1 School of Law and Social Justice, University of Liverpool, Liverpool, UK

2 Faculty of Law, University of Melbourne, Melbourne, Australia

3 School of Medicine, Trinity College Dublin, Dublin, Ireland

4 Department of Law, University of Manchester, Manchester, UK

Correspondence to: D Griffiths
Danielle.griffiths@liverpool.ac.uk

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Regulating invasive cosmetic procedures to reduce harm

Danielle Griffiths and colleagues argue that the rise in invasive cosmetic procedures demands tighter regulation, better consumer protection, and greater awareness

Danielle Griffiths, [1] Ian Freckelton, [2] Barry Lyons, [3] Alex Mullock[4]

In 2024, Alice Webb died after a non-surgical Brazilian butt lift, a cosmetic procedure that was done in the UK by a provider who was not medically qualified.[1] Once considered a consumer concern, cosmetic interventions now raise substantive patient safety and health system issues. Although deaths remain rare, evidence suggests that associated harms are increasing.

Surgical or invasive cosmetic procedures are generally understood as those that involve the insertion of instruments or equipment into the body, such as tummy tuck or breast augmentation, while non-surgical procedures are minimally invasive and include subcutaneous injections to alter appearance such as botox or dermal filler.[2] However, non-surgical procedures are becoming increasingly invasive, blurring the distinction.

Reliable data on cosmetic procedures are hard to find, largely because of the mix of providers, environments, regulatory gaps, absence of structured reporting systems, and cosmetic tourism. Nevertheless, alarm over the numerous publicised cases has prompted regulators in some countries (including Germany and Australia) to impose standards of care and enhanced oversight for cosmetic interventions.[3-6] The governments of Scotland and England look set to follow suit. However, current proposals within the UK are disjointed and insufficiently protective.

How market forces are reshaping cosmetic surgery

The market for cosmetic procedures is growing rapidly. The value of the global industry increased from $25bn in 2016 to $137bn in 2024 and is projected to exceed $180bn by 2033.[7 8] The US has a 36-40% share of global market revenue for non-surgical cosmetic procedures. Europe holds roughly 28-30%, with the UK, Germany, and France dominating.[9]

The increased prevalence of cosmetic procedures is driven by multiple factors. Non-surgical procedures are more accessible because of their lower cost and reduced invasiveness, with delivery in a wider range of clinical and non-clinical settings. Social media are a key element—their interactive nature and the proliferation of idealised, often filtered, bodies affect self-image. Qualitative research indicates that increased exposure to cosmetically enhanced images on social media correlates with people's desire for cosmetic procedures.[10]

Some practitioners exploit idealised body images to push misleading marketing, using celebrities, influencers, and promotional incentives to amplify their reach.[10] An ageing population is also a contributor.[9] Capitalising on these trends, cosmetic surgery tourism has grown rapidly, with Turkey emerging as the top destination from the UK for cosmetic procedures.[11] Consumer motivations for accessing cosmetic services abroad are diverse but most often related to cost.[11]

Harms of cosmetic procedures

Deaths are more common after cosmetic tourism than after domestically provided procedures. Foreign Office data indicate that at least 28 British nationals have died since 2019 after having elective cosmetic procedures in Turkey, including liposuction and hair transplants, as well as non-surgical procedures such as butt lifts.[12] Coroners' prevention of future death reports and other data link these deaths to extremely poor standards of care.[13]

Non-fatal harm is far more common. UK surveys of people receiving aesthetic botox injections commonly report acute complications such as inflammation, alongside longer term problems including anxiety, social withdrawal, dry eyes, vision problems, or nerve damage.[14] Dermal fillers make up around two thirds of non-surgical cosmetic procedures in the UK[2] and seem to have higher rates of complaints and complications than botox.[15] Although many side effects are mild, skin and tissue necrosis, blindness, and sepsis are recognised risks.[16] In one study, half of patients presenting to the NHS with complications after non-surgical procedures required surgical management, including incision and drainage of abscesses, debridement, split skin grafts, and negative pressure dressings.[17] Two thirds had their procedure done in the UK, with 22% having had butt lifts.[17]

