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Literature Search Results

Title
Regulation of cosmetic medicine, and impact of 'cosmetic tourism'

Requested by
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Carried out by
xxxxxxxx

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Contents

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Search Details

Summary

The request was in two parts:

1. Literature on governance, regulation and complications in aesthetic medicine in relation to non-qualified professionals undertaking aesthetic work.
2. Literature on cosmetic tourism in relation to return to UK and subsequent costs to NHS.

The scope was international with no specified date range.

The database searches retrieved a number of resources showing a consistent appetite for stricter regulation of the sector dating back as far as the late 90s.

There are no official statistics on cosmetic surgery and the cost to the NHS, but the best estimates are from the British Association of Aesthetic Plastic Surgeons (BAAPS) and the Office of National Statistics.

Several studies estimating the costs to local health systems were also retrieved during the search.

During the Google search, a number of articles and press releases were retrieved that may be of passing interest. These are not listed here but are available in the attached Zotero file under the 'Google' heading.

All of the references listed here are also available in the attached Zotero file.

Databases searched

Database	Description	Tick if used in this search	
British Nursing Index	A comprehensive index covering all aspects of nursing, midwifery and community healthcare	☒	
CINAHL	Coverage includes nursing and other allied health professions, consumer health and health promotion.	☒	
Embase	A large biomedical and pharmaceutical database, coverage includes drug research, pharmacology, pharmaceutics, health policy and management, public health, occupational health, environmental health, There is selective coverage for nursing, dentistry, psychology, and alternative medicine.	☒	
Emcare	Subjects include nursing, nursing administration and management, medical and nursing education, emergency services, family practice, community and home care, geriatrics and palliative care, healthcare information and management, nutrition and dietetics, public and occupational health, and social medicine.	☒	
Google Scholar	Access to scholarly literature	☒	
HMIC	Focused on the UK, this resource combines the databases of the DHSC and The King's Fund. Subject coverage includes health management and policy, social care, service development, NHS organisation and administration (grey literature).	KF	☐
		DH	☐
The King's Fund Database	A unique and free source of information on health and social care policy and management.	☒	
Medline	Medline is a general medical database covering allied health specialties, dentistry, nursing, medicine and pre-clinical sciences.	☒	
PsycINFO	Covers psychology and psychiatry, education, business, medicine, nursing, and social work	☐	
PubMed	PubMed is a free resource providing access to the Medline database and some additional citations listed here	☐	
Social Care Online	The UK's largest database of information and research on all aspects of social care and social work.	☐	

Other resources searched

Website/Organisation/other resource	Description	Searched?
[e.g. Housing LIN website]	Resource of information on housing and care in England and Wales	☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Search results

Regulation overview

The call for effective regulation of non-surgical cosmetic procedures | Brabners includes a good explainer of the current regulatory landscape leading up to September's consultation launch. Brabners, 18 August 2023.

Joint Council for Cosmetic Practitioners (JCCP)
The self-regulator for the non-surgical aesthetics industry
https://www.jccp.org.uk/

Useful pages on Royal College of Surgeons of England website setting out the regulations and FAQ explainers around the scope of the Standards:
Cosmetic Surgery — Royal College of Surgeons (rcseng.ac.uk)
Cosmetic Surgery Standards FAQ — Royal College of Surgeons (rcseng.ac.uk)

Government consultation launched 2 September 2023
"The government's first-ever consultation on treatments - also known as aesthetic procedures - will be used to shape a new licensing scheme for practitioners and cosmetic businesses which operate in England. This could include age limits and restrictions for high-risk procedures, including those involving injecting fillers into intimate parts of the body - including the breasts and buttocks."
From: Consultation launched into unregulated cosmetic procedures - GOV.UK (www.gov.uk)

Department of Health and Social Care, (2023) **Consultation launched into unregulated cosmetic procedures**. *GOV.UK*. Available at: https://www.gov.uk/government/news/consultation-launched-into-unregulated-cosmetic-procedures [Accessed September 19, 2023].
People and businesses are invited to share their views on how to make non-surgical cosmetic procedures safer as thousands complain of 'botched' procedures.

Department of Health and Social Care, (2023). **Licensing of non-surgical cosmetic procedures**. *GOV.UK*. Available at: https://www.gov.uk/government/consultations/licensing-of-non-surgical-cosmetic-procedures [Accessed September 19, 2023].
We are seeking your views on what procedures should be in scope of the licensing scheme for non-surgical cosmetic procedures in England.

Statistics on 'cosmetic tourism'

There is no official source of data on outbound UK medical tourism, but the Office for National Statistics (ONS) has estimated that 248,000 UK residents went abroad for medical treatment in 2019, compared with 120,000 in 2015. (ONS, FOI request: Medical tourism in 2019 and total visits to and from the UK 2015 to 2019 - Office for National Statistics (ons.gov.uk))

BAAPS have begun collecting statistics on surgeries correcting 'botched' surgery from abroad. Press release from April 2022:

BAAPS Call for Action as Audit Reveals 44% Rise in Botched Cosmetic Surgery from Abroad | The British Association of Aesthetic Plastic Surgeons
"A survey of BAAPS council members showed that 100% of complications came from Turkey and that Abdominoplasty accounted for 75% of complications, followed by breast surgery procedures at 25%."
"This lack of individual responsibility is being highlighted by BAAPS, as many patients suffering complications are treated on an already strained NHS. One study presented to BAAPS in 2017 suggested the average cost to the NHS per patient was a staggering £13,500, a figure which is now estimated to be closer to £15,000. Many also need private treatment, wiping out any saving they may have made by going abroad in the first place."
Available at:
https://baaps.org.uk/media/press_releases/1859/baaps_call_for_action_as_audit_reveals_44_rise_in_botched_cosmetic_surgery_from_abroad

The audit report does not appear to be available on the BAAPS website. It may be worth emailing pr@baaps.org.uk to see if they will send it to you. However it has been widely reported on with statistics quoted:

Botched Cosmetic Surgery Abroad Is Rising | Paul Tulley
"According to the British Association of Aesthetic Plastic Surgeons (BAAPS), in the past four years 324 patients who had cosmetic surgery abroad needed to be treated for serious complications. The biggest rise was seen in 2021 where the number of botched cosmetic procedures rose by 44%."
Available at: https://www.paultulley.com/botched-cosmetic-surgery-abroad-is-rising-audit-reveals/

NHS bill for botched cosmetic surgery now stands at £6miilion | Daily Mail Online
"Taxpayers last year spent a record £1.7million on fixing Brits botched by cosmetic surgery carried out abroad, analysis suggests."
"An audit by the British Association of Aesthetic Plastic Surgeons (BAAPS) — shared with MailOnline — shows 111 Brits needed emergency NHS care after returning from places like Turkey in 2022 to go under the knife. […] BAAPS estimates the cost to the NHS of treating each botched patient is upwards of £15,000, though this naturally varies on a case-per-case basis."
Available at: https://www.dailymail.co.uk/health/article-12152771/NHS-bill-botched-cosmetic-surgery-stands-6miilion.html

Scotland Tonight Türkiye cosmetic surgery special series: 'I could easily have died over there' | STV News
"The British Association of Aesthetic Plastic Surgeons, which represents plastic surgeons in the UK, has started collating the first ever database with the number of corrective procedures carried out in the UK after surgery abroad has gone wrong.
They told Scotland Tonight that 324 people returned home with complications from cosmetic surgery abroad and estimate each patient is costing the NHS around £15,000."
Available at: https://news.stv.tv/scotland/scotland-tonight-turkiye-cosmetic-surgery-special-series-i-could-easily-have-died-over-there

Urgent warning as spike in hospital cases due to botched surgery abroad with one death revealed | The Scottish Sun
The British Association of Aesthetic Plastic Surgeons has reported 324 patients needed surgery after returning to the UK in the past four years. And the Foreign Office said: "We are aware of 22 British nationals who have died in Turkey since January 2019 following medical tourism visits." The Scottish Government confirmed it had "been advised of one fatality since 2020 following a procedure overseas".

Available at: https://www.thescottishsun.co.uk/news/9946250/urgent-warning-hospital-botched-surgery-abroad-death/

Regulation Reading list

Department of Health and Social Care, (2023). **Licensing of non-surgical cosmetic procedures**. *GOV.UK*. Available at: https://www.gov.uk/government/consultations/licensing-of-non-surgical-cosmetic-procedures [Accessed September 19, 2023].
We are seeking your views on what procedures should be in scope of the licensing scheme for non-surgical cosmetic procedures in England.

Starr, L., (2023a). **Regulating cosmetic practice – a necessary reform in a growing industry: ANJ**. *Australian Nursing and Midwifery Journal*, 27(10), p.23. Available at: https://www.proquest.com/scholarly-journals/regulating-cosmetic-practice-necessary-reform/docview/2762946736/se-2?accountid=31583.
[...]today there is a broad range of individuals seeking cosmetic interventions that range from botox to liposuction, body part enlargements and reductions and the emerging practice of female genital cosmetic surgery such as designer laser vaginoplasty. The complaints included: * A failure to conduct appropriate pre-operative assessments of patients and to obtain proper informed consent from them; * inappropriately sitting sedated patients up during surgery to comment on or consent to a breast implant; * failing to provide adequate post-operative care for his patients; * inviting friends and relatives to come into the operating room to obtain their opinion about a patient's breast implants; and * failing to keep appropriate records. The Nursing and Midwifery Board of Australia has published a position statement for nurses working in cosmetic medical procedures.5 It is important that those working in this field are familiar with this document and also the MBA's6 guidelines for medical officers performing cosmetic medical and surgical procedures to ensure they are practising in accordance with the expected level of competency and within their scope of practice.

Wise, J., (2023). **Government delays regulation for non-surgical cosmetic procedures**. *BMJ*, 380, p.p277. Available at: https://www.bmj.com/content/380/bmj.p277 [Accessed September 20, 2023].
The government has rejected an urgent call by MPs to bring in a new licensing regime for non-surgical procedures such as Botox injections, chemical peels, microdermabrasion, and non-surgical laser interventions. Ministers also rejected recommendations by the House of Commons Health and Social Care Committee to make dermal fillers available as prescription only substances—as Botox is—and to bring in specific standards for premises that provide non-surgical cosmetic procedures.

Starr, L., (2023b). **LEGAL. Regulating cosmetic practice -- a necessary reform in a growing industry.** *Australian Nursing & Midwifery Journal*, 27(10), pp.23–23. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=160753469&custid=ns010095.
The article reports on the need to regulate cosmetic surgery and other cosmetic procedures in Austalia. Topics discussed include disciplinary proceedings against cosmetic practitioners, the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia's call for an independent review of the sector, and the Nursing and Midwifery Board of Australia's position statement for nurses working in cosmetic medical procedures.

Borin, M., Degliuomini, R.S., Schiraldi, L., Di Summa, P.G. and Buzzaccarini, G., (2023). **Ensuring Competence and Patient Safety through Regulation and Standardized Training in Aesthetic Medicine.** *Plastic and reconstructive surgery*, (1306050). Available at: https://pubmed.ncbi.nlm.nih.gov/37699549/

Noor S.M. and Sagheer F., (2023). **REGULATING TEACHING AND PRACTICE OF AESTHETIC MEDICINE AND SURGERY**. *Journal of Postgraduate Medical Institute*, 37(2), pp.89–90. Available at: https://jpmi.org.pk/index.php/jpmi/article/download/3250/3333.

Rossiter M., Zargaran D., Zargaran A., Terranova T., Rosenblatt W., Hamilton S., and Mosahebi A., (2023). **UK esthetics associations: A robust safety net or credibility accessories?** *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 84((Rossiter, Zargaran, Zargaran, Mosahebi) University College London, London, United Kingdom), pp.521–530. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1748681523002863.
Background: Currently, safe practice in the UK esthetics industry is largely reliant on self-regulatory bodies. If these bodies do not maintain high standards of safety guidelines and properly accredit practitioners, patient safety may be at risk. To our knowledge, no studies have addressed cosmetic self-regulatory bodies and their websites on Google, the most commonly used information source. This study aimed to map self-regulatory bodies on Google and evaluate their roles in the current UK esthetics industry. Method(s): We conducted a systematic search of Google Search results using eight search terms. The first 100 search results were screened against our eligibility criteria. We searched each website of a self-regulatory body for their requirements to join registers, membership fees, and features listed on the UK government's criteria for an effective self-regulatory body. Result(s): We identified 22 self-regulating bodies for the UK esthetics industry. Only 15% of registers required an in-person assessment of cosmetic skills to qualify for membership. Of the self-regulatory bodies, 65% did not set clear standards and guidelines for practice. No qualifications were required by 14% of surgical and 31% of non-surgical bodies. The mean membership fee was 331. Conclusion(s): This study uncovered important information about the self-regulation of the esthetics industry in the UK. A significant majority of self-regulatory bodies did not meet best practices, potentially putting patients at risk. We recommend further studies screening a higher number of pages in a Google Search to scope all other existing self-regulatory bodies, due to the creation of Google "filter bubbles."Copyright © 2023

Lee, A., (2022). **How national regulation will improve patient outcomes.** *Journal of Aesthetic Nursing*, 11(10), pp.450–454. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=160685538&custid=ns010095.
Anna Lee discusses UK law and ethics within the realm of aesthetic medicine and the upcoming licensing scheme

Anon, (2022). **Ahpra and Medical Board Accept Cosmetic Surgery Review Recommendations.** *Journal of Medical Regulation*, 108(3), pp.45–45. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=160252659&custid=ns010095.
The article informs on report "Independent Review of the Regulation of Medical Practitioners who Perform Cosmetic Surgery" issued by the Australian Health Practice Regulation Agency which include unsafe practice, and misleading advertising across the cosmetic industry.

Robson, S.J., (2022). **Why license non-medics to perform non-surgical cosmetic treatments at all?** *BMJ : British Medical Journal (Online)*, 378. Available at: https://www.proquest.com/scholarly-journals/why-license-non-medics-perform-surgical-cosmetic/docview/2712728594/se-2?accountid=31583.

Splete, H., (2022). **Body contouring tops list of cosmetic procedures with adverse event reports.** *Dermatology News*, pp.8–8. Available at: https://www.mdedge.com/dermatology/article/257394/aesthetic-dermatology/body-contouring-tops-list-cosmetic-procedures.

Cryolipolysis accounted for a majority of noninvasive cosmetic procedures associated with adverse events, according to an analysis of data from the Manufacturer and User Facility Device Experience (MAUDE).

Feng L. and Zhai X., (2022). **Regulation concerns of supply and demand sides for aesthetic medicine from Chinese perspective**. *Developing World Bioethics*, ((Feng) bioethics at the School of Population Medicine&Public Health, Peking Union Medical College, Beijing, China). Available at: http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1471-8847.
Aesthetic medicine has become a booming industry in the world. However, there are widespread social and health risks posed by aesthetic medicine, including illegal practice, and misleading information from aesthetic medicine institutes. Social media and advertisement play important roles in leading to appearance anxiety among young people nowadays. Regarding the chaotic situation in the aesthetic medical field, there is a fact that the practice of aesthetic medicine has been marginally regulated, even in some developed countries. China has the largest population in the world as well as the large number of aesthetic medical customers. Regarding the protection of people from harm, there is a great challenge for the Chinese government. So, China has enacted the toughest governance these years both on the supply and demand side. Some of the strategies may be useful for health authorities in certain countries.

Hunt, J., (2022). **The impact of body image on mental and physical health : : second report of session 2022–23 : report, together with formal minutes relating to the report.** Great Britain. Parliament. House of Commons. Health and Social Care Committee, ed., London : House of Commons,. Available at: https://committees.parliament.uk/work/1674/the-impact-of-body-image-on-mental-and-physical-health/publications/.
This report states that the government must speed up the introduction of a promised licensing regime for non-surgical cosmetic procedures to prevent vulnerable people being exploited. The report identifies a rise in body image dissatisfaction as the driver behind a new market that to date has remained largely unregulated

Jobson, D. and Freckelton, I., (2022). **The changing face of cosmetic surgery regulation: a review of controversies and potential reforms**. *ANZ Journal of Surgery*, 92(5), pp.964–969. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/ans.17648 [Accessed September 22, 2023].
Cosmetic surgery is becoming increasingly popular in Australia with the industry estimated to be worth over 1 billion dollars annually. Regulators both in Australia and internationally have been criticized for not keeping up with the rapidly changing field and keeping patients sufficiently safe in an environment that is problematically entrepreneurial. In this article, we explore the current regulation of and controversies surrounding cosmetic surgery in Australia, including the use of the title ‘cosmetic surgeon’, consent processes and the phenomenon of medical tourism. Lastly, we review the potential future reforms in Australia and how other countries have regulated the industry to keep patients safe.

Parus A., Hartmann T., Foley B.J., and Plank D.M., (2022). **Patient Understanding of Provider Credentials and Selection of Plastic Surgery Providers**. *Annals of plastic surgery*, 89(2), pp.143–147.
BACKGROUND: Many physicians who are not board-certified plastic surgeons have started performing aesthetic procedures, leading to unsafe practices that jeopardize patients' health. METHOD(S): Patients of a cosmetic and reconstructive private plastic surgery practice were asked to complete a survey that assessed their understanding of plastic surgeon credentials and advertising practices, and what influences their choice of a plastic surgeon. RESULT(S): Eighty-five patients completed the survey, with 37.2% reporting prior aesthetic surgery; 84.9% were unaware of the lack of legal regulations governing the advertising practices of physicians. When asked if a doctor can perform surgery to improve their appearance without being a board-certified plastic surgeon, 22.1% responded “yes,” 50% responded “no,” and 27.9% responded “I don’t know;” 98.8% reported a sense of comfort knowing their provider is board-certified in plastic surgery. When asked what factors help them decide if a surgeon is knowledgeable and

trustworthy, the overwhelming majority reported referral from patients and providers as the most important factor, followed by online ratings and reviews. When deciding whether to recommend a plastic surgeon, personal experience was the most important factor. When deciding who should perform their cosmetic procedure, the most important factor was experience, followed by plastic surgery board certification. DISCUSSION: Current physician advertising practices lack strict guidelines and are often misleading. Patients would benefit from more thorough education on these practices. Of the various plastic surgeon assessment factors, most patients rely heavily on feedback obtained from patients and providers.

Zargaran D., Zargaran A., Caine P., Weyrich T., and Mosahebi A., (2022). **An Analysis of the United Kingdom Education Courses for Aesthetic Practice**. *British Journal of Surgery*, 109(Supplement 6), p.vi114.
Aim: The training of cosmetic and aesthetic practitioners has received national attention since the 2013 Keogh review of the regulations of cosmetic interventions. The 2015 HEE cosmetic guidelines recommended level 7 accreditation in Injectables for Aesthetic Medicine. The Royal College of Surgeons has now established the Cosmetic Surgery Certification Scheme and this analysis looks to identify the cost and availability of courses in the UK. Method(s): A review of Google search results using the keywords “Botox”, “Filler”, “Course”, “Certification”, “Level 7”, “Training” and “Foundation” using Boolean operators. The costs of the courses, duration, accreditation, and availability of level 7 certification were extracted from the websites. Result(s): A total of 36 courseswere identifiedwhere a Foundation Course in both Botulinum Toxin and Dermal Fillers were provided. The lowest available cost was 780, a maximum cost of 4,500 and mean cost of 1,557. Mode course duration was 1 day, with a maximum duration of 4 days andmean of 1.4 days. 9 of the 36 providers offered level 7 accreditation. Conclusion(s): The provision of education and training has significant implications for patient safety. The completion of foundation courses is often a requirement for insurance companies to provide coverage to practitioners, however, a wide variety of educational quality may account for complications which are experienced by patients. The lack of accreditation beyond CPD points was noted. These findings call for a unified educational approach to ensure, safe training of practitioners.

STOCUM, L., (2021). **Study Investigates Who Administers Injectables.** *Dermatology Times*, 42(10), pp.38–38. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=152862623&custid=ns010095.
The article reports on the findings of a study of procedures at U.S. dermatology and plastic surgery practices which found that injections to relax wrinkles and add volume are mostly performed by physicians. Nurse practitioners and physician assistants were permitted to administer injectable treatments based on data from the research. As a result, organizations like the American Society for Dermatologic Surgery Association believe that there is insufficient regulation protecting patients.

Rufai, S.R., Nour, R. and Davis, C.R., (2021). **Safety in aesthetic surgery - are we adhering to national guidelines?.** *Journal of plastic, reconstructive & aesthetic surgery : JPRAS*, 74(4), pp.890–930. Available at: https://www.jprasurg.com/article/S1748-6815(20)30535-0/fulltext.
Patient safety remains a fundamental issue in aesthetic surgery. Hippocrates’ dictum, primum non nocere – “first, do no harm" – remains especially relevant in aesthetic surgery, where harm can include morbidity and mortality for patients and litigious repercussions for the provider. In a bid to improve standards and safeguard patients, Professor Sir Bruce Keogh led the UK’s Department of Health and Social Care (DHSC) ‘Review of the Regulation of Cosmetic Interventions’, published in 2013. 1 The same year, we performed a national audit of the UK’s top 50 Google ranked aesthetic surgery providers against these DHSC guidelines and found sub-optimal levels of compliance, albeit these were suggested guidelines and not government policy. 2 The British Association of Aesthetic Plastic Surgeons (BAAPS) included our findings in their 2013 national media campaign for safer aesthetic surgery. 3 More recently, the Royal College of

Surgeons (RCS) of England published the 'Professional Standards for Cosmetic Surgery', with reference to the 2013 DHSC review and relevant General Medical Council standards. 4 Here, we have conducted a national re-audit of clinical and marketing practices in aesthetic surgery, mirroring our original methodology, to close the audit loop and quantify current clinical practice.

Anonymous, (2020). **Warning over cosmetic regulation plans: NT**. *Nursing Times*, 116(2), p.12. Available at: https://www.proquest.com/magazines/warning-over-cosmetic-regulation-plans/docview/2405658777/se-2?accountid=31583.
Scottish Government proposals to give a licence to unregistered professionals to carry out cosmetic procedures are "fundamentally flawed", cosmetic nurses have warned.

