virgina L. (2003). *Flesh Wounds: The Culture of Cosmetic Surgery*. Berkley, California and London: University of California Press.

Bordo, Susan. (1997). *Twilight Zones: The Hidden Life of Cultural Images from Plato to O.J.*. Berkeley, Los Angeles, London: University of California Press.

Cash, T. F., and Smolak, L. (Eds.). (2011). *Body image: A handbook of science, practice, and prevention*. New York: Guilford Press.

Chambers, Clare. (2008). *Sex, Culture and Justice: The Limits of Choice*. University Park, PA: The Pennsylvania State University Press.

Corbett, William. R. (2007). "The ugly truth about appearance discrimination and the beauty of our employment discrimination law." *Duke Journal of Gender Law and Policy*, 14, 153-178.

Davis, Kathy (1995) *Reshaping the Female Body: The Dilemma of Cosmetic Surgery*. New York and London: Routledge

Diedrichs, Phillippa C. Christina Lee and Marguerite Kelly. (2011). "Seeing the beauty in everyday people: A qualitative study of young Australians' opinions on body image, the mass media and models." *Body Image* 8(3), 259-266.

Dworkin, Andrea. (1974). *Women Hating*. New York: E. P. Dutton.

Eagly, Alice H., Richard D Ashmore, Mona G Makhijani and Laura C Longo. (1991). "What is beautiful is good, but.....: a meta-analytic review of research on the physical attractiveness stereotype." *Psychological Bulletin*. 110(1), 109-128.

Edmonds, Alexander. (2007). "The poor have the right to be beautiful': cosmetic surgery in neoliberal Brazil." *Journal of the Royal Anthropological Institute*, 13(2), 363-381.

———(2010). *Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil*. Durham and London: Duke University Press.

Etcoff, Nancy. (1999). *Survival of the Prettiest*. New York: Anchor Books.

General Medical Council (GMC). (2016). *Guidance for Doctors who offer Cosmetic interventions*. Available from https://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf [Accessed 9 April 2017].

Ghaznavi , Jannath, and Laramie D. Taylor. (2015). "Bones, Body Parts, and Sex Appeal: An Analysis of #thinspiration Images on Popular Social Media." *Body Image* 14, 54-61.

Girlguiding (2016). *The Girl's Attitude Survey*. Available from https://www.girlguiding.org.uk/social-action-advocacy-and-campaigns/research/girls-attitudes-survey/ . [Accessed 10 April 2017].

Gimlin, Debra. (2002). *Body work: Beauty and self-image in American culture*. Berkeley, Los Angeles and London: University of California Press.

———(2012). *Cosmetic surgery narratives: A cross-cultural analysis of women's accounts*. Basingstoke: Palgrave Macmillan.

Griffiths, Danielle, and Mullock, Alex. (2017). "Cosmetic Surgery: Regulatory Challenges in a Global Beauty Market." *Health Care Analysis* (online first).

Hamermesh, Daniel S. (2011). *Beauty Pays: Why Attractive People are More Successful*. Princeton and Oxford: Princeton University Press.

Jankowski, G. S. (2016). "Who stops the sweatshops? Our neglect of the injustice of maldistribution." *Social and Personality Psychology Compass*, 10(11), 580-591.

Jeffreys, Sheila. (2005). *Beauty and Misogyny: Harmful Cultural Practices in the West*. London and New York: Routledge.

Jones, Meredith. (2008). *Skintight: An Anatomy of Cosmetic Surgery*. Oxford and New York: Berg.

Kay, Karen (2015). "Is Cosmetic Surgery the new acceptable face of womanhood." *The Guardian*. Available from http://www.theguardian.com/lifeandstyle/2015/jun/28/cosmetic-surgery-normal-acceptable-face-womanhood. [Accessed 9 April 2017].

Keogh, B. (2012). *Poly Implant Prothese (PIP) breast implants: Final report of the expert group*. Department of Health. Available from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214975/dh_134657.pdf [Accessed 9 April 2017].

———(2013). *Review of the regulation of cosmetic interventions*. (Keogh Review) London: Department of Health. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf [Accessed 9 April 2017].