A 2022 study identified that the most common adverse outcomes after cosmetic surgical procedures were wound dehiscence, infection, and seromas[18]; 91% of affected patients had had breast surgery or tummy tucks.[18] In contrast to non-surgical procedures, most patients presenting to the NHS with complications of cosmetic surgery had been treated abroad, mostly in Turkey (73%).[17] These cosmetic tourists may be importantly disadvantaged: the quality of destination surgical services provided varies considerably[11] (in contrast with Care Quality Commission (CQC) regulated cosmetic surgery in the UK); they often delay presenting to domestic health services because of embarrassment or uncertainty, leading to serious morbidity; and access to their healthcare records from overseas clinics can be problematic.[12] Legal recourse for such patients is limited.

Calculated resulting costs to the NHS vary and are probably underestimated. A 17 month audit in one

NHS trust reported costs of £110 690,[17] while a five year study of cosmetic surgery tourism complications estimated costs to NHS Scotland of £755 559.[19] Most data come from single centre studies, and there is no UK-wide reporting or tracking system for complications from private cosmetic procedures. Thus, many cases may never reach datasets. For example, botox complications should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) yellow card scheme. However, 92% of participants in one study reported that they were not informed of the scheme, with many complications thus going unreported.[20] An estimated 900 000 botox-like injections are carried out in the UK each year, yet just 188 adverse reactions were reported to the MHRA between 1991 and 2020.[14] The transient nature of "pop-up" providers on social media may further contribute to underreporting of harms.

Regulatory gaps

The harms that are emerging can be traced to regulatory variability and gaps within the cosmetic intervention legal landscape, though these gaps vary by provider, procedure, and jurisdiction (box 1). All of this creates a siloed, inconsistent, and underwhelming regulatory framework.

Box 1: UK regulation of cosmetic procedures and products

Procedure

- *Cosmetic surgery*—Can only be performed by registered medical practitioners. The law is clear that the type of harm perpetrated by surgical procedures is not lawful unless deemed "reasonable surgery" under the principles outlined in *R v Brown* [1994] 1 AC 212
- *Non-surgical cosmetic procedure*—Can be performed by anyone

Provider

Doctors

- Regulated by the General Medical Council for all surgical and non-surgical cosmetic interventions
- Although cosmetic or aesthetic medicine or surgery is not a recognised specialty, the GMC issued specific advice in 2016 (updated in 2024)[21]
- The Intercollegiate Cosmetic Surgery Board created a code of conduct and outlined an accreditation process,[22] but this applies only to surgeons

Nurses, pharmacists, and dentists

- Guidance from the Nursing and Midwifery Council, General Pharmaceutical Council, and General Dental Council covers[23-25]
- Prescribing aesthetic medications
- Face-to-face consultations before administration, and
- Restrictions on whom the prescriber can delegate administration to
- No code of practice explicitly covers cosmetic procedures.

Non-healthcare professionals

- No regulation and no consistent standards around qualifications or training for non-surgical procedures. Voluntary registration is possible through the Joint Council for Cosmetic Practitioners

Minimum age

- England prohibits certain interventions in those under the age of 18 through the Children Act. Scotland is likely to propose similar legislation soon, but there is no indication whether this might happen in Wales or Northern Ireland

Injectable products

- EU Medical Device Regulation (EU 2017/745) applies in Northern Ireland (designating dermal fillers as a class III medical device)
- Elsewhere in UK, dermal fillers must be UK conformity assessed or Conformité Européenne (CE) marked if the manufacturer makes medical claims
- Regulation can be circumvented if manufacturer does not make medical claims. This can result in poor quality fillers being used
- Botox can be prescribed only by a qualified prescriber

In addition to the regulatory frameworks in box 1, the UK also has registers accredited by the Professional Standards Authority that set standards of competence and training for healthcare professionals—for example, Save Face and the Joint Council for Cosmetic Practitioners, which also includes non-healthcare professionals such as beauty therapists (Joint Council for Cosmetic Practitioners). Registration is not mandatory, and collectively these registers include around 1800 practitioners within an industry of many thousands.[26]

Studies of UK clinic based provision show that botox and dermal filler injections are predominantly administered by healthcare professionals (doctors, nurses, pharmacists, and dentists) who are registered for cosmetic procedures.[27] This suggests that harms do not arise solely from procedures performed by non-healthcare professionals. However, many unregistered and uninsured practitioners will be excluded from the data because they now market services solely through social media and provide procedures in pop-up shops, public toilet cubicles, hotel rooms, and private homes rather than clinics.[2] The risk of harm stemming from such unqualified practitioners is accentuated as non-surgical procedures become increasingly invasive.