Holmberg C., Carlstrom E., and Collier H., (2020). **Registered nurses' perspectives on medically safe practices and sound ethical standards in aesthetic nursing: An interview study**. *Journal of Clinical Nursing*, 29(5-6), pp.944-954. Available at: http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2702.
Aims and objectives: To explore the views of registered nurses experienced in aesthetic nursing regarding medically safe practices and sound ethical standards. Background(s): Aesthetic nursing is an emerging field of modern-day healthcare encompassed within aesthetic medicine. There is a distinct lack of research regarding how registered nurses who specialise in this area of care view medically safe practices and sound ethical standards. This is important to explore, because, in the absence of mandatory regulations within the sector, and it is the aesthetic nurse's own obligation to uphold professional, medical and ethical standards. Design(s): Qualitative study. Method(s): Individual semi-structured interviews were conducted with 13 registered nurses who had worked in aesthetic nursing for at least two years. The interview transcripts were categorised using qualitative content analysis. The COREQ checklist was used to report the study. Result(s): A main theme was generated during the analysis: Considering my professional, the clinic's and the patient's needs. The participants described that they considered medical and ethical aspects pertinent to their professional roles as registered nurses but also undertook practices in addition to what they already did as registered nurses, such as creating professional networks using social media. They also described the importance of establishing local medical and ethical guidelines for their clinics, and that they considered patients' individual needs such as using individual information relating to their patients' previous experiences. Conclusion(s): The study points to the positive tendencies of registered nurses in aesthetics to develop their own professional networks and create local medical and ethical guidelines until more robust mandatory regulations are in place. Relevance to clinical practice: Considering that aesthetic nursing is a young industry, registered nurses are in an excellent position to utilise their professional networks and work with professional bodies to develop standards of professional nursing practice and education for this field. Copyright © 2019 John Wiley & Sons Ltd

Mcgloin, C., (2019). **Aesthetics in Ireland: the publication of IS EN 16844.** *Journal of Aesthetic Nursing*, 8(7), pp.338-339. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=138634003&custid=ns010095.
IS EN 16844 aesthetic medicine services: non-surgical medical procedures has now been published in Ireland. Two years on, what does this mean for Irish nurses and what has changed in Irish aesthetics?

Fitzgerald, B., (2019). **Government campaign to tackle "botched" procedures.** *Journal of Aesthetic Nursing*, 8(4), pp.157-157. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=136278861&custid=ns010095.

Davison S.P., Hancock M., Sinkiat M., and Enchill Z., (2019). **Oral Surgeons as Cosmetic Surgeons and Their Scope of Practice**. *Plastic and Reconstructive Surgery*, 143(4), pp.872E-879E. Available at: http://journals.lww.com/plasreconsurg/pages/issuelist.aspx.
Background: In recent years, the practice of cosmetic surgery has expanded to include oral and maxillofacial surgeons. The groundwork for this scope-of-practice expansion was laid in part by the American Dental Association's definition change of the practice of dentistry. This change modified the scope of dentistry from the earlier "teeth and surrounding and supporting structures" to the maxillofacial area and beyond. A number of states adopted this new definition into legislation, giving practitioners the premise on which to perform cosmetic and other medical procedures on the face and potentially other parts of the body. This expansion has created legal and regulatory issues over scope and truth in advertising. The authors hypothesize that this is confused by a lack of federal guidelines and state-by-state variations in scope-of-practice laws for oral and maxillofacial surgeons. Method(s): This article provides a brief overview of the key legal issues and their impact on legislation in some of the battleground states. The authors review the national distribution of scope of practice for oral and maxillofacial surgeons. Result(s): The most successful path to expanded scope for dentistry has been through control of certification and credentialing. This has marginalized medicine boards from contributory oversight, thus circumventing any arguments over practice parameters. The scope-of-practice dispute is further complicated by the existence of dual-degree oral and maxillofacial surgeons. Conclusion(s): With increasing demand for cosmetic surgical interventions, establishing scope-of-practice standards for single-degreed oral and maxillofacial surgeons is critically important. As physicians, the oral and maxillofacial surgery graduates of the dual M.D./D.D.S. degree programs have no such scope-of-practice restrictions. Furthermore, if plastic surgery is to effectively argue against expanded scope of practice for oral and maxillofacial surgeons, more objective data will be necessary. Copyright © 2019 by the American Society of Plastic Surgeons

De Lima A., Osman B.M., and Shapiro F.E., (2019). **Safety in office-based anesthesia: An updated review of the literature from 2016 to 2019**. *Current Opinion in Anaesthesiology*, 32(6), pp.749–755. Available at: http://journals.lww.com/co-anesthesiology/pages/default.aspx.
Purpose of reviewOffice-based anesthesia (OBA) is rapidly growing across the world. Availability of less invasive interventions has facilitated the opportunity of offering new procedures in office-based settings to patient populations that would not have been considered in the past. This article provides a practical approach to discuss and analyze newest literature supporting different practices in the field of OBA. In addition, an update of the most recent guidelines and practice management directives is included.Recent findingsSelected procedures may be performed in the office-based scenario with exceedingly low complication rates, when the right patient population is selected, and adequate safety protocols are followed. Current regulations are focused on reducing surgical risk through the implementation of patient safety protocols and practice standardization. Strategies include cognitive aids for emergencies, safety checklists, facility accreditation standards among other.SummaryNew evidence exists supporting procedures in the office-based scenario in areas such as plastic and cosmetic surgery, dental and oral surgery, ophthalmology, endovascular procedures and otolaryngology. Different systematic approaches have been developed (guidelines and position statements) to promote standardization of safe practices through emergency protocols, safety checklists, medication management and surgical risk reduction. New regulations and accreditation measures have been developed to homogenize practice and promote high safety standards. Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

Goodman J.R., (2019). **Let the buyer beware: Content analysis of cosmetic surgery websites' provider information**. *Public understanding of science (Bristol, England)*, 28(6), pp.713–729.
Given that many consumers do not understand any licensed physician can perform cosmetic surgery, cosmetic procedure advertising regulation is lacking and differs by state; and consumers often search for providers online and rely on the site's information. Cosmetic surgery websites have the potential to be a threat to consumers' safety and health. This study asked what types of physician information do cosmetic

surgery websites supply. A content analysis was conducted with 873 physicians' information provided on cosmetic surgery websites in the top 10 cosmetic surgery cities, finding members of plastic surgery associations and core providers were more likely to list medical qualifications. All physicians were unlikely to list experience. Two-thirds stated their specific board certification, and 15% to 30% in each city failed to follow their state's regulations for disclosing board certification. The study concludes by suggesting national ethical guidelines.

King, S., (2019). **Hanging by a thread: legislation and protecting the public**. *Journal of Aesthetic Nursing*, 8(5), p.248. Available at: https://www.proquest.com/scholarly-journals/hanging-thread-legislation-protecting-public/docview/2444382230/se-2?accountid=31583.
The aesthetics sector is marred by a lack of legislation and regulation which puts patients and practices at risk. The BACN is calling for greater regulation by the government, but so far this has been slow in coming. In this article, Sharon King discusses some recent developments

Sines, D., (2019). **Responsible prescribing for cosmetic procedures**. *Journal of Aesthetic Nursing*, 8(7), pp.314–316. Available at: https://www.proquest.com/scholarly-journals/responsible-prescribing-cosmetic-procedures/docview/2444379746/se-2?accountid=31583.
This article sets out the Jount Council for Practitioners/Cosmetic Practice Standards Authority position regarding responsible prescribing of POMs used in aesthetic practice. The guidance accords with that set down by the majority of the healthcare professional regulators and by the Royal Pharmaceutical Society. With regard to delegated prescribing, prescribers are reminded that patients remain under the oversight of the prescriber, requiring that the prescriber must be familiar with the patient through an initial face to face consultation and diagnostic assessment of the patient's suitability for treatment. This applies to the routine/planned/repeat administration of medicines that are used specifically for cosmetic purposes, such as botulinum toxins, injected local anaesthetic or topical adrenaline, and the emergency use of medicines such as hyaluronidase. Prescribers are also reminded of their obligation to address the existence of competing interests and to place the needs of the patient first and be transparent about their actions.

Collier, H., (2018a). **Aesthetics: the wild west of medicine.** *Journal of Aesthetic Nursing*, 7(10), pp.548–549. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=133287157&custid=ns010095.
Aesthetic medicine is a specialty with a distinct lack of regulation. As a result, this important field of medicine is often not taken seriously or given the respect and recognition that it deserves. In this article, Helena Collier argues that greater regulation of this field is needed if we are to prevent the aesthetic specialty from becoming the wild wild west of medicine

Collier, H., (2018b). **Sense must prevail in the battle to remedicalise medical aesthetics.** *Journal of Aesthetic Nursing*, 7(5), pp.274–274. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=129919764&custid=ns010095.
Five years on from the publication of a Government review into the regulation of cosmetic interventions, many aesthetic practitioners are disappointed with the progress made with regards to improving standards of care and prioritising patient safety. Helena Collier believes it is this very review that has made a mockery of the field of aesthetic medicine and created gaping loopholes to be exploited

Mosahebi, A., (2018). **Commentary on: Adipose-Derived Stem Cells in Aesthetic Surgery: A Mixed Methods Evaluation of the Current Clinical Trial, Intellectual Property, and Regulatory Landscape.** *Aesthetic Surgery Journal*, 38(2), pp.211–211. Available at: https://academic.oup.com/asj/article/38/2/211/4583508?login=false.

The article confirms the paucity of good quality trials, despite 1250 registered ones, almost none seem to plan long-term follow up of the effect. Additionally, there is no agreed standard methodology of assessment of the quality of the ADSC. This is in spite of the large number of patents put in for separation and concentration technologies, as well as innovative applications. The explanation of regulatory landscape is very enlightening, illustrating the great deal of variability in different continents. In some cases, vagueness and lack of clarity in regulation has enabled potential unscrupulous misinterpretations and misuses false promotion of services. An exemplar regulation is in Japan, where there is a specific section for regenerative medicine. This not only helps to promote innovation and genuine effect and uses, but also reduces the back-street rogue clinics and should be a lesson to regulatory bodies in the United States and European Union. This unique article gives ASJ readers a comprehensive overview of global landscape in ADSC field, trials, and regulation.

Tessler, O., Bourn, L., Lin, S.J., Dupin, C., Mundinger, G.S., Patterson, C., St Hilaire, H., Bartow, M., Torabi, R. and Hanemann, M., (2018). **Cosmetic Surgeon Representation: Ensuring Board Certification Transparency and Patient Awareness.** *Annals of plastic surgery*, 80(6S Suppl 6), pp.S431–S436. BACKGROUND: Previous studies revealed that patients preferred plastic surgeons over cosmetic surgeons for surgical procedures, but few knew that any physician with a medical degree was legally qualified to perform cosmetic surgery. Results also indicated that a primary consideration for patients in selecting a surgeon was board certification. Although patient preferences concerning aesthetic surgery have previously been surveyed, no study examined a consumer's ability delineate between specialties based on Web sites. The purpose of this study was to investigate the responses of medical students to questions regarding a cosmetic and plastic surgeon's board certification., METHODS: A total of 4 cosmetic and 5 plastic surgeon Web sites were selected, in a single large city, from a Google search for the following procedures: liposuction, breast augmentation, blepharoplasty, rhytidectomy, and abdominoplasty. Screenshots of the Google search link, the page after clicking on the link, and the about the doctor page were collected to simulate an actual patient search experience. Four randomized surveys were created using screenshots and scenarios through Survey Monkey. Surveys were distributed and collected anonymously. Data analysis was accomplished using a chi-square test of independence ($P < 0.05$)., RESULTS: A total of 474 medical students responded, and the difference between cosmetic and plastic surgeon variables was significant ($P < 0.001$). Upon comparison of different procedures, the cosmetic and plastic groups were found to be statistically different ($P < 0.05$), with some exceptions. On average, when presented with a plastic surgeon, 95.3% thought this was a board-certified plastic surgeon. When presented with a cosmetic surgeon, 54.3% also thought this was a board-certified plastic surgeon. The decline in responses regarding board certification, for the first and second cosmetic surgeons presented, was found to be statistically different ($P < 0.0001$)., CONCLUSIONS: Over 50% of medical students had difficulty distinguishing between a cosmetic and plastic surgeon based on Web site advertisements; therefore, patients may have a more difficult experience. Results of this study prove the need for a universal definition, and patient education, relating to board certifications.

Leow, L.J., (2017). **Navigating the disparate Australian regulatory minefield of cosmetic therapy**. *Australian Family Physician*, 46(9), pp.697–698. Available at: https://www.proquest.com/scholarly-journals/navigating-disparate-australian-regulatory/docview/1939210423/se-2?accountid=31583. The MBA guidelines are effective from 1 October 2016, and require:2 * a cooling-off period for major procedures (and minor procedures for patients under 18 years of age) * evaluation by a general practitioner (GP), psychologist or psychiatrist prior to major procedures for patients under 18 years of age (and minor procedures when clinically indicated) * explicit responsibility for postoperative care and provision of emergency facilities when using sedation, anaesthesia or analgesia * consultation before prescribing Schedule 4 cosmetic injectables * detailed written information about costs and clear information about risks and possible complications to be provided. [...]the level of theoretical detail for these treatment modalities in certain non-medical university courses on dermal therapy, such as the Bachelor of Dermal Sciences at Victoria University, is comparable to, if not higher than, that of specialist

dermatology training.8-9 Although there is no published local information, legal claims in the US related to cutaneous laser surgery are increasing and result in indemnity payments that exceed the reported average for indemnity payments across all medical specialties.10 A 12-month Australian anonymous survey of 430 medical and non-medical practitioners revealed 416 cases of burns and permanent scarring (including 268 considered severe) and 62 cases of skin cancer (including 22 cases of melanoma) where diagnosis was delayed or missed by the practitioner.5 Differences in regulation across Australia mean it may be legal for certain individuals to administer treatment in one state/territory, yet illegal in another. [...]an authoritative report based on a survey of both non-medical and medical practitioners favoured licensing on the basis of training and qualification over arbitrary restrictions or self-regulation through voluntary accreditation.11 Licensing (as opposed to restriction) of cosmetic therapy by all states/territories could be an effective means of more uniform regulation across Australia.

Robson, S., (2017). **Scottish perspective on regulation of cosmetic treatments**. *BMJ : British Medical Journal (Online)*, 358. Available at: https://www.proquest.com/scholarly-journals/scottish-perspective-on-regulation-cosmetic/docview/1919058569/se-2?accountid=31583.
The first steps have been taken in tackling these issues with the introduction of Health Improvement Scotland (HIS) registration for independent health clinics. The nature of phase two has yet to be announced, but doctors hope it will outlaw all invasive cosmetic procedures by unregulated and unqualified practitioners.

Arie, S., (2017). **Cosmetic industry regulation is only skin deep**. *BMJ : British Medical Journal (Online)*, 357. Available at: https://www.proquest.com/scholarly-journals/cosmetic-industry-regulation-is-only-skin-deep/docview/1913586139/se-2?accountid=31583.
Legislation is urgently needed to protect the increasing number of people having cosmetic procedures to improve their appearance, Sophie Arie reports

Iacobucci, G., (2017). **Private sector should have same safety rigour as NHS, say surgeons after Paterson conviction**. *BMJ : British Medical Journal (Online)*, 357. Available at: https://www.proquest.com/scholarly-journals/private-sector-should-have-same-safety-rigour-as/docview/1899675222/se-2?accountid=31583.
The Royal College of Surgeons has called for a review of transparency and safety standards in the private sector after the conviction of Ian Paterson, a rogue breast surgeon. "Patient safety initiatives have tended to concentrate on the NHS, but we also need a strong focus on the private sector, particularly in the collection and publication of patient safety data in private hospitals.

Park S.-Y. and Park S.H., (2017). **Professionalism and Commercialism on Cosmetic Surgeons' Websites**. *Health Communication*, 32(7), pp.872–879. Available at: http://www.tandf.co.uk/journals/titles/10410236.asp.
This study analyzed the homepages of 250 cosmetic surgeons' websites by focusing on the representation of cosmetic surgery providers, cosmetic surgery recipients, and cosmetic surgery practice itself. Based on a literature review, some common elements of the webpages were preidentified as the indicators of professionalism or commercialism. Subsequently, each homepage was scrutinized for their presence and salience. Overall, cosmetic surgeons' websites were high in professionalism and low in commercialism in their representation of the service providers. In depicting the recipients, the websites were moderate in both professionalism and commercialism. The representation of practice was low in professionalism and moderate in commercialism. Implications of these findings for doctors, regulators, and consumer advocates are discussed and directions for future research are proposed. Copyright © 2016 Taylor & Francis.

Town G., (2017). **Aesthetic clinical practice in the UK-New standards and regulations**. *Lasers in Medical Science*, 32(6), p.1226.

Background: This talk describes the differences in laser and intense light source (ILS) standards and regulations in Scotland, Wales, Northern Ireland and England in aesthetic clinical practice and includes the new BS EN 16372 “Aesthetic surgery services” standard and comments on the status of the corresponding non-surgical standard being developed by the CEN TC. The progress of the new NHS Health Education England (HEE) educational standards published in January 2016 setting down a qualification framework (QCF Levels 4-7) for the delivery of non-surgical cosmetic interventions and hair restoration surgery is discussed. The talk will encompass the anticipated new EC Medical Device Directive (MDD) and Regulations and the likely impact on laser and intense light source (ILS) manufacturers and distributors in UK and probable impact on the marketing of home-use light-based devices to the UK general public. Conclusion(s): Variations in UK regional Government policy have led to significant disparities in licencing and enforcement of controls over the use of lasers and ILS devices in the United Kingdom. Equipment compliance standards are too easily avoided through internet purchase and weak enforcement. Learners in UK have access to a range of credible accredited courses and qualifications. New educational standards are desperately needed for injectables. In the meantime, adverse incidents from laser and ILS use will likely increase.

Wondergem, F., (2017). **Ethics in non-surgical aesthetic medicine: practising safely and appropriately**. *Journal of Aesthetic Nursing*, 6(9), pp.486–489. Available at: https://www.proquest.com/scholarly-journals/ethics-non-surgical-aesthetic-medicine-practising/docview/1972449900/se-2?accountid=31583.
Despite the recommendations made by Sir Bruce Keogh’s 2013 report on the regulation of non-surgical cosmetic interventions, the sector remains rife with cases of unethical practice. All registered health professionals, including nurses, must adhere to ethical principles when providing care. Fiona Wondergem considers ways in which aesthetic practice can be underpinned by professional values and ethics

O’Dowd, A., (2016). **Cosmetic surgery will be regulated more closely in England**. *BMJ : British Medical Journal (Online)*, 354. Available at: https://www.proquest.com/scholarly-journals/cosmetic-surgery-will-be-regulated-more-closely/docview/1814062974/se-2?accountid=31583.
Clinics that provide cosmetic surgery are to come under closer scrutiny and be rated in the same way as GPs and hospitals, under new government plans.

HARRIS, P., (2016). **Patient safety must be prioritised over profit.** *Journal of Aesthetic Nursing*, 5(3), pp.110–110. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=114316530&custid=ns010095.
A 22-year-old trainee teacher came to see me at the beginning of the year to correct her botched breast implant operation. She recounted that ‘the telephone sales lady said that if I signed up for surgery today, then I could have £500 off the price, so I went for it. It was only after the operation that I found out the surgeon wasn’t properly qualified, and it was too late by then’. Since the surgery and the need for prolonged aftercare in the NHS, she suffered from anxiety and had not been able to undress in front of her partner. This type of story is one that is increasingly heard by consultants as more patients are seeking corrective surgery.

POULTER, D., (2016). **Three years after Keogh: triumph or travesty?** *Journal of Aesthetic Nursing*, 5(1), pp.5–5. Available at: https://www.magonlinelibrary.com/doi/full/10.12968/joan.2016.5.1.5.
When a member of the public pays for a cosmetic procedure, they have a legitimate expectation to be treated by a skilled practitioner with knowledge of the human body, who has undertaken extensive training in the art of aesthetic medicine. While there are many dedicated health professionals, including nurses, doctors and dentists, who take pride in looking after their patients, the reality of high street aesthetics is a world increasingly blighted by unskilled, rogue practitioners. Some of these ‘practitioners’ lack even the most basic training in human anatomy, and the frequency of news reports highlighting lives destroyed by untrained, dangerous individuals makes a compelling case for proper regulation.

General Medical Council ed , (2016). **Guidance for doctors who offer cosmetic interventions**, London : GMC. Available at: http://www.gmc-uk.org/Guidance_for_doctors_who_offer_cosmetic_interventions_210316.pdf_65254111.pdf.
This guidance accompanies the Royal College of Surgeons (RCS) guidance on professional standards for cosmetic surgeons. The GMC guidance makes clear the ethical obligations that doctors have towards patients and the standards of care that they need to provide during cosmetic procedures.

Khunger, N., (2016). **Shifting Trends in Cutaneous and Aesthetic Surgery: A Need for Caution and Regulation**. *Journal of cutaneous and aesthetic surgery*, 9(2), pp.57–8. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924414/.
These shifting trends in minimally invasive surgery have also put aesthetic rejuvenation in the hands of minimally trained aestheticians and physicians. It has also shifted out the procedures from the traditional operation theatre room setting to the office procedure setting and minimally equipped medispas. Hence, there is an urgent need for caution and regulation to ensure that seemingly simple procedures are not carried out by unqualified personnel in poorly equipped clinics, particularly when dealing with the eye and the face.

Torjesen, I., (2015). **Surgeons urged to prepare for changes in cosmetic surgery regulation**. *BMJ : British Medical Journal (Online)*, 351. Available at: https://www.proquest.com/scholarly-journals/surgeons-urged-prepare-changes-cosmetic-surgery/docview/1777829475/se-2?accountid=31583.