Laimann, Jessica. (2015). "Should we prohibit breast implants? Collective moral obligations in the context of harmful and discriminatory social norms." *Journal of Practical Ethics*, 3(2), 37-60.

Lazar, Michelle M. (2011). "The Right to be Beautiful: Postfeminist Identity and Consumer Beauty Advertising." In *New Femininities: Postfeminism, Neoliberalism and Subjectivity*, edited by Rosalind Gill and Christina Scharff , 37-51. Basingstoke: Palgrave Macmillan.

McHale, Jean V., and June Jones. (2012). "Privacy, confidentiality and abortion statistics: a question of public interest?" *Journal of Medical Ethics* 38(1), 31-34.

Manson, Neil and O'Neill, Onora. (2007). *Rethinking Informed Consent in Bioethics*. Cambridge: Cambridge University Press

Nir, Sarah Maslin (2015a). "The Price of Nice Nails." *The New York Times*. Available from http://www.nytimes.com/2015/05/10/nyregion/at-nail-salons-in-nyc-manicurists-are-underpaid-and-unprotected.html [Accessed 3 August 2016].

———(2015b). "Perfect Nails, Poisoned Workers." *The New York Times*. Available from http://www.nytimes.com/2015/05/11/nyregion/nail-salon-workers-in-nyc-face-hazardous-chemicals.html [Accessed 3 August 2016].

Nuffield Council on Bioethics, (2017) "*The ethics of cosmetic procedures*." Available from http://nuffieldbioethics.org/wp-content/uploads/Cosmetic-procedures-full-report.pdf [Accessed 28 October 2017].

Rhode, Deborah L. (2010). *The Beauty Bias: The Injustice of Appearance in Law and Life*. Oxford and New York: Oxford University Press.

Royal College of Surgeons (RCS), Professional Clinical Standards. (2016). "Professional Standards for Cosmetic Surgery." Available from https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/professional-cosmetic-surgery/. [Accessed 9 April 2017].

Shakespeare, Tom. (2006). *Disability Rights and Wrongs*. London and New York: Routledge.

Stewart, K. J., Stewart, D. A., Coghlan, B., Harrison, D. H., Jones, B. M., and Waterhouse, N. (2006). "Complications of 278 consecutive abdominoplasties." *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 59(11), 1152-1155.

Stice, Eric, Diane Spangler and W. Stewart Agras. (2001). "Exposure to Media-Portrayed Thin-Ideal Images Adversely affects Vulnerable Girls: A Longitudinal Experiment." *Journal of Social and Clinical Psychology* 20(3), 270-288.

Swami, Viren, and Adrian Furnham. (2008). *The Psychology of Physical Attraction*. London and New York: Routledge.

Takkouche, Bahi, Carlos Regueira-Méndez, and Agustín Montes-Martínez. (2009). "Risk of cancer among hairdressers and related workers: a meta-analysis." *International Journal of Epidemiology* 38 (6), 1512-1531.

Tincknell, Estella. (2011). "Scourging the Abject Body: Ten Years Younger and Fragmented Femininity Under Neoliberalism." In *New Femininities: Postfeminism, Neoliberalism and Subjectivity*, edited by Rosalind Gill and Christina Scharff, 83-95. Basingstoke: Palgrave Macmillan.

Vartanian, L. R. (2009). "When the body defines the self: Self-concept clarity, internalization, and body image." *Journal of Social and Clinical Psychology*, 28(1), 94-126.

Widdows, Heather. (2017) "Exploitation and the Global Demands of Beauty." In *Exploitation: From Practice to Theory*, edited by Monique Deveaux and Vida Panitch London and New York: Rowman & Littlefield International, 179-193

———(forthcoming 2018) *Perfect Me!* Princeton, Princeton University Press.

World Health Organisation (WHO), 2011, "Mercury in Skin Lightening Products." Available from http://www.who.int/ipcs/assessment/public_health/mercury_flyer.pdf [Accessed 20 August 2017].

YMCA (2016) "The Challenge of being Young in Modern Britain." Available from http://www.ymca.co.uk/campaigns/world-of-good. [Accessed 9 April 2017].