Within this opaque landscape of varied provision, regulations are often not adhered to, with implications for patient safety. For example, botox is a prescription-only medicine, although it is often administered by a non-healthcare professional after a face-to-face consultation with a qualified professional. However, many non-qualified providers bypass the medical consultation requirement and use cheap or fake botox.[28] In July and August 2025, there were 41 confirmed cases of botulism.[28] The lack of oversight of unlicensed providers limits the ability of state agencies, including the police and CQC, to intervene until serious harm or death occurs.

A safer approach

Recent efforts have been made to control unregulated non-surgical cosmetic procedures in the UK. In August 2025, the government published proposals for a new licensing scheme for England highlighting the need for knowledge, training, qualification, and indemnity requirements, alongside mandated hygiene standards for premises (table 1).[2] A 2026 report from the Parliamentary Women and Equalities Committee called for an immediate ban on non-surgical butt lifts and for licensing regulations to be adopted by the end of this parliament.[29] Scotland is further ahead and will bring a bill regulating non-surgical cosmetic procedures and functions of medical reviewers before the Scottish parliament in 2026.[30] The bill contains proposals similar to those in England, including a three tier categorisation of procedures based on invasiveness, complexity, and risk.

Table 1 | Risk categories for cosmetic procedures proposed in England

Risk category	Example procedures	Requirements
Green (low risk)	Microneedling, mesotherapy, intense pulsed light (IPL) and light emitting diode (LED) therapies, chemical peels that involve destruction only into viable epidermis (the outermost layer of the skin), "no needle" fillers including pneumatic devices that use intense pressure to pass substances through the epidermis, micropigmentation (semi-permanent make-up), including microblading and nanoblading	Any provider is eligible to perform procedures where they meet agreed standards
Amber (medium risk)	Botox injections, semipermanent dermal fillers injected into the face only, biorevitalisation injections or any injection of hyaluronic acid, vitamin and mineral injection procedures, platelet rich plasma therapy for cosmetic purposes and biofiller, injection microsclerotherapy (spider vein treatment), weight loss injections, carboxytherapy or the infusion of gases under the skin, cellulite subcision, injection lipolysis, cryolipolysis, high intensity focused ultrasound radiofrequency treatments, plasma ablation or plasma fibroblast, medium depth peels that involve full thickness destruction of entire epidermis into upper dermis	Mixed provider requirements. Non-healthcare professionals must be licensed and have relevant oversight by a named healthcare professional (who has gained an accredited qualification to prescribe, administer, and supervise aesthetic procedures). Accredited healthcare professionals are eligible to perform these procedures without oversight where they meet agreed standards
Red (high risk)	All thread lifting procedures, procedures aimed at augmenting any part of the body, in particular the breast, buttocks, and genitals, typically using autologous fat or dermal fillers, the combination of ultrasound and large bore cannula for the purposes of liposuction, deeper chemical peels such as phenol peels, lasers which target the deeper layers of the dermis	Only accredited healthcare professionals Regulated by the Care Quality Commission

While establishing a stronger domestic legislative framework for non-surgical treatments in the UK is a positive development, substantial gaps remain. Licensing schemes in England and Scotland are promising, but there is uncertainty around change in Wales and Northern Ireland. Regulatory inconsistencies across the UK (box 1) risk encouraging internal cosmetic tourism, including among under 18s or patients seeking lower cost treatments.

Even under the proposed licensing schemes in England and Scotland, non-healthcare providers could still perform moderate risk procedures under supervision. Because of the invasiveness and risks associated with some of these procedures, other countries have imposed stricter limits. In many US states it is unlawful for non-healthcare professionals to administer botox injections.[31] In France, since 2004, only doctors can administer botox and dermal filler. If non-healthcare professionals in the UK are to perform moderate risk procedures, accessible and consistent training routes are needed and all providers should be regulated by the CQC.[29] Additionally, although the proposed licensing schemes restrict the highest risk procedures to healthcare professionals, they do not include clear stipulations on the qualifications, training, and competency of providers. Preprocedural assessment, counselling, and consent requirements also need to be stronger.