Barr, J.S., Sinno, S., Cimino, M. and Saadeh, P.B., (2015). **Clinicians performing cosmetic surgery in the community: a nationwide analysis of physician certification.** *Plastic and reconstructive surgery*, 135(1), pp.92e–98e.
BACKGROUND: Practitioners who are not board-certified by the American Board of Plastic Surgery are practicing cosmetic surgery. The extent of this issue across the United States has yet to be examined in detail., METHODS: A systematic search using Google was performed to evaluate the qualifications of clinicians marketing themselves as plastic surgeons. For every U.S. state, the following searches were performed: [state] plastic surgery, [state] cosmetic surgery, and [state] aesthetic surgery. The first 50 Web sites returned for each search were visited and scrutinized using the American Society of Plastic Surgeons and American Board of Plastic Surgery Web sites., RESULTS: In total, 7500 Web sites were visited, yielding 2396 board-certified plastic surgeons (77.9 percent of all practitioners). There were 284 board-certified ear, nose, and throat surgeons, 61 (21.5 percent) of whom practice outside their scope; 106 board-certified general surgeons, 100 (94.3 percent) of whom practice outside their scope; 104 board-certified oral and maxillofacial surgery surgeons, 68 (65.4 percent) of whom practice outside their scope; 70 board-certified ophthalmologists/oculoplastic surgeons, 49 (70 percent) of whom practice outside their scope; and 74 board-certified dermatologists, 36 (48.6 percent) of whom practice outside their scope. There were also 16 internal medicine doctors, 13 obstetrics and gynecology physicians, six emergency medicine physicians, three pediatricians, two urologists, two anesthesiologists, and finally one phlebotomist; all of these practitioners practice outside their scope as defined by Accreditation Council for Graduate Medical Education core competencies., CONCLUSIONS: Many clinicians performing cosmetic surgery are not board-certified. This finding has important implications for patient safety.

Kearney, L., de Blacam, C., Clover, A.J., Kelly, E.J., O'Shaughnessy, M., O'Sullivan, S.T. and O'Broin, E., (2015). **Cosmetic surgical practice: are we complying with professional standards?.** *Aesthetic plastic surgery*, 39(3), pp.449–51.
UNLABELLED: Aesthetic surgery is a rapidly expanding industry and patient safety is a fundamental issue. The need for regulation has been outlined by the Professional Standards for Cosmetic Practice Report, published by the Royal College of Surgeons in January 2013 which highlighted standards of patient care. The aim of this study was to review institutional compliance with these standards. A retrospective chart

review of 40 consecutive patients who underwent either bilateral breast augmentation or bilateral breast reduction between November 2012 and November 2013 within our unit was performed. Compliance with standards relating to practice management, patient consultation, patient communication and record-keeping was examined. While details of past medical history were recorded in most cases, few consultations referred to psychiatric history and cosmetic surgical history specifically. Perioperative documentation and compliance with surgical safety processes were excellent. As a self-regulating profession, it is important that plastic surgeons take the lead in auditing their practice against such published standards. We urge all professionals who carry out cosmetic procedures to regularly review their practice, thereby promoting accountability and maintaining the trust of the general public in the aesthetic surgery industry., LEVEL OF EVIDENCE V: This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266 .

Parina, R., Chang, D., Saad, A.N., Coe, T. and Gosman, A.A., (2015). **Quality and safety outcomes of ambulatory plastic surgery facilities in California.** *Plastic and reconstructive surgery*, 135(3), pp.791–797.
BACKGROUND: Although most cosmetic surgery procedures are performed at outpatient surgery facilities, there is little published literature on the quality and safety of such facilities. Furthermore, regulation of such facilities varies widely and may leave room for poor outcomes. The authors sought to determine whether all outpatient surgery facilities that are licensed by the California Department of Public Health have similar rates of postoperative complications., METHODS: A retrospective review was performed of all data collected from 2005 to 2010 by the California Office of Statewide Health Planning and Development. All outpatient surgery facilities licensed by the Department of Public Health must report encounter-level data to that office. Patients' subsequent inpatient admissions and emergency department visits were identified. Several cosmetic procedures were studied. Outcomes analyzed were the 30-day venous thromboembolism, hospital admission, and emergency department visit rates., RESULTS: A total of 160,847 patients and 635 facilities were included. By facility, the range for 30-day venous thromboembolism rates was 0 to 3.4 percent, the range for 30-day admission rates was 0 to 7.7 percent, and the range for 30-day emergency department visits was 0 to 22.8 percent., CONCLUSIONS: Analysis showed a significant variability in the rate of 30-day venous thromboembolism incidents, admissions, and emergency department visits. Some facilities had complication rates that were a significant deviation from the mean, whereas others had no complications. To ensure optimal quality and patient safety, it is necessary to analyze why outliers exist and identify ways to improve on the current system of licensure and outcomes reporting.

SCANLON, C., (2014). **Where should aesthetic nurses practise? An evaluation of national health guidelines.** *Journal of Aesthetic Nursing*, 3(2), pp.74–77. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=94847097&custid=ns010095.
The article examines several frameworks for determining a suitable environment for the practice of medical aesthetics in Great Britain. There is said to be a lack of formal guidance on minimum standards for non-surgical cosmetic medicine in the country. It discusses the "Professional Standards for Cosmetic Practice" published by the Royal College of Surgeons in 2013. It also describes the importance of risk assessment under the Health and safety at Work Act 1974.

criticised, C. surgery regulation and Kmietowicz, Z., (2014). **Surgeons condemn UK's lack of action on regulating cosmetic treatments**. *BMJ : British Medical Journal (Online)*, 348. Available at: https://www.proquest.com/scholarly-journals/surgeons-condemn-uks-lack-action-on-regulating/docview/1930594697/se-2?accountid=31583.
The review followed a scandal involving the French company Poly Implant Prothèse, which had been making breast implants using non-medical grade silicone. 2 It also recommended that people who

administer non-surgical interventions should have accredited qualifications, that they should be registered, and that their work should be overseen by a qualified medical practitioner. In its response to the review the government said that it had accepted "the principles of the Keogh review and the overwhelming majority of its recommendations," but it did not commit to legislative action on any of these recommendations. 3 The Royal College of Surgeons will ensure standards for cosmetic surgery for surgeons, but there is no such oversight for other medical and non-medical practitioners who are involved in many non-surgical treatments, such as injections of dermal fillers and Botox. Last December the presidents of the British Association of Dermatologists, the British Association of Aesthetic Plastic Surgeons, and the British Association of Plastic, Reconstructive and Aesthetic Surgeons warned, "Without a compulsory specialist register, that includes all practitioners in this field-both medical and non-medical-the public will be prey to a two tier system; good practice by well qualified professionals on one level, a level that will almost certainly cost the consumer more, and a cut price, budget approach provided by untrained practitioners with little consideration of risk and redress for complications on the other, lower, level."

CLWYD, A., (2014). **Self-regulation system: a recipe for exploitation.** *Journal of Aesthetic Nursing*, 3(1), pp.5–5. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=94352345&custid=ns010095.
The author reflects on the need for regulating the cosmetics industry in Great Britain with the failure of the self-regulation system. The author mentions the second 10-minute rule bill she introduced in 2013 to regulate the industry. She also applauds the recommendation of Sir Bruce Keogh that laser practitioners and aesthetic medicine be compulsary registrated in his review.

Great Britain. Department of Health, (2014). **Government response to the review of the regulation of cosmetic interventions**, London: Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf.
This paper outlines a range of measures already underway on which we are working with healthcare regulators and patient safety organisations to improve the quality of training and care provided by the industry to practitioners and patients. This is the beginning of a process in which we shall ensure proportionate and appropriate improvements in the industry to better protect the consumers and patients of tomorrow

Gunn E.G.M., Loh C.Y.Y., and Athanassopoulos T., (2014). **Cosmetic websites Scotland: Legal or lurid**. *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 67(8), pp.1144–1147. Available at: http://www.elsevier.com.
Background The provision of cosmetic interventions and their advertising have recently come under intense scrutiny in the wake of the PIP scandal and Keogh report. Aim A study of Scottish websites offering esthetic procedures was conducted to determine adherence to the advertising standards and regulations currently in place. Methods Regulations are provided by the Advertising Standards Authority, Committee on Advertising Practice, Independent Healthcare Advisory Services and General Medical Council. An Internet search was then conducted to search for providers of non-surgical and surgical cosmetic procedures. Results Overall 125 websites were reviewed. 109 local and 16 national with 17 websites associated with cosmetic surgeons. 26 websites failed to adhere to regulations. Failure was related to advertising of POM on the homepage or dropdown menu (20), offering enticements inappropriately (6). 26.6% of websites did not display qualifications of the practitioners. Only 16.6% of websites described the specific and the non-specific side effects of "anti-wrinkle injections" and only 12.5% mentioned alternative treatments. Conclusions The majority of websites reviewed adhered to current advertising standards. Plastic surgeons provide a small percentage of cosmetic procedures. Greater regulation at the point of product entry and of all esthetic practitioners is required. © 2014

Latham M., (2014). **"If it ain't broke, don't fix it?": scandals, "risk", and cosmetic surgery regulation in the UK and France**. *Medical law review*, 22(3), pp.384–408.
The recent PIP scandal that affected patients worldwide, and received extensive media coverage, led to concerns being felt by patients about the "risks" of cosmetic surgery. Theories about regulation and risk refer to societies such as those in the West becoming more risk averse. Regulation, in turn, has come to be seen as an instrument to solve a problem for a community seen to be or which perceives itself to be at risk. The political and electoral risk acknowledged by government if it ignores that concern, or at least media coverage of it, can lead to regulation, or the tightening up of regulation, as a response. This article looks at current proposals for legislation in the UK following the PIP silicone implant scandal as an example of the risk-regulation premise. Are cosmetic surgery patients in the UK now going to see stricter regulation of the cosmetic surgery industry? The article argues that the UK and France have both reacted to healthcare scandals and the ensuing societal conception of risk by drawing up more thorough legislation on cosmetic surgery than previously existed. France enacted the Kouchner law in 2002 and the UK government published the Keogh Report in April 2013. A comparison is made of these to establish whether the UK can learn from the French legislation when it comes to drafting actual regulation in the future, perhaps in 2014. Finally, some arguments are made about whether risk aversion may make better law.

Rufai S.R. and Davis C.R., (2014). **Aesthetic surgery and Google: Ubiquitous, unregulated and enticing websites for patients considering cosmetic surgery**. *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 67(5), pp.640–643.
Background Patient safety is a fundamental issue in aesthetic surgery. In an attempt to improve safety, the Department of Health (DoH) and Professor Sir Bruce Keogh published a review in 2013 of the regulation of cosmetic interventions. Proposals included: (1) Banning free consultations; (2) Restricting time-limited promotional deals; (3) Two-stage written pre-operative consent; (4) Consultations with a medical professional rather than a sales "consultant". The Cosmetic Surgical Practice Working Party (CSWP) recommended a two week 'cooling off' period before surgery. This study quantified compliance with the above national initiatives by aesthetic surgery providers in the UK. Methods To replicate a patient searching for aesthetic surgery providers, 'cosmetic surgery UK' was searched via Google. The top fifty websites of aesthetic surgery providers were included in the study. Websites were analysed for compliance with the DoH Keogh and CSWP recommendations. When clarification was required, aesthetic surgery providers were contacted via telephone. Pearson's Chi-squared test compared actual compliance with national recommendations of full compliance. Results Fifty cosmetic surgery providers in the UK entered the study. Consultations with the operating surgeon occurred in 90% of cases. Mean compliance with all parameters from the national guidelines was 41%, significantly less than the desired level of full compliance ($P < 0.001$). The majority offered free consultations (54%) and promotional deals (52%), of which 27% were time limited. No provider stipulated compliance with two stages of signed consent. Conclusion This study demonstrated low compliance with national guidelines for aesthetic surgery. Aggressive sales techniques and enticing offers by aesthetic surgery providers were widespread. Statutory government guidelines on aesthetic surgery and increased public awareness into potential risks from inappropriate cosmetic surgery may improve patient decision making and safety.

COLLIER, H., (2013). **Patients at risk of "butchery" by greedy, incompetent people.** *Journal of Aesthetic Nursing*, 2(6), pp.265–265. Available at:

https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=89560768&custid=ns010095.
The author reflects on a bill regulating cosmetic surgery introduced by Labour Minister of Parliament Ann Clwyd on July 17, 2012 which aims to establish minimum standards for the practice of cosmetic surgery including non-surgical procedures. She believes that the Bill generated more hope for the future of aesthetic medicine than the recommendations from Sir Bruce Keogh. She notes that Ann Clwyd's proposals were transparent and provided a direct pathway to regulation.

Anon, (2013a). **New recommendations to protect people who choose cosmetic surgery.** *Operating Theatre Journal*, (272), pp.3–3. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=87656434&custid=ns010095.
The article focuses on the new recommendations that were aimed at protecting people who choose to undergo cosmetic surgery have been released following a review led by National Health Service (NHS) Medical Director, Professor Sir Bruce Keogh. An independent review of cosmetic surgery recommends better regulation, better training and proper redress if things go wrong. It states that the review has assessed the current rules in England.

Anon, (2013b). **Spire Liverpool Hospital and surgeons welcome the governments recommendations for the regulation of the growing cosmetic surgery industry.** *Operating Theatre Journal*, (272), pp.4–4. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=87656439&custid=ns010095.
The article reports that Spire Liverpool Hospital, Great Britain has welcomed the study by the (National Health Service) NHS which reviews Great Britain's cosmetic surgery industry and the government's advocacy to establish a national implant register for cosmetic intervention providers.

Torjesen, I., (2013). **Cosmetic interventions need tighter controls to protect patients, review concludes**. *BMJ : British Medical Journal (Online)*, 346. Available at: https://www.proquest.com/scholarly-journals/cosmetic-interventions-need-tighter-controls/docview/1973434417/se-2?accountid=31583.
The review's final report said that production of dermal fillers should be subject to the same controls as other implants to ensure that only those that had passed rigorous safety tests were available and that only practitioners who were properly trained and regulated could administer them. 3 Currently dermal fillers fall under the general product and safety regulations part of the European Union's directive on product safety, which covers products such as toothbrushes and electric plugs. The review said that all people who carry out cosmetic procedures should have to have indemnity insurance to compensate patients if procedures go wrong and that the sector should establish risk pool arrangements, similar to that of the Association of British Travel Agents, to cover product failures, companies going out of business, and certain complications of surgery. [...]the review stopped short of calling for a ban on advertising of cosmetic surgery, as has been advocated by the British Association of Aesthetic Plastic Surgeons, 4 but said that restrictions and rules needed to be revised to ensure that advertising and marketing were "responsible."

DEVAN, N., (2013). **Regulation in aesthetics has to start somewhere.** *Journal of Aesthetic Nursing*, 2(2), pp.103–103. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=87646399&custid=ns010095.
The author comments on developments related to government regulation of medical aesthetics as of March 2013. Health professionals specialising in medical aesthetics have called for closer regulation of their profession. Background is presented on the British Department of Health's review into the safety

and quality of surgical and non-surgical cosmetic procedures in the country. The House of Commons will hold the second reading of the Cosmetic Surgery Bill 2012-13 on March 1, 2013.

Mercer, N., (2013). **What has happened to clinical risk in aesthetic surgery since 2009?** *Clinical Risk*, 19(2), pp.34–36. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=104161330&custid=ns010095.

Wise, J., (2013). **Surgeons set new standards for cosmetic treatments**. *BMJ : British Medical Journal (Online)*, 346. Available at: https://www.proquest.com/scholarly-journals/surgeons-set-new-standards-cosmetic-treatments/docview/1945792888/se-2?accountid=31583.
The college has produced new guidelines, Professional Standards for Cosmetic Practice, 1 in the wake of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) in 2010, 2 which exposed a lack of consistent professional standards in the field of cosmetic practice. Only qualified medical doctors who have done postgraduate surgical training should do invasive procedures such as breast surgery or liposuction Practitioners should not imply that a patient will feel better or look nicer after treatment but should use straightforward terms such as bigger or smaller Any guidance should use either accurate diagrams or photographs of real patients, not models or airbrushed photographs There should be a cooling-off period of at least two weeks between the initial consultation and any invasive surgical procedure There should be no financial inducements, such as time limited special offers, which may speed up a patient's decision to have a procedure Cosmetic practice should be done only in licensed premises with resuscitation equipment readily available. A Department of Health spokesperson said: "The report from the Royal College of Surgeons is timely as NHS medical director Sir Bruce Keogh is currently carrying out a review into regulation of cosmetic interventions, including cosmetic surgery.

Anon, (2013c). **COSMETIC SURGERY INDUSTRY IN NEED OF RIGOROUS REGULATION.** *Nursing Standard*, 27(19), pp.10–10. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=84738624&custid=ns010095.
Tougher regulation is needed to ensure nurses in the cosmetics industry are trained adequately and meet nationally set standards for providing treatments, experts have warned.

Anon, (2013d). **CALLS TO CURB SURGERY SALES TECHNIQUES.** *Operating Theatre Journal*, (268), pp.10–10. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=85820914&custid=ns010095.
The article focuses on the findings an interim report published by National Health Service (NHS) medical director Bruce Keoghs on December 31, 2012, which found that respondents want to see tighter restrictions in the cosmetic surgery industry in Great Britain.

Great Britain. Department of Health ed , (2013). **Review of the regulations of cosmetic interventions : : final report.**, London : DH,. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf.

Martindale, V., (2013). **The PIP scandal : : an analysis of the process of quality control that failed to safeguard women from the health risks**, Available at: http://jrs.sagepub.com/content/106/5/173.full.
Plastic surgery is a sector of medicine that continues to show strong trends in growth. In 2011, women accounted for 90% of all procedures, with breast augmentation being the most common. There are estimated to be a total of 130,000 women in the UK who have received breast implants and around 47,000 of these were silicone implants manufactured by the French-based company Poly Implant Prothèse (PIP).

Following the misuse by PIP of industrial grade silicone, an expert panel, chaired by Sir Bruce Keogh, was appointed by the Department of Health to investigate the consequences of this scandal. They concluded in their final report of June 2012 that 'PIP implants have not shown any evidence of significant risk to human health'. We disagree with their conclusion. Here we aim to share our concerns on the regulatory and quality control procedures that failed to safeguard thousands of women from the health risks associated with PIP breast implants. In light of the current ongoing review into cosmetic surgery which is also being led by Sir Bruce Keogh, it is vital that such failings are identified and tightened to ensure such a scandal is not repeated. [Introduction]

Bunker, C. and Griffiths, T., (2012a). **Non-surgical invasive procedures such as dermal fillers should also be regulated**. *BMJ : British Medical Journal (Online)*, 345. Available at: https://www.proquest.com/scholarly-journals/non-surgical-invasive-procedures-such-as-dermal/docview/1945326628/se-2?accountid=31583.
Dermal filler injections are an invasive medical procedure; the cosmetic indication does not obviate the inherent procedural risks. (7 November.) 2 Fatah F. Should all advertising of cosmetic surgery be banned?

Fatah, F., (2012). **Should all advertising of cosmetic surgery be banned? Yes**. *BMJ : British Medical Journal (Online)*, 345. Available at: https://www.proquest.com/scholarly-journals/should-all-advertising-cosmetic-surgery-be-banned/docview/1945314220/se-2?accountid=31583.
After the recent breast implant debacle, the Department of Health is reviewing cosmetic procedures in the UK, including advertising to the public. Fazel Fatah says advertising preys on patients' vulnerability and should be banned, but Sally Taber thinks regulation can give sufficient protection

Taber, S., (2012). **Should all advertising of cosmetic surgery be banned? No**. *BMJ : British Medical Journal (Online)*, 345. Available at: https://www.proquest.com/scholarly-journals/should-all-advertising-cosmetic-surgery-be-banned/docview/1945318135/se-2?accountid=31583.
After the recent breast implant debacle, the Department of Health is reviewing cosmetic procedures in the UK, including advertising to the public. Fazel Fatah says advertising preys on patients' vulnerability and should be banned (doi: 10.1136/bmj.e7489), but Sally Taber thinks regulation can give sufficient protection

O'Dowd, A., (2012a). **Government considers a national implant register in review of cosmetic procedures**. *BMJ : British Medical Journal (Online)*, 345. Available at: https://www.proquest.com/scholarly-journals/government-considers-national-implant-register/docview/1945286055/se-2?accountid=31583.
Around 47000 women in the UK are thought to have received the former French manufacturer Poly Implant Prosthèse (PIP) breast implants, which were found to contain non-medical grade silicone, prompting concerns about their safety.2 3 As part of the response to the scandal, health secretary Andrew Lansley has called for this new review, to be led by England's NHS medical director, Bruce Keogh and an expert panel that will look at the best way to protect patients having cosmetic interventions. Cosmetic surgery interventions have increased over the last decade, and non-surgical cosmetic interventions, such as botulinum toxin injections (for example, Botox) and injectable dermal fillers, are part of the UK cosmetic interventions industry estimated to be worth £2.3bn (€2.94bn; $3.6bn) in 2010. Patient safety charity, Action against Medical Accidents, welcomed the call for evidence, but its chief executive Peter Walsh said: "The review must not dodge the central issue of the need to better protect patients through statutory regulation."

Davies, E., (2012). **Training in aesthetic nursing: are you ticking all the right boxes?** *Journal of Aesthetic Nursing*, 1(1), pp.48–51. Available at: https://www.proquest.com/scholarly-journals/training-aesthetic-nursing-are-you-ticking-all/docview/1440668227/se-2?accountid=31583.

In the current climate, it is essential that official bodies such as the Royal College of Nursing and the Medicines and Healthcare Products Regulatory Agency invest in the training of aesthetic nurses. Not only must these organisations support education and training, but product manufacturers are also advised to take responsibility for raising standards in aesthetic medicine. In this article, the author provides an overview of the current status of education and training, and outlines the topics that should ideally be included in every course. The author also discusses the need for improvement in these courses and how that might best be achieved. 3 references

Torjesen, I., (2012). **Device regulator is told to improve its safety monitoring after breast implant debacle**. *BMJ : British Medical Journal (Online)*, 344. Available at: https://www.proquest.com/scholarly-journals/device-regulator-is-told-improve-safety/docview/1945188634/se-2?accountid=31583.
A government review has concluded that the UK regulator of medical devices, the Medicines and Healthcare Products Regulatory Agency (MHRA), acted "reasonably" in communicating to the public safety issues related to breast implants made by the French company Poly Implant Prothèse (PIP). The review was ordered by the health secretary for England, Andrew Lansley, in January, when it became clear that more than 40000 UK women had been fitted with the defective implants, which had fraudulently been filled with non-medical grade silicone. 1 Although the review, conducted by the health minister Earl Howe, exonerates the actions of the MHRA and the Department of Health, it says that both organisations need to learn lessons, particularly in how to communicate information promptly and appropriately to affected individuals, the medical profession, the public, and the press. 2 Although the MHRA was found to have followed clinical and scientific advice, the minister said, "There is room for improvement in the operation of the MHRA and the regulation of medical devices." Earl Howe's review was published alongside the government's response 5 to the recent report of the parliamentary health select committee on the defective PIP implants, which found that the actions of the MHRA and the health department in publicising the problem were "inadequate" and called on the government to allow the NHS to replace as well as remove defective implants in patients who had them inserted privately. 6 The government's response says that some of the committee's criticisms have been dealt with in Earl Howe's report and that others, such as its call for a compulsory register of patients who have had implants fitted to help monitor problems and trace people affected, would be picked up by an ongoing review by the NHS's medical director, Bruce Keogh, on the regulation of cosmetic interventions. 1 1 O'Dowd A. England's health secretary orders three new inquiries into safety of cosmetic surgery and devices.

Santry, C., (2012). **Regulator to be measured on care outcomes**. *The Health Service Journal*, 122(6293), pp.12–13. Available at: https://www.proquest.com/trade-journals/regulator-be-measured-on-care-outcomes/docview/1039547720/se-2?accountid=31583.

O'Dowd, A., (2012b). **Surgeons' leaders call for ban on cosmetic surgery advertising**. *BMJ : British Medical Journal (Online)*, 344. Available at: https://www.proquest.com/scholarly-journals/surgeons-leaders-call-ban-on-cosmetic-surgery/docview/1945213526/se-2?accountid=31583.
The British Association of Aesthetic Plastic Surgeons published a six point plan on 23 January in which it called for steps to be taken to improve the regulation of the cosmetic industry and to protect patients' interests. The move comes after recent concerns over possible rupturing of breast implants made by the former French company Poly Implant Prosthèse (PIP)-which closed after it emerged that it had used non-medical grade silicone-and how these could affect the 40000 woman in the United Kingdom who have these implants. In its proposals the British Association of Aesthetic Plastic Surgeons called for a ban on all advertising of cosmetic surgery and mandatory annual checks on all plastic surgeons as part of their revalidation to continue practising.

Radcliffe, M., (2012). **"NHS shouldn't be safety net for irresponsible cosmetic clinics": NT**. *Nursing Times*, 108(4), p.9. Available at: https://www.proquest.com/magazines/nhs-shouldnt-be-safety-net-irresponsible-cosmetic/docview/1038836220/se-2?accountid=31583.

Which inevitably leads us to the issue of breast implants and the reluctance of some private cosmetic clinics to replace the ones they accepted money to put in, despite the fact that they have since proved to be substandard. [...]you've already got air conditioning."

O'Dowd, A., (2012c). **UK launches inquiry into safety of PIP breast implants**. *BMJ : British Medical Journal (Online)*, 344. Available at: https://www.proquest.com/scholarly-journals/uk-launches-inquiry-into-safety-pip-breast/docview/1945162829/se-2?accountid=31583.
Leaders in the field of plastic surgery have, however, called for all PIP implants to be removed, and continuing speculation has prompted the Department of Health for England to launch a review of all the scientific evidence available on their safety, which is being led by Bruce Keogh, medical director of the NHS in England. Media reports that the private Transform cosmetic surgery clinic had said that the rate of implant ruptures among UK women was as high as 7% have been rejected by Transform as taken out of context, and the Medicines and Healthcare Products Regulatory Agency has said that a 1% rupture rate is more likely. Fazel Fatah, president of the British Association of Aesthetic Plastic Surgeons, said, "We believe there is a moral and ethical obligation on the clinics who performed these operations in the first place to facilitate the removal of the faulty implants for free or at the bare minimum cost."

O'Dowd, A., (2012d). **England's health secretary orders three new inquiries into safety of cosmetic surgery and devices.** *BMJ: British Medical Journal (Clinical Research Edition)*, 344, pp.e388–e388. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=107819300&custid=ns010095.

Bunker, C. and Griffiths, T., (2012b). **Regulate non-surgical invasive procedures as well.** *BMJ: British Medical Journal*, 345(7885), pp.31–31. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=86865533&custid=ns010095.
The article reports that the British Association of Dermatologists emphasize on controlled and limited advertising of cosmetic surgery, and mentioned are the adverse effects of the surgery such as necrosis, granuloma formation, and blindness.

Curzon, F., 7th Earl Howe, (2012). **Poly Implant Prothèse (PIP) silicone breast implants : : review of the actions of the Medicines and Healthcare products Regulatory Agency (MHRA) and the Department of Health** Great Britain. Department of Health, ed., London : DH,. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134043.pdf.

Great Britain. Department of Health ed , (2012a). **Review of the regulations of cosmetic interventions : : summary of the responses to the call for evidence.**, London : DH,. Available at: https://www.wp.dh.gov.uk/publications/files/2012/12/Call-for-evidence-summary-report.pdf.

Great Britain. Department of Health, (2012b). **The government's response to the House of Commons Health Committee : : sixteenth report of session 2010-12 : PIP breast implants and regulation of cosmetic interventions**, London: Stationery Office. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134042.pdf.

Great Britain. Parliament. House of Commons. Health Committee and Dorrell, S., (2012). **PIP breast implants and regulation of cosmetic interventions : : sixteenth report of session 2010-12 : report, together with formal minutes and oral and written evidence**, London: Stationery Office. Available at: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1816/1816.pdf.

Kennedy A., (2012). **Regulating bodily integrity: cosmetic surgery and voluntary limb amputation**. *Journal of law and medicine*, 20(2), pp.350–362.
Cosmetic surgery and voluntary limb amputation share a number of features. Both procedures are patient-driven forms of body shaping that can only be performed by surgeons, and therefore the procedures require the imprimatur of the medical profession to be lawful. Both invoke identity construction as a central legitimating factor that renders the procedures therapeutic. The legal regulation of surgery is subsumed within general principles regulating medical practice, where autonomy and consent are constituted as fundamental authorising principles. The legitimacy of consent to surgical intervention operates unevenly in relation to these two forms of surgery. Amputation of healthy limbs is presumed to be non-therapeutic. Capacity is closely interrogated and minutely scrutinised. Consent to cosmetic surgery, by contrast, is presumed to be a valid expression of autonomy and self-determination.

McHale J.V., (2012). **Regulating cosmetic surgery: A scalpel where it is needed**. *British Journal of Nursing*, 21(3), pp.190–191. Available at: http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=89674;article=BJN_21_3_190_191;format=pdf.
This paper considers the recent controversies around the regulation of cosmetic surgery procedures. The author suggests that any review considering reform of the law in this area should not only look at issues concerning the safety of the procedures and competence of the practitioners, but should also address the question of which procedures should be allowed. In particular, the author advocates that there should be a review as to the whether cosmetic procedures should be made available to those under the age of 18 years. The paper also discusses analogous legislation in Queensland, Australia and explores whether this could be a useful model for legislative reform.

Naughton, L., (2012). **Implanting fear: cosmetic surgery complications in primary care.** *Nursing in Practice*, (65), pp.18–19. Available at: https://www.proquest.com/scholarly-journals/implanting-fear-cosmetic-surgery-complications/docview/1019612317/se-2?accountid=31583.
Impact on general practice of complications caused by private cosmetic surgery. Complications and long-term risks of breast augmentation, eyelid surgery and abdominoplasty, the 3 most common cosmetic surgery procedures in the UK, are described. Advice is provided on what practice nurses can do and when they should refer patients to cosmetic surgeons and A&E. Cosmetic surgery regulation and the creation of a database for all medical devices fitted in private clinics, to be shared with the NHS, are discussed. 0 references

Spatafora F., Argo A., and Campisi G., (2012). **The role of the dentist in aesthetic medicine: Rules and indications**. *Dental Cadmos*, 80(6), pp.301–318.
Objectives: The aim of this paper is to evaluate the roles played by dentistry graduates in Aesthetic Medicine interventions involving the face and the lips and to analyze age-related esthetic changes in the perioral structures. Material(s) and Method(s): We briefly review the treatments in which dentists are involved, including the injection of fillers or botulinum toxin, and the professional liability and insurance issues related to these interventions. Result(s) and Conclusion(s): In the last decade, there have been dramatic increase in both the supply and demand for Aesthetic Medicine interventions involving the face and the lips, but clear laws regulating the roles of dentists in this professional activity are lacking. In response to this situation, the presidency of the Italian Board of Dentists Board expressed its opinion on the lawfulness of such treatment by dentists in June 2010. The authors maintain that individuals holding graduate degrees in dentistry and prosthodontics from Italian universities are competent to perform Aesthetic Medicine treatments within the limits prescribed by the current law. © 2011 Elsevier Srl.

Shepelavy, R.P., (2011). **Nip/tuck nightmare: who's holding the knife?** *Health*, 25(8), pp.120–162. Available at:

https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=104694295&custid=ns010095.

Legido-Quigley, H., Passarani, I., Knai, C., Busse, R., Palm, W., Wismar, M. and McKee, M., (2011). **Cross-border healthcare in the European Union: clarifying patients' rights**. *BMJ : British Medical Journal (Online)*, 342. Available at: https://www.proquest.com/scholarly-journals/cross-border-healthcare-european-union-clarifying/docview/1910776965/se-2?accountid=31583.
The adoption of a new directive on cross-border healthcare in Europe could bring clarity for patients, health professionals, and policy makers, as well as raising awareness of how healthcare differs between EU member states, say Helena Legido-Quigley and colleagues

Gilmartin J., (2011). **Contemporary cosmetic surgery: The potential risks and relevance for practice**. *Journal of Clinical Nursing*, 20(13-14), pp.1801-1809. Available at: http://www.blackwellpublishing.com/journal.asp?ref=0962-1067.
Aims and objectives. To examine and critique the risks of cosmetic surgery and consider implications for practice. Background. Cosmetic surgery is a growing industry with a significant global phenomenon. Feminists have been critical of aesthetic surgery practice, offering a range of representations in regard to "identity", "normality", "cultural and social pressures", "agency" and "self-enhancement". Discourses around minimising risk information acknowledge deficits in not supplying patients with full risk information. The results are usually devastating and lead to serious health complications that incisively diminish well-being for patients and increase health costs. Design. Critical review. Method. This paper represents a critical review of risks associated with cosmetic surgery. A Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System online (Medline) and British Nursing Index (BNI) search with relevant key words were undertaken and selected exemplary articles and research describing and/or evaluating cosmetic surgery risk. Only papers in the English language from 1982-2009 were reviewed. The papers examined were mainly empirical studies; some opinion papers, policy documents, textbooks and websites were examined too. Conclusion. The literature revealed that several factors influence consumer risks including regulation vagaries, medicalisation processes, fear of ageing discrimination, wanting to avoid ethnic prejudice and media pressure. Government strategies in the United Kingdom (UK) have attempted to improve clinical standards; however, little attempt has been made globally to raise institutional and professional awareness of the huge impact of cultural and social pressures on consumers. Relevance to clinical practice. Avoiding shattering complications by improving the provision of risk information for patients is a worthwhile goal. Therefore, health professionals need to consider consumer rights and autonomy more carefully, facilitate rigorous screening and develop knowledge in regard to relational autonomy and alternative interventions. © 2010 Blackwell Publishing Ltd.

Kmietowicz, Z., (2010a). **UK cosmetic surgeons lack training, says report**. *BMJ : British Medical Journal (Online)*, 341. Available at: https://www.proquest.com/scholarly-journals/uk-cosmetic-surgeons-lack-training-says-report/docview/1909599873/se-2?accountid=31583.
Many surgeons in the United Kingdom who carry out cosmetic procedures are not getting enough training, says a report from the National Confidential Enquiry into Patient Outcome and Death. Alex Goodwin, the inquiry's clinical coordinator and a consultant in anaesthesia and intensive care at the Royal United Hospital in Bath, said, "Cosmetic surgery is far too dispersed, with too many teams prepared to "have a go" at procedures that they rarely perform. The inquiry also...

Kmietowicz, Z., (2010b). **Scheme to register Botox clinics is criticised for "lacking teeth."** *BMJ : British Medical Journal (Online)*, 341. Available at: https://www.proquest.com/scholarly-journals/scheme-register-botox-clinics-is-criticised/docview/1909600382/se-2?accountid=31583.
Surgeons have called for the scrapping of a scheme designed to offer some protection against unscrupulous practices among clinics and beauty parlours that provide cosmetic injectable treatments,

such as botulinum toxin and cosmetic fillers. The government has asked the cosmetic industry's trade association, the Independent Healthcare Advisory Services, to set up a register of providers of injectable cosmetics to ensure standards of safety. The charity is concerned that the previous Labour government did not act...

Panetta, E., (2010). **Cosmetic surgery regulation: CMAJ**. *Canadian Medical Association. Journal*, 182(10), p.1. Available at: https://www.proquest.com/scholarly-journals/cosmetic-surgery-regulation/docview/612696244/se-2?accountid=31583.
In April, the college was granted the authority "to assess physicians who perform anesthetic-related procedures in prescribed premises, and to inspect the premises to ensure that patients are receiving quality care that is provided safely" (www.cpso.on.ca/whatsnew /news/default.aspx?id=4046). "This regulation gives the College the authority to help ensure that patients who undergo procedures are receiving quality care in compliance with the proper standards," Dr. Jack Mandel, the college's president, said in a news release. - Emily Panetta, Ottawa, Ont.

Camp, M.C., Wong, W.W., Wong, R.Y., Camp, J.S., Son, A.K. and Gupta, S.C., (2010). **Who is providing aesthetic surgery? A detailed examination of the geographic distribution and training backgrounds of cosmetic practitioners in Southern California.** *Plastic and reconstructive surgery*, 125(4), pp.1257–1262. Available at:
https://journals.lww.com/plasreconsurg/fulltext/2010/04000/who_is_providing_aesthetic_surgery__a_detailed.29.aspx.
BACKGROUND: In recent years, there has been a significant increase in the number of non-plastic surgeons performing cosmetic procedures. This has the potential to have an impact on the plastic surgery practitioner by increasing competition and bringing into question the assurance of patient safety. In this study, a demographic analysis was performed of providers of invasive and minimally invasive cosmetic treatments in the Southern California region., METHODS: Providers of minimally invasive aesthetic procedures were catalogued using the sales lists from the manufacturers of the hyaluronic acid fillers Juvederm and Restylane. The data set was further analyzed to enumerate the providers of surgical treatments, with a focus on the provision of liposuction. Data were analyzed using Environmental Systems Research Institute ArcGIS to focus on the Southern California area. Physician board certification and training background were detailed exhaustively., RESULTS: In the 45,238-square mile area encompassing the San Diego/Los Angeles megalopolis, there are 1867 cosmetic practitioners offering hyaluronic acid injections. Of this number, 495 are trained in plastic surgery. In the same geographic region, there are 834 individuals offering liposuction. Practitioners are concentrated in downtown Los Angeles and San Diego, where the potential patient-to-provider ratios are 1088:1 and 1185:1, respectively. Interestingly, primary care physicians comprise the third largest group providing hyaluronic acid fillers and the fourth largest group of liposuction providers., CONCLUSIONS: The authors' data demonstrate that there are numerous non-plastic surgeons performing cosmetic procedures, especially in the field of minimally invasive therapies. In addition, there is a growing contingent of non-surgery-trained individuals providing surgical cosmetic treatments, especially liposuction.

Goodwin, A.P.L., Martin, I.C. and Shotton, H., (2010). **On the face of it : : a review of the organisational structures surrounding the practice of cosmetic surgery** National Confidential Enquiry into Patient Outcome and Death, ed., London: NCEPOD. Available at:
http://www.ncepod.org.uk/2010report2/downloads/CS_report.pdf.

Latham M., (2010). **A poor prognosis for autonomy: Self-regulated cosmetic surgery in the United Kingdom**. *Reproductive Health Matters*, 18(35), pp.47–55. Available at:
https://www.elsevier.com/locate/issn/0968-8080.
In recent years, cosmetic surgery in the United Kingdom, which is provided almost entirely by the private sector, has gained in popularity despite evidence of its potential risks to patients. Over 32,000 procedures

were reported by one association of cosmetic surgeons alone in 2007, three times more than in 2003. This article examines the regulation of cosmetic surgery in the UK, in light of the need for informed consent and the importance of patient autonomy. Since 2000, the government has attempted through legislation covering all health care provision to regulate cosmetic surgeons' qualifications, patient rights to information, and the inspection and registration of premises. However, the risk to patients from unregistered and poorly qualified surgeons, and from private clinics with a poor quality of care, has still not been adequately addressed. Moreover, ensuring informed consent and the maintenance of standards has been left to professional self-regulation. An independent, government-funded umbrella organisation with lay representation and sufficient powers of registration and inspection of all relevant cosmetic surgery practitioners is needed to fully protect patients, and should have its roots in specific legislation governing cosmetic surgery. © 2010 Reproductive Health Matters.

Mercer N, (2009). **Clinical risk in aesthetic surgery.** *Clinical Risk*, 15(6), pp.215–217. Available at: https://journals.sagepub.com/doi/10.1258/cr.2009.090043.
The authors of the invited articles in this issue of Clinical Risk were given a broad remit to enable them to explore 'clinical risk' as it applies to their practice, expertise and healthcare system in relation to aesthetic surgery. Like it or not, we live in a 'globalized' world in which patients have endless information easily available via the Internet, broadcast and printed media, as well as from advertising in all its forms. In addition, travel is easier now than ever before and few countries are 'out of bounds', and patients who can afford cosmetic surgery, can afford to travel. Cosmetic surgery and treatments are not covered by any healthcare, or insurance, system in the world but consumer demand for cosmetic procedures has increased dramatically over the last 20 years, slowing only as the 'crunch' started in 2007. As a direct result, market forces have been allowed to work with even less regulation than in the financial markets.

Slack R, (2009). **Aesthetic surgery and regulatory risk for doctors.** *Clinical Risk*, 15(6), pp.218–220. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=105253554&custid=ns010095.
The regulatory framework, in which all doctors work, is governed by the General Medical Council (GMC) in the United Kingdom. This article highlights areas of risk by reference to GMC publications and rulings, which can lead to doctors working in aesthetic surgery, coming under their scrutiny, and how best to avoid that event.

Nahai F and Nahai, F., (2009). **Patient safety: time for government to step up to the plate.** *Aesthetic Surgery Journal*, 29(5), pp.443–445. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=105230561&custid=ns010095.

Scott K, (2009). **Under the knife: an analysis of the Medical Council of New Zealand's Statement on Cosmetic Procedures.** *Journal of Law & Medicine*, 16(4), pp.625–652. Available at: https://pubmed.ncbi.nlm.nih.gov/19297871/.
The lack of regulation in the field of appearance medicine has long been a cause for concern in New Zealand. As an industry, it has fallen outside the protective ambit of the regulatory framework that governs all other areas of medicine. This article examines the Medical Council of New Zealand's attempt to address some of the concerns that have existed by producing a Statement on Cosmetic Procedures. The author concludes that this statement goes a long way towards better ensuring consumer safety and wellbeing in this area. It also offers valuable guidance to practitioners in the areas of advertising and promotion, obtaining consent and providing care. The author does, however, propose and discuss several possible changes that could be made to improve the statement that has been produced.

Anon, (2009). **[Aesthetic surgery.]**,
This issue of Clinical Risk contains the following articles concerning clinical risk and cosmetic surgery: Aesthetic surgery and regulatory risk for doctors, Robert Slack, pages 218-220; Managing risk to reputation, Magnus Boyd, pages 221-223; France sets standards for practice of aesthetic surgery, Alain Fogli, pages 224-226; Clinical risk in cosmetic surgery, Eileen Bradbury, pages 227-231; Minimizing risk in aesthetic surgery, Foad Nahai, pages 232-236; Risk reduction in cosmetic surgery, Christopher Khoo, pages 237-240; and Improving the safety of aesthetic surgery : recommendations following a 14-year review of cases referred to the Medical Defence Union from across the United Kingdom (1990–2004), Rajiv Grover, pages 241- 243. [KJ]

Fogli A., (2009). **France sets standards for practice of aesthetic surgery**. *Clinical Risk*, 15(6), pp.224–226. Available at: http://cr.rsmjournals.com/cgi/reprint/15/6/224.
Dr Alain Fogli is a member of the ISAPS Specialty Promotion Committee and ISAPS National Secretary for France. Dr Fogli has been Chairman of the Board of Directors of the Syndicate of Plastic Surgery in France for over five years. The National Syndicate is a National Union whose purpose is to protect the specialty and the Syndicate has an official spokesperson for the Government. Members of the Board of Directors are elected by French plastic surgeons. The changes initiated in France were in response to extensive publicity about cosmetic surgery that drew attention to the lack of traditional safeguards for patients. It became necessary for the Government to learn more about the field of cosmetic surgery, including its financial and safety aspects. The Government initiated an inquiry and the Syndicate was subsequently invited to participate in the writing new regulations. Dr Fogli and Dr Hepner met with the Health Minister to assist in formulating the regulations and the final proposition was put to Parliament and passed into Law. The regulations are also designed to monitor the practice of cosmetic surgery and to avoid possible abuse.

Anonymous, (2008a). **Aesthetic medicine practitioners want government regulation of the industry**. *Nursing Standard (through 2013)*, 23(3), p.11. Available at: https://www.proquest.com/scholarly-journals/aesthetic-medicine-practitioners-want-government/docview/219867358/se-2?accountid=31583.
Nurses have rejected government plans to introduce self-regulation for injectable cosmetic treatments later this year. A voluntary se lf-regulatory model for the industry, including a set of standards and quality mark, is being drawn up by the Independent Healthcare Advisory Services and is expected to be finalised before the end of the year. But nurses at the RCN forum for nurses working in aesthetic medicine annual conference in London this month snubbed the plan and said they wanted the government to introduce legislation instead.