Australia's comprehensive reforms provide a valuable model for the UK. It has extensive guidance on cosmetic surgery from several regulators, including on formal standards for both the accreditation of cosmetic surgery programmes and the training, assessment, accreditation, and visibility of cosmetic surgery practitioners,[3] in addition to legal restrictions on the use of the title surgeon.[4] A single set of guidelines has been issued for all registered healthcare practitioners detailing comprehensive requirements for assessment, consultation, and consent.[5] Regulations on advertising by registered and unregistered practitioners reinforce existing obligations to avoid giving false or misleading information, which generates unreasonable expectations of beneficial treatment. Videos and images used must not be sexualised, include gratuitous nudity, or employ negative body language. Medical practitioners must provide clear information about risks and recovery and identify any cosmetic surgery advertising as adult content.[6] Such measures are similar to those in Germany, which has banned advertising of medically unnecessary cosmetic procedures.

These developments are too new for their impact on the quality and safety of Australian cosmetic services to be assessed. However, emerging studies in the UK indicate that non-surgical procedures performed by healthcare professionals are associated with fewer reported harms than those performed by medically untrained providers, highlighting the need for better training.[15] Quantifying any effect of regulation in the UK will not be straightforward given the absence of any effective preregulation data collection system. However, there are relevant examples to learn from in the UK where regulation serves both practical and symbolic purposes. Regulatory standards set by the UK Human Fertilisation and Embryology Authority promote public accountability, have an important educational role, and uphold high standards, even in the context of fertility tourism and unregulated reproductive procedures.[32] Cosmetic services require a similarly robust, statutory, and enforced regulation. In the short term the UK government and regulators should prioritise the feasible reforms adopted by Australia and other countries to advance consumer safety, particularly through restricting the most invasive procedures to appropriately qualified healthcare professionals and promulgating a single set of cohesive guidelines on non-surgical procedures applicable to all providers.

Yet even strong domestic regulation cannot fully control a global and dynamic market. Cosmetic tourism presents substantial domestic regulatory challenges. When care abroad goes wrong health tourists may face a "legal limbo" because of jurisdictional complexities and limited domestic oversight. Enhanced UK regulation may increase costs and restrict access to cosmetic procedures, potentially driving growth of cosmetic tourism. Similarly, domestic unlicensed practitioners may continue to work underground, where regulators may struggle to monitor activity. To combat this and protect vulnerable consumers, complementary non-regulatory efforts are essential, especially public health information campaigns, perhaps coordinated through the Office for Health Improvements and Disparities. Priority should also be

given to communicating how to choose practitioners safely, including promoting the accredited registers for cosmetic procedures.[26]

Further government initiatives are needed to tackle the wider problem of body image and mental health.[33] This includes addressing the underlying drivers of "cosmetic need," such as distorted and idealised social media images, as well as imposing tighter rules around advertising as seen in Australia and in Germany, where the ban on "before and after" pictures limits misleading content. There is also scope to improve information for patients seeking cosmetic procedures overseas. Although the reach of such efforts is uncertain, availability of accurate information can protect those contemplating health affecting choices.

In conclusion, all invasive cosmetic procedures should be performed by trained healthcare professionals under statutory oversight. Coordinated regulation across the four UK nations, alongside public education and advertising controls, is essential to safeguard patients and reduce cosmetic tourism.

Key messages

- The growing use and invasiveness of cosmetic procedures is increasing the risk of harm
- Consistent regulation across all four UK nations is essential to protect patient safety and reduce cosmetic tourism
- High risk invasive cosmetic procedures (surgical and non-surgical) should be performed by trained healthcare professionals only with standardised qualifications and oversight
- A single set of guidelines on non-surgical cosmetic procedures, applicable to all registered practitioners, should detail requirements for training, assessment, consultation, and consent
- Broader interventions, including public education, advertising controls, and accredited registers, are essential to ensure reliable information, realistic expectations, and safe access to cosmetic procedures

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