Anonymous, (2008b). **Policing cosmetic surgery: CMAJ**. *Canadian Medical Association. Journal*, 178(11), p.1412. Available at: https://www.proquest.com/scholarly-journals/policing-cosmetic-surgery/docview/205053748/se-2?accountid=31583.
General practitioners in Ontario will be prohibited from declaring that they are ?cosmetic surgeons? or advertising that they have such capabilities, under new regulations adopted by the College of Physicians and Surgeons of Ontario. In the wake of extended controversy over the lack of integrity in the regulation and licensing of cosmetic and aesthetic surgery (CMAJ2008;178[3]:274- 5), the College adopted new regulatory amendments on Apr. 10, 2008, that will require ?physicians to be clear and accurate about their credentials and training in their advertising and other communications with patients.?

Lett, D., (2008). **The search for integrity in the cosmetic surgery market: CMAJ**. *Canadian Medical Association. Journal*, 178(3), pp.274–5. Available at: https://www.proquest.com/scholarly-journals/search-integrity-cosmetic-surgery-market/docview/204823504/se-2?accountid=31583.
Dr. Gordon Wilkes, president of the Canadian Society of Plastic Surgeons, says most so-called “cosmetic surgery” procedures are actually extensions of complex reconstructive surgery that plastic surgeons train for years to perfect. Despite this, aggressive advertising by cosmetic surgeons attempts to convince

prospective patients that procedures are simple and risk free. "There is no integrity in the market-place," Wilkes says. "The public confuses cosmetic surgery with plastic surgery. And the term cosmetic surgery is thrown around a lot despite the fact it is not a term that has a lot of integrity for licensing and accreditation bodies." The Australian Society of Plastic Surgeons lashed out in December 2007 at a group of self-described cosmetic surgeons advertising half-price liposuction to patients willing to act as "live guinea pigs" for liposuction trainees, many of whom have no experience as surgeons. Society President Dr. Howard Webster acknowledged that in Australia right now, "any [general practitioner] can call themselves a cosmetic surgeon."

Lett D and Lett, D., (2008). **The search for integrity in the cosmetic surgery market.** *Canadian Medical Association Journal (CMAJ)*, 178(3), pp.274–275. Available at: https://www.cmaj.ca/content/178/3/274. The death of a Toronto woman from complications following liposuction has prompted Ontario to undertake a wholesale review of the regulation of cosmetic and aesthetic surgery, and sparked a national debate over which physicians should be allowed to perform invasive procedures.

Latham M., (2008). **The shape of things to come: Feminism, regulation and cosmetic surgery**. *Medical Law Review*, 16(3), pp.437–457. Available at: https://academic.oup.com/medlaw/article-abstract/16/3/437/1007997.
This article offers a critique of the regulation of cosmetic surgery in England and Wales in the case of competent adults. It draws on the arguments of feminist scholars in order to assess the current scheme of regulation. Feminists have generally been critical of cosmetic surgery practices. Some are particularly critical of the effects of a culture which encourages women to subject themselves to surgery in the name of beauty, and see cosmetic surgery as extremely harmful to women.1 Others argue that cosmetic surgery patients are able to demonstrate agency and rationality and be self-governing in their treatment decisions. This article offers a third way between these apparently irreconcilable positions: a synthesis of feminist concerns about the effects of culture, and of liberal preoccupations with agency, through the autonomy- enhancing conditions of relational autonomy. Such a perspective would seek ways to enable women to better negotiate the effects of culture by placing a greater emphasis on constructive dialogue, counselling and fully informed consent.2 This may suggest ways to improve the regulation of cosmetic surgery currently in place in England and Wales.

Anonymous, (2007). **Remote prescribing of Botox continues against NMC advice**. *Nursing Standard (through 2013)*, 22(13), p.7. Available at: https://www.proquest.com/scholarly-journals/remote-prescribing-botox-continues-against-nmc/docview/219844991/se-2?accountid=31583.

Snow, T., (2007). **Nurses told to stop giving Botox under group directions**. *Nursing Standard (through 2013)*, 22(5), p.11. Available at: https://www.proquest.com/scholarly-journals/nurses-told-stop-giving-botox-under-group/docview/219846379/se-2?accountid=31583.

Keng Boon Harold Tan, (2007). **Aesthetic medicine: a health regulator's perspective**. *Clinical Governance*, 12(1), p.13. Available at: https://www.proquest.com/scholarly-journals/aesthetic-medicine-health-regulators-perspective/docview/208457198/se-2?accountid=31583.
The purpose of this paper is to help understand the extent of regulation of aesthetic medicine in various developed countries and to discuss the current pitfalls and potential strategies in regulating this area of healthcare. A range of published articles and press reports from bound and internet sources on aesthetic medicine in the recent five to six years were obtained to allow a better understanding of existing practices and regulatory climate. Reports from relevant authorities in various countries were also referred to for information on proposed regulatory regimes and future regulatory directions. The practice of aesthetic medicine has been marginally regulated, even in more highly developed countries. The main regulatory concern appears to be the practice of minimally invasive aesthetic surgery by general practitioners. Professional voluntary self-regulation would probably not be effective in view of the

peculiar nature of aesthetic medicine vis-à-vis conventional medicine. There is a need for health regulatory bodies across the world to brace themselves for potentially more widespread health and social risks posed by aesthetic medicine. Statutory governance is needed to maintain safe practice standards and to manage the supply and demand of aesthetic services. In less developed countries, there is a need for better public education and empowerment to enable patients to make better-informed decisions and assume greater responsibility for the aesthetic services that they seek. This paper discusses regulatory issues concerning aesthetic medicine which are rarely featured in academic journals. It offers some strategies for better regulation of aesthetic medicine which health authorities in certain countries may find useful.

Parker R., (2007). **Cosmetic surgery in Australia: a risky business?** *Journal of law and medicine*, 15(1), pp.14–18.
Cosmetic surgery is increasing in popularity in Australia and New Zealand, as it is across other Western countries. However, there is no systematic mechanism for gathering data about cosmetic surgery, nor about the outcomes of that surgery. This column argues that the business of cosmetic surgery in Australia has questionable marketing standards, is conducted with little scrutiny or accountability and offers patients imperfect knowledge about cosmetic procedures. It also argues that while medical practitioners debate among themselves over who should carry out cosmetic procedures, little attention has been paid to questionable advertising in the industry and even less to highlighting the real risks of undergoing cosmetic surgery. While consumers are led to believe that cosmetic surgery is accessible, affordable and safe, they are sheltered from the reality of invasive and risky surgery and from the ability to clearly discern that all cosmetic procedures carry risk. While doctors continue to undertake advertising and engage in a territorial war, they fail to address the really important issues in cosmetic surgery. These are: providing real evidence about what happens in the industry, developing stringent regulations under which the industry should operate and ensuring that all patients considering cosmetic surgery are fully informed as to the risks of that surgery.

Smith Jr. S.P. and Williams III E.F., (2007). **The Delivery of Aesthetic Medicine: Illegal or Not?** *Facial Plastic Surgery Clinics of North America*, 15(2), pp.265–271.
The field of aesthetic facial surgery is dynamic and may be driven by new technology and market trends. It is important that we respond to these pressures as small business persons, but only in the context of our obligations to our state regulatory boards, the Hippocratic Oath, and our patients' best interests. Regulations with regard to the scope of practice of aesthetic medicine and the corporate practice of medicine have the greatest potential to affect facial plastic surgeons. This article provides basic information regarding these medicolegal issues and resources to examine physician compliance. There may be an opportunity for the American Academy of Facial Plastic and Reconstructive Surgery to provide its membership with basic guidelines for scope of practice and corporate practice of medicine in an effort to optimize patient care.

Paterson P. and Allison K., (2006). **Maintaining standards of aesthetic practice in trainees subject to NHS restrictions**. *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 59(8), pp.856–859.
The Specialist Advisory Committee (SAC) in plastic surgery within the United Kingdom (UK) recommends a modular training programme to include aesthetic surgery. The intercollegiate board examinations test candidates on all aspects of aesthetic practice yet there is no formal, national aesthetic training in the UK. Closure of National Health Service (NHS) private patient facilities has reduced training opportunity [Nicolle FV. Sir Harold Gillies Memorial Lecture; Aesthetic plastic surgery and the future plastic surgeon. Br J Plast Surg 1998;51:419-24.] Calmanisation [Hospital doctors: training for the future. The Report of the Working Group on Specialist Medical Training (The Calman Report). London: HMSO; 1993.], the European Working Time Directive (EWTD) [www.rcseng.ac.uk/ewtd/consultants_html; Phillips H, Fleet Z, Bowman K. The European Working time Directive-interim report and guidance from The Royal College of Surgeons of England working party chaired by Mr Hugh Phillips; 2003

[=http://www.rcseng.ac.uk/services/publications/publications/index_html?pub_id=68]; Chesser S, Bowman K, Phillips H. The European Working Time Directive and the training of surgeons. BMJ Careers Focus 2002;s69-7.], and more importantly the implementation of "local" aesthetic guidelines have placed further pressures on training. Reductions of NHS case mix will ultimately lead to a reduction in trainee experience. With increasing regulatory pressure from the Commission for Healthcare Improvement, standards of aesthetic practice can only be maintained by increasing private/independent sector involvement. At present a disparity exists between the demand and provision of aesthetic surgery training in the UK. Aesthetic surgery forms part of the training curriculum for plastic surgery and as such remains a training issue. A review of aesthetic surgery training is needed in the UK through consultation with trainers and trainee representatives. © 2005 The British Association of Plastic Surgeons.

Duffin, C., (2005). **Aesthetic care boom puts staff on the spot**. *Nursing Standard (through 2013)*, 19(51), p.9. Available at: https://www.proquest.com/scholarly-journals/aesthetic-care-boom-puts-staff-on-spot/docview/219816651/se-2?accountid=31583.
A GP wanting to bump up his income asked practice nurses to inject botulinum toxin into a patient who had brought it into the surgery. RCN independent sector adviser Val Smith was contacted by the two nurses, who were worried because they did not even know if the product was what the patient claimed it was.

Reid, K., (2005). **Chief medical officer announces regulations on cosmetic surgery**. *BMJ : British Medical Journal*, 330(7486), p.274. Available at: https://www.proquest.com/scholarly-journals/chief-medical-officer-announces-regulations-on/docview/1777629224/se-2?accountid=31583.
The chief medical officer, Liam Donaldson, announced measures to improve the regulation of private cosmetic surgery last week, after the publication of two reports by the Healthcare Commission and an expert group set up to investigate practice.

Great Britain. Department of Health. ed , (2005a). **Expert Group on the Regulation of Cosmetic Surgery : report to the Chief Medical Officer**. Available at: https://web.archive.org/web/http://www.dh.gov.uk/assetRoot/04/10/21/00/04102100.pdf.
The Report of the Expert Group on the Regulation of Cosmetic Surgery advises and makes recommendations to the CMO on whether or not the current system of regulation for cosmetic surgery is sufficient to ensure patient safety

Great Britain. Department of Health. ed , (2005b). **Response to the expert group report on the regulation of cosmetic surgery : action plan**. Available at: https://web.archive.org/web/http://www.dh.gov.uk/assetRoot/04/10/21/01/04102101.pdf.
The Expert Group Report on the Regulation of Cosmetic Surgery provides a set of sensible recommendations which form a firm platform for further action.

Mehlman, M.J., Binstock, R.H., Juengst, E.T., Ponsaran, R.S. and Whitehouse, P.J., (2004). **Anti-Aging Medicine: Can Consumers Be Better Protected?** *The Gerontologist*, 44(3), pp.304–10. Available at: https://www.proquest.com/scholarly-journals/anti-aging-medicine-can-consumers-be-better/docview/211022509/se-2?accountid=31583.
The use of interventions claiming to prevent, retard, or reverse aging is proliferating. Some of these interventions can seriously harm older persons and aging baby boomers who consume them. Others that are merely ineffective may divert patients from participating in beneficial regimens and also cause them economic harm. "Free market regulation" does not seem to weed out risky, ineffective, and fraudulent anti-aging treatments and products. Public health messages, apparently, are having little effect. What more can be done to achieve better protection for older consumers? An analysis of the potential for federal and state action reveals many barriers to effective governmental regulation of anti-aging interventions. In view of dim prospects for stronger public regulation, physicians and other professionals-

especially geriatricians and gerontologists-will need to be more aggressive in protecting older consumers. In particular, The Gerontological Society of America and the American Geriatrics Society should undertake a sustained program of specific educational efforts, directed at health professionals and the general public, in which they sort out as best they can the helpful, the harmful, the fraudulent, and the harmless anti-aging practices and products. [PUBLICATION ABSTRACT] Key Words: Anti-aging, Geriatrics, Gerontology, Government regulation, Professional regulation

Markey A.C., (2004). **Dermatologists and cosmetic surgery - A personal view of regulation and training issues**. *Clinical and Experimental Dermatology*, 29(6), pp.690–692.

Orton, C., (2002). **Regulating cosmetic surgery**. *BMJ : British Medical Journal*, 324(7348), p.1229. Available at: https://www.proquest.com/scholarly-journals/regulating-cosmetic-surgery/docview/1777614148/se-2?accountid=31583.
[...]most cosmetic surgery operations are extremely complex and require a high degree of anatomical knowledge and surgical skill as well as aesthetic appreciation. The public's increasing interest is accompanied by a reduction in the provision of cosmetic surgery in the NHS, so that patients look to the private sector, financing their treatment through bank loans and finance agreements. 2 3 These patients have been prey to organisations that offer discounts, privacy, and no waiting time but are not staffed by accredited surgeons.

Hochstadt A, (2002). **How states regulate office surgery -- a primer.** *Plastic Surgical Nursing*, 22(3), pp.133–146. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=106807805&custid=ns010095.

Alderman, C., (2001). **Beauty business**. *Nursing Standard (through 2013)*, 16(4), p.19. Available at: https://www.proquest.com/scholarly-journals/beauty-business/docview/219793637/se-2?accountid=31583.
Nurse Constance Campion-Awwad wants effective legislation to outlaw bad practice in cosmetic surgery. She spoke to Charlotte Alderman

Mathieson, A., (2001). **Cosmetic surgery standards**. *British Journal of Perioperative Nursing*, 11(9), p.377. Available at: https://www.proquest.com/scholarly-journals/cosmetic-surgery-standards/docview/217765385/se-2?accountid=31583.
The Department of Health was preparing to launch draft professional standards on cosmetic surgery as BJPN went to press. The standards, drawn up by the Independent Healthcare Association and the Health Quality Service, aim to provide regulation in an area which is perceived by many to be lacking in effective controls, and are likely to have a significant focus on nursing interventions.

Anonymous, (2001). **New cosmetic surgery standards**. *Nursing Standard (through 2013)*, 15(44), p.8. Available at: https://www.proquest.com/scholarly-journals/new-cosmetic-surgery-standards/docview/219834769/se-2?accountid=31583.

Quattrone MS, (2000). **Is the physician office the wild, wild west of health care?** *Journal of Ambulatory Care Management*, 23(2), pp.64–64. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=106097239&custid=ns010095.
Elective, office-based surgery has captured the interest of consumers and, more recently, the attention of state health care regulatory agencies. In most states today, patients can undergo cosmetic surgery, liposuction, endoscopy, colonoscopy, microlaparoscopy, and various other procedures requiring sedation or anesthesia in physician offices even though no regulatory safeguards that would ordinarily benefit

patients in accredited or licensed facilities exist. Media accounts of deaths and serious injuries associated with liposuction and anesthesia performed in physician offices resulted in legislative and regulatory initiates, such as those in California and New Jersey. Increased regulatory oversight, changes in patterns of reimbursement, and greater consumer awareness of safety and quality-ofcare issues should aid in reducing the risks of office-based surgery.

Anello, S., (2000). **Office-based surgery? Advantages, disadvantages, and the nurse's role**. *Plastic Surgical Nursing*, 20(4), pp.218–221. Available at: https://www.proquest.com/scholarly-journals/office-based-surgery-advantages-disadvantages/docview/203341561/se-2?accountid=31583.
Office-based surgery is a growing trend in surgical services offered to may patients, however, it is not without risk. In knowing the facts about office-based surgery, nurses will be able to assist our patients in the most appropriate decisions regarding their surgical care.

Dugas, B., (1999). **The good old days: A look back at cosmetic surgery**. *Plastic Surgical Nursing*, 19(2), pp.74-76+. Available at: https://www.proquest.com/scholarly-journals/good-old-days-look-back-at-cosmetic-surgery/docview/203336974/se-2?accountid=31583.
During the 25-year history of the American Society of Plastic and Reconstructive Surgical Nurses (ASPRSN), cosmetic surgery procedures and nursing care have undergone constant change. Lessons learned over the past quarter-century will be discussed as we live and learn from our past experiences.

Charatan, F., (1998). **Warnings about plastic surgery in Florida**. *BMJ : British Medical Journal*, 317(7173), p.1615. Available at: https://www.proquest.com/scholarly-journals/warnings-about-plastic-surgery-florida/docview/1777604061/se-2?accountid=31583.
The huge increase in the number of Florida residents undergoing plastic surgery in doctors' offices--mostly elderly people in search of improved appearance--over the past few years has prompted calls from the state's department of health for tighter regulations.

Mahony C, (1998). **Nice nose for profit...the cosmetic surgery business**. *Nursing Times*, 94(36), pp.24–26. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=107156648&custid=ns010095.
Cosmetic surgery can have a huge impact on a person's appearance, well-being--and wallet. Yet it is poorly regulated and sales patter often takes precedence over medical advice. Chris Mahony reports.

Anon, **Government to crack down on unregulated cosmetic procedures**. *GOV.UK*. Available at: https://www.gov.uk/government/news/government-to-crack-down-on-unregulated-cosmetic-procedures [Accessed September 19, 2023].
The government announces its intention to introduce a licensing regime for non-surgical cosmetic procedures such as Botox and fillers.

Cosmetic tourism – cost to healthcare systems

There is no official source of data on outbound UK medical tourism, but the Office for National Statistics (ONS) has estimated that 248,000 UK residents went abroad for medical treatment in 2019, compared with 120,000 in 2015. (ONS, FOI request: Medical tourism in 2019 and total visits to and from the UK 2015 to 2019 - Office for National Statistics (ons.gov.uk))

Ford, E.W., (2023). **The Rising Tide of Medical Tourism: Opportunities and Challenges for Healthcare Organizations.** *Journal of Healthcare Management*, 68(4), pp.215–217. Available at:

https://journals.lww.com/jhmonline/fulltext/2023/07000/the_rising_tide_of_medical_tourism__opportunities.1.aspx.
The global medical tourism market has experienced a significant expansion driven by factors such as rising local healthcare costs, long waiting times, and the availability of high-quality care at relatively low prices in destination countries. Medical tourism is forecast to grow from $115.6 billion in 2022 to $346.1 billion by 2032 (Sharma et al., 2020). More patients seeking treatments ranging from cosmetic procedures to lifesaving surgeries are crossing borders, resulting in a flourishing industry. For both healthcare leaders and consumers, this trend presents tantalizing opportunities and notable challenges.

Cheung M.Y., Aggarwala S., Lam T.C., Moisidis E., Soliman B.A.B., and Hsieh F., (2023). **The impact of overseas cosmetic surgery on our public hospital system**. *ANZ journal of surgery*, 93(1–2), p.435. Available at: https://onlinelibrary.wiley.com/doi/10.1111/ans.18245.

McAuliffe, P.B., Muss, T.E.L., Desai, A.A., Talwar, A.A., Broach, R.B. and Fischer, J.P., (2023). **Complications of Aesthetic Surgical Tourism Treated in the USA: A Systematic Review.** *Aesthetic plastic surgery*, 47(1), pp.455–464. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9619012
BACKGROUND: Medical tourism has grown increasingly popular in the past few decades. Cosmetic surgery centers have developed in vacation locales, offering procedures at lower prices. However, surgeons and patients alike are often unprepared for management of complications after patients return to the USA. The aim of this study is to provide an overview of US cosmetic surgery tourism patients and the complications faced by US healthcare providers., METHODS: A systematic review was performed using the Web of Science, Cochrane, Embase, Scopus, and PubMed databases up to February 2022; included articles were full-text, English language, and reported complications of patients receiving postoperative care in the USA after cosmetic surgery abroad. Two independent reviewers performed screening for article eligibility with a 3rd for conflict resolution. Patient demographics, procedure characteristics, and outcomes were extracted and aggregated., RESULTS: Twenty studies were included, describing 214 patients. Most patients were female (98.1%, n = 210), middle-aged, and Hispanic. The most common destination country was the Dominican Republic (82.7%, n = 177) and the most common surgical procedure was abdominoplasty (35.7%, n = 114). Complications were mainly infectious (50.9%, n = 112) and required prolonged treatment periods often greater than two months, with high rates of hospitalization (36.8%) and surgical management (51.8%)., CONCLUSIONS: Cosmetic surgery tourism is a growing industry with adverse implications for the US healthcare system and patients themselves. This review aims to serve as a reference to prepare plastic surgeons for the scope of complications associated with cosmetic tourism and improve counseling to better prepare patients for the financial and health risks., LEVEL OF EVIDENCE III: This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266. Copyright © 2022. Springer Science+Business Media, LLC, part of Springer Nature and International Society of Aesthetic Plastic Surgery.

Yoganathan A., Chatzidimitrio C., Stephanos M., and Pennick M., (2023). **How healthy is health tourism?** *European Journal of Surgical Oncology*, 49(5), p.e252. Available at: https://www.ejso.com/article/S0748-7983(23)00309-8/fulltext
Health tourism is increasing with breast augmentation being a favoured procedure. Patients are seduced by low costs and the promise of a holiday. What is not included is appropriate aftercare and reassurance of a validated and indemnified UK surgeon to rely on in the event of complications. The burden falls onto the NHS. The legal implications of managing these patients are poorly defined however recent guidance from ABS is welcomed. We aim to identify the impact of such complications on NHS resources within our breast unit. Method(s): Data were collected over 12 months relating to patients presenting with complications following cosmetic breast surgery abroad. Investigations, follow, and management were recorded. Photographs were taken and are presented with consent. Hospital legal team were contacted

for advice on management beyond the emergency setting. Result(s): Five patients were identified, all had wound infection, two with dehiscence. Only one patient had cosmetic insurance and returned to the operating surgeon abroad. A further patient is requesting implant removal 6 weeks after their placement abroad. The overall time spent on follow-up/clinic is about five 30-minute visits. The cost of non-life-threatening treatment averaged 950 per patient. Our legal team were non-committal with their support for how we should manage these patients beyond emergency care. Conclusion(s): High quality patient care and treatment is provided to those presenting with emergency breast complications. There are significant costs associated with management beyond the emergency setting. ABS guidelines are welcomed to support NHS teams in redirecting patients to the private sector for non-emergency care.Copyright © 2023

Jobson, D. and Freckelton, I., (2022). **The Perils of Cosmetic Surgery Tourism: Evolving Knowledge, Awareness, and Challenges**. *Journal of Law and Medicine*, 29(2), pp.406–420. Available at: https://pubmed.ncbi.nlm.nih.gov/35819381/
Concern has been expressed for some years about the risks of complications and the need for revision procedures after cosmetic surgery tourism. Such tourism is large and growing. Recent literature and coroners' inquests have provided a new evidence base for evaluating the extent of the dangers posed by a variety of overseas cosmetic surgery procedures. This article reviews such literature and identifies reason for considerable concern about cosmetic surgery tourism as well as about the deficits in regulatory and legal liability that might otherwise inhibit substandard practice. Provision of carefully drafted information about risk issues which patients can factor into their decision-making before embarking on overseas trips for the purpose of cosmetic surgery is a constructive initiative deserving of further attention by relevant Colleges, professional association and health advocacy groups.

Murphy, D., Lane-O'Neill, B. and Dempsey, M.P., (2022). **COVID-19 and cosmetic tourism: A Google trends analysis of public interests and the experience from a tertiary plastic surgery centre**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 75(4), pp.1497–1520. Available at: https://linkinghub.elsevier.com/retrieve/pii/S1748681522000560 [Accessed September 20, 2023].

Jobson D. and Freckelton I., (2022). **The changing face of cosmetic surgery regulation: a review of controversies and potential reforms**. *ANZ journal of surgery*, 92(5), pp.964–969. Available at: https://onlinelibrary.wiley.com/doi/10.1111/ans.17648
Cosmetic surgery is becoming increasingly popular in Australia with the industry estimated to be worth over 1 billion dollars annually. Regulators both in Australia and internationally have been criticized for not keeping up with the rapidly changing field and keeping patients sufficiently safe in an environment that is problematically entrepreneurial. In this article, we explore the current regulation of and controversies surrounding cosmetic surgery in Australia, including the use of the title "cosmetic surgeon", consent processes and the phenomenon of medical tourism. Lastly, we review the potential future reforms in Australia and how other countries have regulated the industry to keep patients safe.Copyright © 2022 Royal Australasian College of Surgeons.

Rafeh S., Tara M C., Michael F., Amy G., Elaf O., Paul R., James O., Aidan M., Seamus M., and Gerrard O., (2022). **An analysis of the cost and impact of cosmetic tourism and its associated complications: A multi institutional study**. *The surgeon : journal of the Royal Colleges of Surgeons of Edinburgh and Ireland*, 20(6), pp.339–344. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1479666X2100202X?via%3Dihub.
BACKGROUND AND PURPOSE: The increasing cost of cosmetic procedures, long elective waiting times in the public system and affordability of procedures offered abroad has driven the rapid growth of cosmetic tourism. The incidence and cost of patients presenting to the Irish health service with complications related to cosmetic procedures carried out in overseas institutions is largely unknown. This heterogenous group of patients is challenging to identify. Limited data exists for this patient group in the Irish context.

We aimed to perform a multicentre audit and cost analysis of patients presenting to Irish health services with complications related to cosmetic procedures performed in overseas institutions over a 2 year period. METHOD(S): Patients presenting to two University Hospitals from March 2019-April 2021 with complications after a cosmetic surgical procedure was performed abroad were studied. The HPO ABF 2020 price list data was used to calculate the inpatient and procedure cost for each subject. MAIN FINDINGS: 14 (13/92.8% female, mean age 43 +/- 11.85 years) patients presented during the study period. Countries of cosmetic operation included: Belgium (6/46.2%), the UK (2/15.4%), Latvia, Turkey, Poland, Lithuania, and Estonia (1 patient/7.7% each country). All required a re-operative procedure. These interventions included: removal of infected implant (n = 1), adjustment or removal of a gastric band (n = 9) and debridement of an infected/necrotic wound (n = 3). Mean length of stay was 9.14 +/- 7.48 (range 2-28) days. Five (38.4%) patients required vac dressing. The mean cost of the cohort for the interventional procedure and in-patient stay was 15912.53 (+/- 6388). The sum total of all the costs for the cohort was 231038.60. CONCLUSION(S): Significant costs were associated with prolonged hospital admissions, operative interventions, intravenous antibiotics, VAC dressing application and follow up visits. Complications from procedures performed in overseas institutions account for a significant cost burden to health services in Ireland.

Ashiti, S. and Moshkun, C., (2021). **Dental tourists: treat, re-treat or do not treat?** *British Dental Journal*, 230(2), pp.73–76. Available at: https://www.nature.com/articles/s41415-020-2591-6 [Accessed September 22, 2023].
Many UK patients in the search for their perfect smile have now decided to have their dental treatment abroad, the main reasons being that they believe they can have the same treatment but at a much lower price. With many overseas clinics offering treatment packages that also include a holiday, dental tourism seems an opportunity not to be missed. Although not always the case, some treatments unfortunately do not go to plan, often leaving distraught patients and their apprehensive dentists in a difficult situation. This article will discuss the reasons behind dental tourism and if the health system has contributed to the increasing demand for dental tourism. We will touch on the impact dental tourism has had on UK dentistry and if the NHS should be responsible for handling the consequences of any failed or incomplete dental treatment carried out abroad. It will also put the spotlight on dentists' responsibilities and to what extent they should treat these patients, as these cases can leave clinicians in primary and secondary care in a challenging predicament, not only clinically but also ethically and medico-legally.

Henry N., Abed H., and Warner R., (2021). **The Ever-Present Costs of Cosmetic Surgery Tourism: A 5-Year Observational Study**. *Aesthetic plastic surgery*, 45(4), pp.1912–1919. Available at: https://link.springer.com/article/10.1007/s00266-021-02183-w.
BACKGROUND: Cosmetic surgery tourism is an ever-growing industry. Despite its associated risks, an increasing number of patients are presenting to NHS services with resulting complications. This study aims to evaluate the current presentation patterns for complications in cosmetic surgery tourism, and the financial burden to the NHS reported by a single UK level one trauma centre in Birmingham, UK. METHOD(S): From 2015 to 2020, all patients presenting to the department of plastic surgery with complications of cosmetic surgery performed outside of the UK were included. Data were collected for patients' characteristics including demographics, performed procedures, complications and treatment. A cost analysis was performed for each patient using published "National Schedule of NHS Costs." RESULTS: A total of 26 patients presented to our hospital within the study period. All patients were female, with the mean age being 35.1 years (range 22-55years). A total of 32 cosmetic procedures were undertaken, with the majority performed in Turkey (n = 14). Abdominoplasty was the most common procedure, followed by gluteal enhancement surgery. The total financial cost to the NHS from all cosmetic surgery-related complications was 152,946, with an average cost per patient of 5,882.54 (range 362-26,585). CONCLUSION(S): Patients seek out medical tourism for multiple reasons including cost savings, shorter waiting times and surgical expertise. The costs displayed should predominantly be viewed as a reflection

of the detrimental effect these complications can have on patients' lives. Global governing bodies should focus efforts on educating patients and raising awareness on this ever-prevalent issue. LEVEL OF EVIDENCE IV: This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266 .Copyright © 2021. Springer Science+Business Media, LLC, part of Springer Nature and International Society of Aesthetic Plastic Surgery.

McCrossan S., Martin S., and Hill C., (2021a). **Cosmetic tourism in aesthetic breast surgery**. *British Journal of Surgery*, 108(SUPPL 6), p.vi73.
Introduction: Medical tourism is expanding on a global basis, with patients seeking cosmetic surgery in countries abroad. Little information is known regarding the risks and outcomes of cosmetic tourism, in particular, for aesthetic breast surgery. Method(s): A systematic-review was conducted using the PRISMA (Preferred Reporting Items for Systematic-reviews and Meta-analyses) guidelines. Fifty-seven titles were screened, 42 abstracts were reviewed leaving 30 full texts. Twenty-one of these met the inclusion criteria. Result(s): One-hundred and fifty patients partook in cosmetic tourism for aesthetic breast surgery. Forty-two percent of patients had an implant- based procedure. Other procedures included mastopexy (n=4), bilateral breast reduction (n=10) and silicone injections (n=2). Onehundred and sixty complications were recorded, common complications included wound infection 31% (n=46), breast abscess/ collection 14% (n=21), wound dehiscence 12% (n=18) and ruptured implant 9% (n=13). Clavien-Dindo classification of complications includes 67 (45%) IIIb-complications with 78 returns-to-theatre, 2 class-IV complications (ICU stay) and one class-V-death of a patient. Explanation occurred in 38% (n=24) of implant-based augmentation patients. Conclusion(s): Aesthetic breast surgery tourism is popular within the cosmetic tourism industry. However, with infective complications (31%) and return-to-theatre rates (45%) significantly higher than expected, it is clear that having these procedures abroad significantly increases the risks involved. Professional bodies for cosmetic surgery in each country must highlight and educate patients how to lower this risk if they do choose to have cosmetic surgery abroad. In this current era of an intra-pandemic world where healthcare is already stretched, the burden from cosmetic tourism complications must be minimised.

McCrossan S., Martin S., and Hill C., (2021b). **Medical Tourism in Aesthetic Breast Surgery: A Systematic Review**. *Aesthetic plastic surgery*, 45(4), pp.1895–1909.
INTRODUCTION: Medical tourism is expanding on a global basis, with patients seeking cosmetic surgery in countries abroad. Little information is known regarding the risks and outcomes of cosmetic tourism, in particular, for aesthetic breast surgery. The majority of the literature involves retrospective case series with no defined comparator. We aimed to amalgamate the published data to date to ascertain the risks involved and the outcomes of cosmetic tourism for aesthetic breast surgery on a global basis. METHOD(S): A systematic review of PubMed, Google Scholar, EMBASE, the Cochrane library and OVID Medline was conducted using the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-analyses) guidelines. Keywords such as "medical tourism", "cosmetic tourism", "tourism", "tourist", "surgery", "breast" and "outcomes" were used. Seven hundred and seventy-one titles were screened, and 86 abstracts were reviewed leaving 35 full texts. Twenty-four of these met the inclusion criteria and were used to extract data for this systematic review. RESULT(S): One hundred and seventy-one patients partook in cosmetic tourism for aesthetic breast surgery. Forty-nine percent of patients had an implant-based procedure. Other procedures included: mastopexy (n=4), bilateral breast reduction (n=11) and silicone injections (n=2). Two-hundred and twenty-two complications were recorded, common complications included: wound infection in 39% (n=67), breast abscess/ collection in 12% (n=21), wound dehiscence in 12% (n= 20) and ruptured implant in 8% (n=13). Clavien-Dindo classification of the complications includes 88 (51%) IIIb complications with 103 returns to theatre, 2 class IV complications (ICU stay) and one class V death of a patient. Explantation occurred in 39% (n=32) of implant-based augmentation patients. CONCLUSION(S): Aesthetic breast surgery tourism is popular within the cosmetic tourism industry. However, with infective complications (39%) and return to theatre rates (51%)

significantly higher than expected, it is clear that having these procedures abroad significantly increases the risks involved. The high complication rate not only impacts individual patients, but also the home country healthcare systems. Professional bodies for cosmetic surgery in each country must highlight and educate patients how to lower this risk if they do choose to have cosmetic surgery abroad. In this current era of an intra-pandemic world where health care is already stretched, the burden from cosmetic tourism complications must be minimised. LEVEL OF EVIDENCE III: This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266 .Copyright © 2021. Springer Science+Business Media, LLC, part of Springer Nature and International Society of Aesthetic Plastic Surgery.

Venditto C., Gallagher M., Hettinger P., Havlik R., Zarb R., Argenta A., Doren E., Sanger J., Klement K., Dzwierzynski W., Logiudice J., and Jensen J., (2021). **Complications of Cosmetic Surgery Tourism: Case Series and Cost Analysis**. *Aesthetic Surgery Journal*, 41(5), pp.627–634. Available at: http://asj.oxfordjournals.org/content/by/year.
Background: Cosmetic surgery tourism is increasing exponentially. Patients seek cosmetic procedures within the United States and abroad, lured by lower cost procedures, shorter waiting lists, and affordable airfare and hotel accommodations. Unfortunately, operations are often performed by non-board-certified plastic surgeons, sometimes not even by plastic surgeons. Preoperative counseling, frequently limited to a video-chat with an office secretary, provides inadequate discussion regarding potential complications. Postoperative care is careless and rarely involves the operating surgeon. Complications are frequent, with management falling into the hands of plastic surgeons unfamiliar with the patient's care. Furthermore, the physician, rather than the patient or hospital, faces the largest cost burden. Objective(s): The authors sought to explore their institution's experience treating complications of cosmetic tourism and investigate associated costs. Method(s): The retrospective review of 16 patients treated for complications related to cosmetic surgery tourism plus cost analysis revealed a substantial discrepancy between money saved by undergoing surgery abroad and massive costs accrued to treat surgical complications. Result(s): The most common complication was infection, often requiring surgery or IV antibiotics on discharge. Mean cost per patient was $26,657.19, ranging from $392 (single outpatient visit) to $154,700.79 (prolonged admission and surgery). Overall, the hospital retained 63% of billed charges, while physicians retained only 9%. The greatest amount paid by any single patient was $2635.00 by a patient with private insurance. Conclusion(s): Cosmetic tourism has severe medical repercussions for patients and complications that burden hospitals, physicians, and the US medical system. Physicians treating the complications suffer the greatest financial loss. Level of Evidence: 4:Copyright © 2020 The Aesthetic Society.

Asher C.M., Fleet M., Jivraj B., and Bystrzonowski N., (2020). **Cosmetic Tourism: a Costly Filler Within the National Health Service Budget or a Missed Financial Opportunity? A Local Cost Analysis and Examination of the Literature**. *Aesthetic plastic surgery*, 44(2), pp.586–594.
BACKGROUND: Cosmetic tourism is a global commodity, but patients seeking treatment for complications of international cosmetic tourism appear to be on the rise. We calculate the financial burden to a single NHS trust and summarise the literature, reviewing the implications of cosmetic tourism and summarising available guidance to assist surgeons in this ethically challenging, but expanding, field. METHOD(S): Hospital episodes for patients with complications from cosmetic tourism between January 2016 and March 2017 were retrieved using the patient management system. The coding department provided the episode costs. A literature search was conducted using Medline, EMBASE and HBE identifying 273 English abstracts. The abstracts were reviewed for relevance followed by assessment of the 48 selected full articles by all authors and 17 papers contained relevant, new information. RESULT(S): Eleven patients underwent management for complications of cosmetic surgery, most commonly infection, with a sum of 29 inpatient episodes and total cost of 259,732. DISCUSSION: Our study illustrates the management of complications of cosmetic surgery carries a high cost. This is not an experience limited to just this trust in the UK. Internationally, healthcare systems are evolving to raise the safety profile for cosmetic tourists, some

going the extra mile to accommodate healthcare tourists, reaping the financial reward. Following the examination of the literature, we query whether NHS trusts should heighten their presence as providers of private services on the international market, eliminating numerous medical-ethic concerns associated with substandard cosmetic tourism. LEVEL OF EVIDENCE V: This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266.

Mathez-Loic C., Raffoul W., and Di Summa P.G., (2020). **Dealing with acute complications of aesthetic surgery procedures performed abroad: Cost analysis for the Swiss health system**. *Praxis*, 109(12), pp.961–966. Available at: https://econtent.hogrefe.com/loi/prx.
Aesthetic surgery tourism is a growing phenomenon, with a steady increase of people travelling abroad for surgical procedures. In our hospital, a relevant number of patients consulted the emergency department for complications after cosmetic surgery performed in foreign countries. This progressively increasing trend leads to multiple outpatient clinic consultations and surgical re-operations. We investigated this phenomenon at Lausanne University Hospital from May 2015 to December 2018, with the aim to give a review of the surgical and hospital care costs, finally affecting the Swiss insurance system.

Wheeler, J., (2020). **Cosmetic surgery treatment injuries: the New Zealand experience both at home and from cosmetic surgery tourism**. *Australas J Plast Surg.*, 3(2), pp.59–64. Available at: https://ajops.com/article/33251.pdf.
Objective: Complications arising from cosmetic surgery are burdensome for the patient and for the community. This article attempts to understand the number of complications arising in patients returning to New Zealand from cosmetic surgery tourism destinations with reference to the number of patients with complications from cosmetic surgery undertaken in New Zealand. Methods: Data were requested under the New Zealand Official Information Act 1982 from the Accident Compensation Corporation (ACC) regarding the number of claims for treatment injury following cosmetic surgery undertaken both in New Zealand and overseas for the period 1 July 2014 to 30 June 2019. Separate to that request, a prospective audit was conducted of patients admitted to Middlemore Hospital over the one-year period 1 March 2018 to 30 March 2019 for complications arising as a result of cosmetic surgery tourism. Results: A total of 1048 claims were made to the ACC for treatment injuries arising from cosmetic surgery in New Zealand and from overseas treatment over the five-year period to 30 June 2019. Of these, 738 were accepted by the ACC, with the leading three events being breast reduction/reconstruction, breast implant/augmentation and septorhinoplasty. Bariatric surgery, vein treatment/sclerotherapy, orthodontics and isolated septoplasties were excluded by the ACC as not being 'cosmetic surgery'. The ACC valued the total cost of treatment of these accepted claims at NZ$6.3 million dollars

Sadr, A.H., Pau, A., Griffin, M.F., Butler, P.E. and Mosahebi, A., (2019). **The implications of cosmetic tourism on tertiary plastic surgery services; The need for a national reporting database☆**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 72(7), pp.1219–1243. Available at: https://www.jprasurg.com/article/S1748-6815(19)30093-2/fulltext [Accessed September 22, 2023].
Cosmetic surgery is becoming increasing popular in the UK. However, despite the stringent measures of improving cosmetic standards in the UK through the healthcare commissions and General Medical Council (GMC), satisfactory results, patients are choosing to receive cosmetic procedures abroad. The major attraction for the patient is the overall cost of cosmetic procedure is cheaper aboard. For example, the Guardian online in 2014 reported that a rhinoplasty procedure would cost £847 aboard compared the UK rate of £3557. 1 The rise in cosmetic tourism has also been fueled by cheap airfare, low cost insurance and rising advertisement about the opportunities for cosmetic procedures abroad on public media. 2 , 3 , 4 , 5 For patients travelling abroad for cosmetic procedures, the aftercare may be limited due to

time and expenses incurred by the patient. 3 Hence, the cost of the post-operative cosmetic procedures has become a burden of the patient's home country. 4 , 5 However, despite the realization of this burden only few studies have evaluated the costs of such complications. We aimed to identify and assess the costs of patients representing to a busy tertiary center with complications from aesthetic procedures abroad and estimate their costs to the NHS health-care-system. Between 2015 and 2017 all patients presenting as emergency cases or as GP referrals to the plastic surgery department at Royal Free Hospital in London, UK who had complications arising from cosmetic surgery outside the UK were identified prospectively.

Qureshi, A.A., Gould, D.J., Stevens, W.G. and Fernau, J., (2019). **Report on Current Experience of ASAPS Membership and Management of Cosmetic Tourism Complications**. *Aesthetic Surgery Journal Open Forum*, 1(2), p.ojz009. Available at: https://doi.org/10.1093/asjof/ojz009 [Accessed September 22, 2023].
Cosmetic tourism is an expanding industry with increasing scrutiny in the public domain of complications and patient safety issues. The health and financial implications for patients are large and deserve further investigation.The aim of this study was to understand the experience of the American Society for Aesthetic Plastic Surgery (ASAPS) members treating medical tourism patients with complications who returned to the United States for secondary management.A 20-question survey was administered electronically in August 2018 to ASAPS members with voluntary participation. Questions about surgeon experience, the nature of complications, type of initial surgery, and subsequent management were asked. Responses were tabulated and percentages of response choices were calculated and reported.Ninety-three responses were received from the 1611 physician ASAPS members (5.8% response rate). More than half of respondents had seen 2 to 5 patients in the last 12 months with a complication from cosmetic tourism. The most common procedure that patients had done abroad was abdominoplasty. The most common complication was infection caused by Gram-positive organisms, managed on an outpatient basis without surgical intervention. Involvement of an ASAPS member led to successful resolution of complications in the vast majority of patients. Estimated costs out of pocket for management of complications were most commonly between $1001 and 5000.While the experience of ASAPS members is as varied as the complications faced by cosmetic tourism patients, the vast majority of complications is infectious and can be managed on an outpatient basis successfully with the involvement of an ASAPS member. Further collaborative efforts both domestically and internationally can help improve patient safety for cosmetic tourism patients.

Farid, M., Nikkhah, D., Little, M., Edwards, D., Needham, W. and Shibu, M., (2019). **Complications of Cosmetic Surgery Abroad - Cost Analysis and Patient Perception.** *Plastic and reconstructive surgery. Global open*, 7(6), p.e2281.
BACKGROUND: Cosmetic surgery tourism is rapidly becoming more prevalent in the United Kingdom. We aim to identify the motivational factors underlying patients' decisions to go abroad for their treatment and gather information about the ensuing complications., METHODS: A retrospective review (January 2013-August 2017) was conducted of patients seen at a single major trauma center for complications from cosmetic surgery performed overseas. Cost analysis was performed based on national tariffs. Complications were grouped based on Clavien-Dindo classification and the Clinical Commissioning Group cost. A telephone survey was conducted to evaluate reasons for travel, details of complications, and impression of healthcare at home and abroad., RESULTS: A total of 20 patients (one male, 19 females) with a mean age 36 years (23-59 years) were included. Lower cost was the most popular reason for travel, followed by lack of expertise and friend's recommendation. Abdominoplasty (n = 9) had the highest number of complications followed by gluteal augmentation (n = 7). All major complications were due to gluteal augmentation (n = 4). The cost was for minor (n = 8, 3,448), intermediate (n = 8, 18,271), and major (n = 4, 42,083.59) complications., CONCLUSIONS: We raise serious concerns about the lack of regulation in cosmetic tourism and the absence of patient follow-up abroad. A particular concern was all gluteal augmentation cases had major complications. An international consensus to regulate surgical

practice abroad is crucial to protect patients' interests and promote safe cosmetic surgery. Copyright © 2019 The Authors. Published by Wolters Kluwer Health, Inc. on behalf of The American Society of Plastic Surgeons.

Martin S., Long R., Hill C., and Sinclair S., (2019). **Cosmetic Tourism in Northern Ireland**. *Annals of plastic surgery*, 83(6), pp.618–621.
AIM: Over the new year period, we recognized a high number of admissions with postoperative complications following cosmetic surgery abroad. We aimed to determine the driving forces behind this and financial impact on the National Health Service (NHS). METHOD(S): Cases of all patients attending the regional plastic surgery unit with complications following surgery abroad were reviewed. Patients completed a survey on the perioperative period abroad and driving forces. In addition, the costing department was contacted to determine the financial burden associated with cosmetic tourism. RESULT(S): Six patients were admitted to the regional unit after independently organizing surgery abroad. Countries visited included Turkey, Belgium, Poland, Estonia, and India. Reasons included cost and access to procedures not recommended by UK surgeon. Type of surgery included breast (5), abdominoplasty (2), liposuction (2), and labiaplasty (1), and 50% had multiple procedures. Complications included necrotic wounds (33%), infected breast implant (33%), venous thromboembolism investigated (33%), and wound infection (17%). Overall, 67% required surgery on the NHS. The total cost was 23,976.82, with an average of 4000/patient (range, 1294-6291). DISCUSSION/CONCLUSIONS: This surge in cosmetic complications occurred in the New Year period. Complications were seen after a wide range of surgical procedures. All patients required an inpatient stay, and two-thirds required surgery with a significant cost burden to the NHS. Patients are unaware of the risks involved, highlighted by the lack of preoperative counseling and follow-up. In addition, this series has highlighted the risks associated with traveling in the perioperative period, with 2 patients investigated for pulmonary embolus.

Thacoor, A., van den Bosch, P. and Akhavani, M.A., (2019). **Surgical Management of Cosmetic Surgery Tourism-Related Complications: Current Trends and Cost Analysis Study of the Financial Impact on the UK National Health Service (NHS).** *Aesthetic surgery journal*, 39(7), pp.786–791.
BACKGROUND: Cosmetic surgery tourism is thriving. Lower costs and all-inclusive cosmetic surgery holiday packages have led to more patients seeking cheaper aesthetic surgery abroad. However, limited postoperative care results in patients frequently presenting to UK National Health Service hospitals with postoperative complications requiring surgery., OBJECTIVES: The authors sought to identify current trends and the financial impact of surgically managed complications from cosmetic surgery tourism., METHODS: A retrospective review of consecutive surgically managed patients attending a London Teaching Hospital between 2006 and 2018 with complications following cosmetic surgery abroad was performed. Patient demographics, procedure characteristics, and length of stay were determined and a comprehensive cost analysis was performed., RESULTS: Twenty-four patients presented with complications. Twenty-two were females aged a mean of 36 years (range, 25-58 years). Gluteal enhancement was the most common procedure (38%) and infection (92%) was the primary complication. Most procedures were undertaken in Turkey (29%) and performed in the last 5 years (63%). Twenty-one patients were inpatients and mean length of stay was 8 days (range, 1-49 days); abdominoplasty patients stayed the longest. The total cost to the hospital was $406,233, leading to an average cost per patient of $16,296 (range, $817-$41,778). Complications from abdominoplasty resulted in the highest cost per patient of $20,404., CONCLUSIONS: Cosmetic surgery tourism is on the rise as patients travel for cheaper aesthetic surgery. There is urgent need to better address this issue to help reduce the growing financial strain on the National Health Service, safeguard patients, and optimize the use of valuable resources. Copyright © 2018 The American Society for Aesthetic Plastic Surgery, Inc. Reprints and permission: journals.permissions@oup.com.

Widdows, H. and MacCallum, F., (2018). **The Demands of Beauty: Editors' Introduction.** *Health Care Analysis*, 26(3), pp.207–219. Available at:

https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=130935601&custid=ns010095.
This article introduces a Special Issue comprising four papers emerging from the Beauty Demands Network project, and maps key issues in the beauty debate. The introduction first discusses the purpose of the Network; to consider the changing demands of beauty across disciplines and beyond academia. It then summarises the findings of the Network workshops, emphasising the complex place of notions of normality, and the different meanings and functions attached to 'normal' in the beauty context. Concerns are raised here about the use of normal to justify and motivate engaging in beauty practices such as cosmetic surgery and 'non-invasive' procedures. Other workshop findings included the recognition of beauty as increasingly a global value rather than a culturally distinct ideal, and the understanding that there is no clear distinction between beauty practices that are considered standard and those that are considered extreme. These themes, especially the concerns around understanding of normal, are reflected in the recommendations made by the Network in its Briefing Paper, which are presented next in this introduction. A further theme picked up by these recommendations is the extent to which individuals who are not traditionally vulnerable may be so in the beauty context. Finally, the introduction highlights the key matters covered in the four papers of the Special Issue: regulatory concerns around cosmetic surgery tourism; the impact of digitally altered images from psychological and philosophical perspectives; the ethics of genetic selection for fair skin; and the attraction and beauty of the contemporary athletic body.

QUAILE, A., (2018). **Complications from medical cosmetic tourism result in costs to the NHS.** *Journal of Aesthetic Nursing*, 7(1), pp.28–29. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=127944612&custid=ns010095.
As cosmetic procedures are not routinely provided on the NHS, those wanting treatment have to pay privately. This has encouraged people to look abroad for cheaper alternatives. For many, the ability to combine a holiday with a treatment can be alluring; however, it presents complicated issues around where the responsibility lies with follow-up care, should something go wrong, explains Alistair Quaile

Pereira, R.T., Malone, C.M. and Flaherty, G.T., (2018). **Aesthetic journeys: a review of cosmetic surgery tourism.** *Journal of Travel Medicine*, 25(1), p.N.PAG-N.PAG. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=cin20&AN=133920269&custid=ns010095.
Background: Medical tourism has witnessed significant growth in recent years. The emerging trend towards international travel for cosmetic surgical interventions has not previously been reviewed. The current review aims to critically address the scale and impact of cosmetic surgical tourism and to delineate the complication profile of this form of medical tourism.Methods: Articles published in the English language on the PubMed database that were relevant to surgical tourism and the complications of elective surgical procedures abroad were examined. Reference lists of articles identified were further scrutinized. The search terms used included combinations of "surgery abroad", "cosmetic surgery abroad", "cosmetic surgery tourism", "cosmetic surgery complications" and "aesthetic tourism".Results: This article critically reviews the epidemiology of cosmetic surgical tourism and its associated economic factors. Surgical complications of selected procedures, including perioperative complications, are described. The implications for travel medicine practice are considered and recommendations for further research are proposed.Conclusion: This narrative literature review focuses on the issues affecting travellers who obtain cosmetic surgical treatment overseas. There is a lack of focus in the travel medicine literature on the non-surgery-related morbidity of this special group of travellers. Original research exploring the motivation and pre-travel preparation, including the psychological counselling, of cosmetic surgical tourists is indicated.

Brightman L., Ng S., Ahern S., Cooter R., and Hopper I., (2018). **Cosmetic tourism for breast augmentation: a systematic review**. *ANZ journal of surgery*, 88(9), pp.842–847.
BACKGROUND: The medical tourism industry, and in particular cosmetic tourism for breast augmentation, is becoming an increasingly popular global phenomenon. The objective of this study is to determine the extent of medical literature and the patient risk profiles associated with cosmetic tourism for breast augmentation both locally and abroad. DATA SOURCES: OVID MEDLINE, OVID Embase, Cochrane Central and Proquest electronic databases. METHOD(S): The search was conducted through to April 2017. Studies pertaining entirely or partly to cosmetic tourism for breast augmentation were considered for inclusion. Exclusion criteria included non-English articles, studies relating to non-cosmetic or non-implant breast augmentation, and studies that did not separately report on findings associated with breast augmentation abroad. RESULT(S): We identified 17 observational studies. Common destinations included Europe, South America and South East Asia. Infectious complications were common. Wound dehiscence and aesthetic dissatisfaction also featured. Catastrophic outcomes such as sepsis, intubation and ventilation, radical bilateral mastectomy, irreversible hypoxic brain injury and death were also reported. There were expectations that home country health systems would treat complications and provide non-medically indicated revision procedures. The burden on home country health systems was evident from a public health perspective. CONCLUSION(S): Determining the extent of cosmetic tourism for breast augmentation, including outcomes and complications, will help to inform Australian patients who this seek procedure abroad. Furthermore, it will aid in better understanding the health system implications and may help to guide future research and public health interventions both locally and internationally.

Griffiths, D. and Mullock, A., (2018). **Cosmetic surgery : : regulatory challenges in a global beauty market**,
The market for cosmetic surgery tourism is growing with an increase in people travelling abroad for cosmetic surgery. While the reasons for seeking cosmetic surgery abroad may vary the most common reason is financial, but does cheaper surgery abroad carry greater risks? We explore the risks of poorly regulated cosmetic surgery to society generally before discussing how harm might be magnified in the context of cosmetic tourism, where the demand for cheaper surgery drives the market and makes surgery accessible for increasing numbers of people. This contributes to the normalisation of surgical enhancement, creating unhealthy cultural pressure to undergo invasive and risky procedures in the name of beauty. In addressing the harms of poorly regulated surgery, a number of organisations purport to provide a register of safe and ethical plastic surgeons, yet this arguably achievess little and in the absence of improved regulation the risks are likely to grow as the global market expands to meet demand. While the evidence suggests that global regulation is needed, the paper concludes that since a global regulatory response is unlikely, more robust domestic regulation may be the best approach. While domestic regulation may increase the drive towards foreign providers it may also have a symbolic effect which will reduce this drive by making people more aware of the dangers of surgery, both to society and individual physical wellbeing. [Abstract]

Lee J.C., Morrison K.A., Maeng M.M., Ascherman J.A., and Rohde C.H., (2018). **Financial Implications of Atypical Mycobacterial Infections After Cosmetic Tourism: Is It Worth the Risk?** *Annals of plastic surgery*, 81(3), pp.269–273.
BACKGROUND: Cosmetic tourism has become increasingly popular despite many associated risks. The economic impact of atypical mycobacterial infections in cosmetic tourism is poorly defined in the literature. We sought to investigate the costs and clinical course of patients with these infections. METHOD(S): A retrospective review of all patients managed by the Plastic Surgery Division at Columbia University Medical Center from 2013 to 2014 with atypical mycobacterial surgical site infections after cosmetic surgery outside the United States was performed. Data including patient demographics, procedure costs, clinical course, impact on daily life, and costs associated with complications were collected using hospital billing information, patient questionnaires, telephone interviews, and clinical

charts. Cost analysis was done to identify the personal and societal costs of these complications. RESULT(S): Data from 10 patients were collected and analyzed. Management of mycobacterial infections cost an average of $98,835.09 in medical charges. The indirect cost of these infections was $24,401 with a mean return to work time of 6.7 months. Total patient savings from cosmetic tourism was $3419. The total cost of a mycobacterial infection was greater than $123,236.47. Although the incidence of mycobacterial infection abroad is unknown, the potential cost of an infection alone outweighs the financial benefits of cosmetic tourism if the risk exceeds 2.77%. CONCLUSION(S): Atypical mycobacterial infections as a result of cosmetic tourism come at considerable cost to patients and the health care system. When our results are taken into consideration with other risks of cosmetic tourism, the financial risks likely far outweigh the benefits.

Gulland, A., (2017). **Plastic surgeons report surge in reoperations for patients treated abroad**. *BMJ : British Medical Journal (Online)*, 359. Available at: https://www.proquest.com/scholarly-journals/plastic-surgeons-report-surge-reoperations/docview/1948366996/se-2?accountid=31583.
Plastic surgeons are warning about a rise in the number of patients needing treatment for complications after travelling abroad for cosmetic procedures. To coincide with the conference, the association conducted a straw poll of its 230 members and found that many reported a rise in the number of patients coming to them with complications after cosmetic procedures-about 30% of the rise was because of the growth in cosmetic surgery tourism, the poll showed. "There is currently-perhaps unsurprisingly, in these turbulent times-a measure of financial uncertainty in the UK. [...]affordability is one of the biggest drivers in the rise of “cosmetic medical tourism” deals offering all-inclusive package holidays and the promise of a high quality service at heavily discounted rates.

Adabi K., Stern C.S., Weichman K.E., Garfein E.S., Pothula A., Draper L., and Tepper O.M., (2017). **Population Health Implications of Medical Tourism**. *Plastic and Reconstructive Surgery*, 140(1), pp.66–74. Available at: http://journals.lww.com/plasreconsurg/pages/issuelist.aspx.
Background: Fifteen million U.S. patients each year seek medical care abroad; however, there are no data on outcomes and follow-up of these procedures. This study aims to identify, evaluate, and survey patients presenting with complications from aesthetic procedures abroad and estimate their cost to the U.S. health care system. Method(s): A single-center retrospective review was conducted. A cohort of patients presenting with complications from aesthetic procedures performed abroad was generated. Demographic, complication, and cost data were compiled. Patients were surveyed to assess their overall experience. Result(s): Over a 36-month period, 42 patients met inclusion criteria (one man and 41 women), with an average age of 35 +/- 11.4 years (range, 20 to 60 years). Comorbidities included four active smokers, two patients with hypertension, and one patient with diabetes. Average body mass index was 29 +/- 4.4 kg/m2 (range, 22 to 38 kg/m2). Procedures performed abroad included abdominoplasty (n = 28), liposuction (n = 20), buttock augmentation (n = 10), and breast augmentation (n = 7), with several patients undergoing combined procedures. Eleven patients presented with abscesses and eight presented with wound dehiscence. Eight of the 18 patients who were surveyed were not pleased with their results and 11 would not go abroad again for subsequent procedures. Average cost of treating the complications was $18,211, with an estimated cost to the U.S. health care system of $1.33 billion. The main payer group was Medicaid. Conclusion(s): Complications from patients seeking aesthetic procedures abroad will continues to increase. Patients should be encouraged to undergo cosmetic surgery in the United States to improve patient outcomes and satisfaction and because it is economically advantageous. Copyright © 2017 by the American Society of Plastic Surgeons.

Klein H.J., Simic D., Fuchs N., Schweizer R., Mehra T., Giovanoli P., and Plock J.A., (2017). **Complications after cosmetic surgery tourism**. *Aesthetic Surgery Journal*, 37(4), pp.474–482. Available at: https://academic.oup.com/asj/article/37/4/474/2520993.
Background: Cosmetic surgery tourism characterizes a phenomenon of people traveling abroad for aesthetic surgery treatment. Problems arise when patients return with complications or need of follow-up

care. Objective(s): To investigate the complications of cosmetic surgery tourism treated at our hospital as well as to analyze arising costs for the health system. Method(s): Between 2010 and 2014, we retrospectively included all patients presenting with complications arising from cosmetic surgery abroad. We reviewed medical records for patients' characteristics including performed operations, complications, and treatment. Associated cost expenditure and Diagnose Related Groups (DRG)-related reimbursement were analyzed. Result(s): In total 109 patients were identified. All patients were female with a mean age of 38.5 +/- 11.3 years. Most procedures were performed in South America (43%) and Southeast (29.4%) or central Europe (24.8%), respectively. Favored procedures were breast augmentation (39.4%), abdominoplasty (11%), and breast reduction (7.3%). Median time between the initial procedure abroad and presentation was 15 days (interquartile range [IQR], 9) for early, 81.5 days (IQR, 69.5) for midterm, and 4.9 years (IQR, 9.4) for late complications. Main complications were infections (25.7%), wound breakdown (19.3%), and pain/discomfort (14.7%). The majority of patients (63.3%) were treated conservatively; 34.8% became inpatients with a mean hospital stay of 5.2 +/- 3.8 days. Overall DRG-related reimbursement premiums approximately covered the total costs. Conclusion(s): Despite warnings regarding associated risks, cosmetic surgery tourism has become increasingly popular. Efficient patients' referral to secondary/tertiary care centers with standardized evaluation and treatment can limit arising costs without imposing a too large burden on the social healthcare system.

Snyder, J., Johnston, R., Adams, K., Morgan, J. and Crooks, V.A., (2017). **How medical tourism enables preferential access to care : : four patterns from the Canadian context**,
Medical tourism is the practice of traveling across international borders with the intention of accessing medical care, paid for out-of-pocket. This practice has implications for preferential access to medical care for Canadians both through inbound and outbound medical tourism. In this paper, we identify four patterns of medical tourism with implications for preferential access to care by Canadians: (1) Inbound medical tourism to Canada's public hospitals; (2) Inbound medical tourism to a First Nations reserve; (3) Canadian patients opting to go abroad for medical tourism; and (4) Canadian patients traveling abroad with a Canadian surgeon. These patterns of medical tourism affect preferential access to health care by Canadians by circumventing domestic regulation of care, creating jurisdictional tensions over the provision of health care, and undermining solidarity with the Canadian health system. [Abstract]

Leggat, P., (2015). **Medical tourism**. *Australian Family Physician*, 44(1/2), pp.16–21. Available at: https://www.proquest.com/scholarly-journals/medical-tourism/docview/1655540654/se-2?accountid=31583.
This article provides an outline of the current research around medical tourism, especially its impact on Australians.

Holliday R., Bell D., Cheung O., Jones M., and Probyn E., (2015). **Brief encounters: Assembling cosmetic surgery tourism**. *Social Science and Medicine*, 124((Holliday, Bell) University of Leeds, United Kingdom), pp.298–304. Available at: http://www.elsevier.com/locate/socscimed.
This paper reports findings from a large-scale, multi-disciplinary, mixed methods project which explores empirically and theoretically the rapidly growing but poorly understood (and barely regulated) phenomenon of cosmetic surgery tourism (CST). We explore CST by drawing on theories of flows, networks and assemblages, aiming to produce a fuller and more nuanced account of - and accounting for - CST. This enables us to conceptualise CST as an interplay of places, people, things, ideas and practices. Through specific instances of assembling cosmetic surgery that we encountered in the field, and that we illustrate with material from interviews with patients, facilitators and surgeons, our analysis advances understandings and theorisations of medical mobilities, globalisation and assemblage thinking.

Li-Hsing, H., Shu-Yun, F., and Tieh-Min Yen, (2015). **Using fuzzy gap analysis to measure service quality of medical tourism in Taiwan**. *International Journal of Health Care Quality Assurance*, 28(7), pp.648-659. Available at: https://www.proquest.com/scholarly-journals/using-fuzzy-gap-analysis-measure-service-quality/docview/2108838541/se-2?accountid=31583.
Purpose – The purpose of this paper is intended to create a model to measure quality of service, using fuzzy linguistics to analyze the quality of service of medical tourism in Taiwan so as to find the direction for improvement of service quality in medical tourism. Design/methodology/approach – The study developed fuzzy questionnaires based on the characteristics of medical tourism quality of service in Taiwan. Questionnaires were delivered and recovered from February to April 2014, using random sampling according to the proportion of medical tourism companies in each region, and 150 effective samples were obtained. The critical quality of service level is found through the fuzzy gap analysis using questionnaires examining expectations and perceptions of customers, as the direction for continuous improvement. Findings – From the study, the primary five critical service items that improve the quality of service for medical tourism in Taiwan include, in order: the capability of the service provider to provide committed medical tourism services reliably and accurately, facility service providers in conjunction with the services provided, the cordial and polite attitude of the service provider eliciting a sense of trust from the customer, professional ability of medical (nursing) personnel in hospital and reliability of service provider. Originality/value – The contribution of this study is to create a fuzzy gap analysis to assess the performance of medical tourism service quality, identify key quality characteristics and provide a direction for improvement and development for medical tourism service quality in Taiwan.

Livingston, R., Berlund, P., Eccles-Smith, J. and Sawhney, R., (2015). **The Real Cost of "Cosmetic Tourism" Cost Analysis Study of "Cosmetic Tourism" Complications Presenting to a Public Hospital.** *Eplasty*, 15(101316107), p.e34. Available at: https://pubmed.ncbi.nlm.nih.gov/26240672/.
"Cosmetic Tourism," the process of traveling overseas for cosmetic procedures, is an expanding global phenomenon. The model of care by which these services are delivered can limit perioperative assessment and postoperative follow-up. Our aim was to establish the number and type of complications being treated by a secondary referral hospital resulting from "cosmetic tourism" and the cost that has been incurred by the hospital in a 1-year period. Retrospective cost analysis and chart review of patients admitted to the hospital between the financial year of 2012 and 2013 were performed. Twelve "cosmetic tourism" patients presented to the hospital, requiring admission during the study period. Breast augmentation was the most common procedure and infected prosthesis was the most common complication (n = 4). Complications ranged from infection, pulmonary embolism to penile necrosis. The average cost of treating these patients was $AUD 12 597.71. The overall financial burden of the complication to the hospital was AUD$151 172.52. The "cosmetic tourism" model of care appears to be, in some cases, suboptimal for patients and their regional hospitals. In the cases presented in this study, it appears that care falls on the patient local hospital and home country to deal with the complications from their surgery abroad. This incurs a financial cost to that hospital in addition to redirecting medical resources that would otherwise be utilized for treating noncosmetic complications, without any remuneration to the local provider.

Anon, (2014). **We need a better understanding of the effects of 'medical tourism' on health systems to have an informed debate about fairness and regulation**. *British Politics and Policy at LSE*. Available at: https://blogs.lse.ac.uk/politicsandpolicy/medical-tourism-costs-benefits-and-ethics/ [Accessed September 19, 2023].
Medical tourism is not a one-way street. Research shows the number of patients travelling from the UK for treatment abroad is greater than the number coming to the UK. Johanna Hanefeld, Neil Lunt a…

Hanefeld J., Smith R., Horsfall D., and Lunt N., (2014). **What do we know about medical tourism? A review of the literature with discussion of its implications for the UK national health service as an**

example of a public health care system. *Journal of Travel Medicine*, 21(6), pp.410–417. Available at: https://pubmed.ncbi.nlm.nih.gov/25156070/.
Background. Medical tourism is a growing phenomenon. This review of the literature maps current knowledge and discusses findings with reference to the UK National Health Service (NHS). Methods. Databases were systematically searched between September 2011 and March 2012 and 100 papers were selected for review. Results. The literature shows specific types of tourism depending on treatment, eg, dentistry, cosmetic, or fertility. Patient motivation is complex and while further research is needed, factors beyond cost, including availability and distance, are clearly important. The provision of medical tourism varies. Volume of patient travel, economic cost and benefit were established for 13 countries. It highlights contributions not only to recipient countries' economies but also to a possible growth in health systems' inequities. Evidence suggests that UK patients travel abroad to receive treatment, complications arise and are treated by the NHS, indicating costs from medical travel for originating health systems. Conclusion. It demonstrates the importance of quality standards and holds lessons as the UK and other EU countries implement the EUDirective on cross-border care. Lifting the private-patient-cap for NHS hospitals increases potential for growth in inbound medical tourism; yet no research exists on this. Research is required on volume, cost, patientmotivation, industry, and on long-term health outcomes in medical tourists.Copyright © 2014 International Society of Travel Medicine.

Lunt, N., Smith, Richard D. and Mannion, R., (2014). **Implications for the NHS of inward and outward medical tourism : : a policy and economic analysis using literature review and mixed-methods approaches**, Available at: https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr02020#/abstract.
BACKGROUND: The study examined the implications of inward and outward flows of private patients for the NHS across a range of specialties and services. OBJECTIVES: To generate a comprehensive documentary review; to better understand information, marketing and advertising practices; examine the magnitude and economic and health-related consequences of travel; understand decision-making frames and assessments of risk; understand treatment experience; elicit the perspectives of key stakeholder groups; and map out medical tourism development within the UK. DESIGN AND PARTICIPANTS: The study integrated policy analysis, desk-based work, economic analysis to estimate preliminary costs, savings and NHS revenue, and treatment case studies. The case studies involved synthesising data sources around bariatric, fertility, cosmetic, dental and diaspora examples. Overall, we drew on a mixed-methods approach of qualitative and quantitative data collection. The study was underpinned by a systematic overview and a legal and policy review. In-depth interviews were carried out with those representing professional associations, those with clinical interests and representative bodies (n = 16); businesses and employees within medical tourism (n = 18); NHS managers (n = 23); and overseas providers. We spoke to outward medical travellers (46 people across four treatment case studies: bariatric, fertility, dental and cosmetic) and also 31 individuals from UK-resident Somali and Gujarati populations. RESULTS: The study found that the past decade has seen an increase in both inward and outward medical travel. Europe is both a key source of travellers to the UK and a destination for UK residents who travel for medical treatment. Inward travel often involves either expatriates or people from nations with historic ties to the UK. The economic implications of medical tourism for the NHS are not uniform. The medical tourism industry is almost entirely unregulated and this has potential risks for those travelling out of the UK. Existing information regarding medical tourism is variable and there is no authoritative and trustworthy single source of information. Those who travel for treatment are a heterogeneous group, with people of all ages spread across a range of sociodemographic groups. Medical tourists do not appear to inform their decision-making with hard information and consequently often do not consider all risks. They make use of extensive informal networks such as treatment-based or cultural groups. Motivations to travel are in line with the findings of other studies. Notably, cost is never a sole motivator and often not the primary motivation for seeking treatment abroad. LIMITATIONS: One major limitation of the study was the abandonment of a survey of medical tourists. We sought to avoid an extremely small survey, which offers no real insight. Instead we redirected our resources to a deeper analysis of qualitative interviews, which proved remarkably fruitful. In a similar vein, the economic analysis proved more difficult and time

consuming than anticipated. Data were incomplete and this inhibited the modelling of some important elements. CONCLUSIONS: In 2010 at least 63,000 residents of the UK travelled abroad for medical treatment and at least 52,000 residents of foreign countries travelled to the UK for treatment. Inward referral and flows of international patients are shaped by clinical networks and longstanding relationships that are fostered between clinicians within sender countries and their NHS counterparts. Our research demonstrated a range of different models that providers market and by which patients travel to receive treatment. There are clearly legal uncertainties at the interface of these and clinical provision. Patients are now travelling to further or 'new' markets in medical tourism. Future research should: seek to better understand the medium- and long-term health and social outcomes of treatment for those who travel from the UK for medical treatment; generate more robust data that better capture the size and flows of medical travel; seek to better understand inward flows of medical travellers; gather a greater level of information on patients, including their origins, procedures and outcomes, to allow for the development of better economic costing; explore further the issues of clinical relationships and networks; and consider the importance of the NHS brand. [Abstract]

Hanefeld, J., Horsfall, D. and Lunt, N., (2013). **Medical tourism : : a cost or benefit to the NHS?**, Available at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0070406.
'Medical Tourism' - the phenomenon of people travelling abroad to access medical treatment - has received increasing attention in academic and popular media. This paper reports findings from a study examining effect of inbound and outbound medical tourism on the UK NHS, by estimating volume of medical tourism and associated costs and benefits. A mixed methods study it includes analysis of the UK International Passenger Survey (IPS); interviews with 77 returning UK medical tourists, 63 policymakers, NHS managers and medical tourism industry actors policymakers, and a review of published literature. These informed costing of three types of treatments for which patients commonly travel abroad: fertility treatment, cosmetic and bariatric surgery. Costing of inbound tourism relied on data obtained through 28 Freedom-of-Information requests to NHS Foundation Trusts. Findings demonstrate that contrary to some popular media reports, far from being a net importer of patients, the UK is now a clear net exporter of medical travellers. In 2010, an estimated 63,000 UK residents travelled for treatment, while around 52,000 patients sought treatment in the UK. Inbound medical tourists treated as private patients within NHS facilities may be especially profitable when compared to UK private patients, yielding close to a quarter of revenue from only 7% of volume in the data examined. Costs arise where patients travel abroad and return with complications. Analysis also indicates possible savings especially in future health care and social costs averted. These are likely to be specific to procedures and conditions treated. UK medical tourism is a growing phenomenon that presents risks and opportunities to the NHS. To fully understand its implications and guide policy on issues such as NHS global activities and patient safety will require investment in further research and monitoring. Results point to likely impact of medical tourism in other universal public health systems. [Abstract]

Hanefeld, J., Lunt, N., Horsfall, D. and Smith, R., (2012). **Discussion on banning advertising of cosmetic surgery needs to consider medical tourists**. *BMJ : British Medical Journal (Online)*, 345. Available at: https://www.proquest.com/scholarly-journals/discussion-on-banning-advertising-cosmetic/docview/1945325789/se-2?accountid=31583.
The discussion on banning advertising of cosmetic surgery neglects an important aspect of safeguarding UK consumers from direct marketing by cosmetic surgery providers to the public 1 : an increasing number of UK patients travel abroad for cosmetic surgery. [...]a comprehensive review of cosmetic surgery needs to consider the increasing number of patients travelling abroad for cosmetic procedures or risk that its recommendations are little more than a short term fix.

Smith, R., Lunt, N. and Hanefeld, J., (2012). **The implications of PIP are more than just cosmetic**. *The Lancet*, 379(9822), pp.1180–1. Available at: https://www.proquest.com/scholarly-journals/implications-pip-are-more-than-just-cosmetic/docview/992945991/se-2?accountid=31583.

What “moral responsibility” does the Government expect the private sector to bear for foreign patients who were treated in the UK? [...] does the NHS have an obligation to all patients treated in the UK, irrespective of whether by an NHS or private provider?

Smith, R., (2012). **Online marketing of medical procedures needs better regulation**. *BMJ : British Medical Journal (Online)*, 344. Available at: https://www.proquest.com/scholarly-journals/online-marketing-medical-procedures-needs-better/docview/1945170297/se-2?accountid=31583.
Advertising for medical products, for instance, is strictly controlled by legislation and codes of practice. 2 3 Promotional material on the internet directed at a UK audience is also subject to the Association of the British Pharmaceutical Industry’s code of practice. 4 In reality, however, enforcement is only possible against entities with a presence in the regulator’s jurisdiction. 5 With the increase in so called medical tourism, where surgeons or providers of a medical service are based abroad and market themselves to patients in the UK, regulating and enforcing codes of practice are becoming serious problems. Research shows a burgeoning number of sites dedicated to medical tourists in recent years. 8 A major growth area has, in particular, been advertising and marketing of cosmetic surgery that predominantly present treatment as a lifestyle choice, rather than as a serious surgical procedure with accompanying risks and potential long term health consequences. In the European Union, an e-commerce directive (2000/31/EC) requires companies to display ways in which the website can be contacted, but this is minimal information given the nature of services and products marketed by medical providers. 9 A systematic review of websites aimed at potential UK medical tourists found limited information available, for example, on care after operations, quality, or even the qualifications of surgeons. 10 Selective information may be presented, or presented out of the wider context, such as ignoring issues of after care and support.

Boultbee, E., (2012). **Medical tourism : : overview and cost comparisons**,
Medical tourism is a term which has come into common usage. It is a segment of the broader health tourism market, which can be broken down into several major components. This article seeks to provide an overview of the subject, the reasons for its popularity and comparisons of cost to the patient involved. [Introduction]

Hodges, J.R., Turner, L. and Kimball, A.M., (2012). **Risks and challenges in medical tourism : : understanding the global market for health services**. King’s Fund Library HOHCC

Miyagi, K., Auberson, D., Patel, A.J. and Malata, C.M., (2012). **The unwritten price of cosmetic tourism: an observational study and cost analysis.** *Journal of plastic, reconstructive & aesthetic surgery : JPRAS*, 65(1), pp.22–8. Available at: https://www.jprasurg.com/article/S1748-6815(11)00423-2/fulltext.
INTRODUCTION AND AIMS: Cosmetic tourism, driven by the promise of inexpensive operations abroad, is increasingly popular despite warnings from professional bodies regarding associated risks. Increasing numbers of individuals have presented to our department requesting NHS treatment of complications from such surgery. We set out to characterize these patients and evaluate costs incurred through their assessment and management., MATERIAL AND METHODS: An observational study was conducted from 2007 to 2009 on patients presenting to a tertiary referral Plastic Surgery practice with complications of cosmetic tourism surgery. Demographic characteristics, as well as those related to the operation, were recorded. Hospital patient flow pathways were constructed, cost analysis performed using Patient Level Costing, and expenditure and profitability calculated., KEY RESULTS: Nineteen patients presented within the study period. Most operations were performed in Europe or Asia, and were primarily breast augmentation procedures (n=13). The principal complications were wound infection or dehiscence, and poor cosmetic results. Eleven patients received NHS treatment, at a cost of 120,841. The mean cost for all patients’ management was 6360 (range: 114-57,968), rising to 10,878 for those accepted for treatment. For 8 of the 9 patients (89%) for whom full patient level costing was available, the hospital incurred a financial loss., CONCLUSION: The costs to the NHS of managing complications of cosmetic

tourism are substantial, and underestimated by central funding agencies. Copyright © 2011 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.

Vick L., (2012). **The perils of cosmetic surgery/medical tourism**. *Clinical Risk*, 18(3), pp.106–109. Available at: http://cr.rsmjournals.com/content/18/3/106.full.pdf+html.
The article discusses a case involving negligent aesthetic surgery. The surgery took place in a Belgian clinic and was performed by an Italian surgeon.

Jeevan R., Birch J., and Armstrong A.P., (2011). **Travelling abroad for aesthetic surgery: Informing healthcare practitioners and providers while improving patient safety**. *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 64(2), pp.143–147. Available at: https://www.jprasurg.com/article/S1748-6815(10)00242-1/fulltext.
Travelling abroad for surgery is a phenomenon reported internationally. It is particularly likely for aesthetic procedures not undertaken routinely by national health services. We assessed the impact of these patients presenting to the UK National Health Service (NHS) with concerns or complications on their return. All 326 UK consultant members of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) were asked to complete a short questionnaire about patients that had presented to the NHS with complications or concerns following surgery abroad. The results were subsequently presented to the Department of Health (DH). 203 (62%) UK consultant plastic surgeons responded. 76 (37%) of the 203 respondents had seen such patients in their NHS practice, most commonly following breast or abdominal procedures. A quarter underwent emergency surgery, a third out-patient treatment and a third elective surgical revision. In response to these findings, the DH clarified that NHS teams should provide emergency care to such patients but should not undertake any elective revision procedures. Travelling abroad for aesthetic surgery may reduce its cost. However, aesthetic procedures have high minor complication rates, and peri-operative travel is associated with increased risks. Fully informed consent is unlikely when patients do not meet their surgeon prior to paying and travelling for surgery, and national health services are used to provide a free safety net on their return. To help minimise the potential risks, BAPRAS has clarified the responsibilities of the NHS and is acting to better inform UK patients considering travelling abroad. © 2010 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.

Lunt, N., Smith, R.D., Exworthy, M., Green, S.T., Horsfall, D.G. and Mannion, R., (2011). **Medical Tourism: Treatments, Markets and Health System Implications: A scoping review**, OECD.

Nassab R., Hamnett N., Nelson K., Kaur S., Greensill B., Dhital S., and Juma A., (2010). **Cosmetic tourism: Public opinion and analysis of information and content available on the internet**. *Aesthetic Surgery Journal*, 30(3), pp.465–469. Available at: http://asj.oxfordjournals.org/content/by/year.
Background: The medical tourism market is a rapidly growing sector fueled by increasing health care costs, longer domestic waiting times, economic recession, and cheaper air travel. Objective(s): The authors investigate public opinion on undergoing cosmetic surgery abroad and then explore the information patients are likely to encounter on the Internet when searching for such services. Method(s): A poll of 197 members of the general public was conducted in the United Kingdom. An Internet search including the terms plastic surgery abroad was conducted, and the first 100 relevant sites were reviewed. Result(s): Of the 197 respondents, 47% had considered having some form of cosmetic surgery. Most (97%) would consider going abroad for their procedure. The Internet was a source of information for 70%. The review of the first 100 sites under “plastic surgery abroad” revealed that most centers were located in Eastern Europe (26%), South America (14%), and the Far East (11%). Exploring the information provided on the Web sites, we found 37% contained no information regarding procedures. Only 10% of sites contained any information about potential complications. Even less frequently mentioned (4%) were details of aftercare or follow-up procedures. Conclusion(s): The authors found that the overwhelming majority of

respondents considering plastic surgery would also consider seeking cosmetic surgical treatment abroad. The Internet sites that appear most prominently in an online search contained a distinct lack of information for potential patients, particularly with regard to complications and aftercare. There is, therefore, a need for improved public awareness and education about the considerations inherent in medical tourism. The introduction of more stringent regulations for international centers providing such services should also be considered to help safeguard patients. © 2010 The American Society for Aesthetic Plastic Surgery, Inc.

Turner L., (2010). **"Medical tourism" and the global marketplace in health services: U.S. patients, international hospitals, and the search for affordable health care**. *International Journal of Health Services*, 40(3), pp.443–467. Available at: http://joh.sagepub.com/content/by/year.
Health services are now advertised in a global marketplace. Hip and knee replacements, ophthalmologic procedures, cosmetic surgery, cardiac care, organ transplants, and stem cell injections are all available for purchase in the global health services marketplace. "Medical tourism" companies market "sun and surgery" packages and arrange care at international hospitals in Costa Rica, India, Mexico, Singapore, Thailand, and other destination nations. Just as automobile manufacturing and textile production moved outside the United States, American patients are "offshoring" themselves to facilities that use low labor costs to gain competitive advantage in the marketplace. Proponents of medical tourism argue that a global market in health services will promote consumer choice, foster competition among hospitals, and enable customers to purchase high-quality care at medical facilities around the world. Skeptics raise concerns about quality of care and patient safety, information disclosure to patients, legal redress when patients are harmed while receiving care at international hospitals, and harms to public health care systems in destination nations. The emergence of a global market in health services will have profound consequences for health insurance, delivery of health services, patient-physician relationships, publicly funded health care, and the spread of medical consumerism.

Ben-Natan, M., RN, BA, MA, PhD, Ben-Sefer, E., RN, BS, MN, PhD and Ehrenfeld, M., RN, PhD, (2009). **Medical Tourism: A New Role for Nursing?** *Online Journal of Issues in Nursing*, 14(3), p.8. Available at: https://www.proquest.com/scholarly-journals/medical-tourism-new-role-nursing/docview/501914039/se-2?accountid=31583.
Medical tourism is on the rise; however this healthcare trend raises significant issues related to the safety and appropriateness of care. The purpose of this article is to provide healthcare professionals with a better understanding of the phenomenon of medical tourism. The authors will begin by reviewing the history of medical tourism, noting specific medical tourism destinations, and presenting reasons for this increase in medical tourism. Next they will discuss quality and safety issues associated with medical tourism, provide criteria to assess quality of care in other countries, and address ethical and legal consideration inherent in medical tourism. They will conclude with a consideration of the nursing role in medical tourism.

Cockburn T. and Madden B., (2009). **Legislative intervention in Queensland to restrict access to solariums and cosmetic procedures by children and young persons**. *Journal of law and medicine*, 16(4), pp.653–665.
Breaking new ground, Queensland has enacted laws restricting access to cosmetic surgery by those under 18 years of age. Legislation in other Australian jurisdictions is narrower in scope, focusing on niche areas such as solarium use, tattoos and body piercing. Even in those niche areas there are inconsistencies of approach and now the unique Queensland cosmetic surgery restrictions further raise the prospects of "medical tourism" and highlight the difficulties of differing legislation throughout Australia. All implementations, however, face the same challenge: to balance protection of vulnerable children, respect for a young person's autonomy and due regard to parental consent.

Jeevan, R. and Armstrong, A., (2008). **Cosmetic Tourism and the burden on the NHS**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 61(12), pp.1423–1424. Available at: https://www.jprasurg.com/article/S1748-6815(08)01006-1/fulltext [Accessed September 21, 2023].
The past decade has seen dramatic changes in the workload of UK plastic surgeons, with increasing awareness and demand for aesthetic surgery among the general public. Globalisation has led to an increased acceptance of outsourcing in the provision of key goods and services to the UK population as a whole. In parallel, the increased availability of cheap flights abroad has removed a key financial barrier for those seeking aesthetic surgery abroad, a phenomenon labelled as 'cosmetic tourism. 1 , 2 , 3 More and more patients 4 travel abroad to undertake such procedures, in many cases assisted by agencies that offer 'package' 5 deals to a multitude of destinations.

Birch, J., Caulfield, R. and Ramakrishnan, V., (2007). **The complications of 'cosmetic tourism' - an avoidable burden on the NHS**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 60(9), pp.1075–1077. Available at: https://www.jprasurg.com/article/S1748-6815(07)00213-6/fulltext [Accessed September 21, 2023].
Aesthetic procedures are an increasing proportion of the modern reconstructive surgeon's workload. Recent press coverage in the print media, on television and the internet 1 , 2 has brought the phenomenon of cosmetic tourism to the attention of the public and the plastic surgical community. 3 , 4 Patients are increasingly travelling to other countries lured by the promise of reduced cost, increased ease of accessibility and reduced waiting times.

MacReady, N., (2007). **Developing countries court medical tourists**. *The Lancet*, 369(9576), pp.1849–50. Available at: https://www.proquest.com/scholarly-journals/developing-countries-court-medical-tourists/docview/198999373/se-2?accountid=31583.
Shrewd hospital administrators in these countries are actively courting patients who are willing and able to circumvent the shortcomings of their own health-care systems, opting instead to have their prostate surgeries or joint replacements at foreign hospitals that welcome them-and their pounds, dollars, and euros-with open arms. Under this model, governments and private businesses, eager to take advantage of the cost savings of medical tourism, will establish formal agreements with foreign health-care providers that will set quality standards and safeguard patient safety.

Search Strategies

The King's Fund Database

su: 'cosmetic surgery' or 'plastic surgery' and su: 'regulation or 'patient safety'
20 results
su: 'cosmetic surgery' or 'plastic surgery' and kw: regulat*
16 results

Embase, Emcare, Medline

Embase <1974 to 2023 September 14>
Ovid Emcare <1995 to 2023 Week 36>
Ovid MEDLINE(R) ALL <1946 to September 14, 2023>

1 ("cosmetic surgery" or "cosmetic medicine" or "aesthetic medicine" or "aesthetic surgery").mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, bt, nm, ox, px, rx, an, ui, sy, ux, mx] 11689
2 regulat*.mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, bt, nm, ox, px, rx, an, ui, sy, ux, mx] 6527102
3 "patient safety".mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kf, fx, dq, bt, nm, ox, px, rx, an, ui, sy, ux, mx]287784
4 2 or 3 6802991
5 1 and 4 631

"cosmetic tourism"
"medical tourism" and cosmetic
276 results

CINAHL

(("cosmetic surgery" or "cosmetic medicine" or "aesthetic medicine" or "aesthetic surgery")) AND ((regulat*) or "patient safety")
Expanders - Apply equivalent subjects
Search modes - Boolean/Phrase
Interface - EBSCOhost Research Databases
Search Screen - Advanced Search
Database - CINAHL
Results: 203

"cosmetic tourism"
"medical tourism" and cosmetic
76 results

British Nursing Index

("cosmetic surgery" or "cosmetic medicine" or "aesthetic medicine" or "aesthetic surgery") AND ((regulat*) OR ("patient safety"))
276 results

"cosmetic tourism"
"medical tourism" and cosmetic
46 results