Cosmetic Surgery

Sarah Wollaston (Totnes, Conservative)

It is a pleasure to serve under your chairmanship, Mr Rosindell. I thank the Chairman of the Health Committee for this excellent report.

Let me touch on just four areas: putting patients first; the ethics of the industry; how we reduce the burden for the future because this is not the first time that we have had scares about breast implants; and the need for a register of all implants and an update on how that might progress.

Of course it is a tremendous relief that the expert group concluded in its final report that there is no evidence that PIP implants represent a materially greater risk to health than other types of silicone implant. However, the point is that PIP implants rupture much more frequently—six times more often—and when they do they cause severe local reactions in many cases. For that reason, many women will opt to have them removed. If their private clinic has gone out of business and the procedure is offered under the NHS, there is an issue about whether the NHS should then allow them to pay separately to have a private implant fitted.

The reality is that having an implant removed does not just result in a minor cosmetic difference to a woman's appearance. There is a very significant difference in the appearance of the breast once an implant has been removed. For women who cannot afford a separate operation, there will be a devastating impact on their body image and the way that they feel about themselves.

Of course, we already have a precedent for top-ups and I take issue with the point in the report that top-ups cannot occur. Although I completely agree that as far as possible, we should separate private and NHS treatment, we recognise that in dentistry, for example, a patient can already pay to have a different type of filling and have a top-up in that way. The precedent is already there.

At the core of the issue must be putting the patient first. It cannot be ethically right to force women to go through a separate surgical procedure, with all the risks that go with having a second general anaesthetic: these are not simple procedures carried out under local anaesthetic. I hope that the Minister will reassure us that the NHS will uphold the overriding principle, which is that we put the needs of those women first, over and above the other principle, which we all accept is important; nevertheless, it must take second place in this instance.

Secondly, there is the question of who should fund this type of treatment in the future. As I have already said, this is not the first time that we have had implant scandals. Would it be reasonable to expect those who have cosmetic procedures to take out some form of insurance, because of the risk of clinics going out of business and to cover the long-term liability? Can the Minister say whether that is being considered for the long-term, so that we do not find ourselves in this position again 10 years down the line, perhaps with other types of implants? There is sometimes a great temptation for clinics to declare themselves...
bankrupt, only for the same surgeons to set up down the road and for the NHS to pick up significant costs in the future.

Thirdly, let me turn to the ethics of the industry. I wrote an article for The Guardian on 2 January. I actually wrote:

"Perhaps women damaged by complications from oversized breast implants should take their cases to the General Medical Council and ask them to consider how those surgeons mutilating them...could in any way have put their safety first."

What happened was that The Guardian, as a result of advice from its legal department, removed the word "oversized" without my permission. There is a distinction to be made. For example, a teenage girl may wish to go into the glamour industry; she goes to see a surgeon and has the size of implant that cannot put her safety first in the long term. There are ethical considerations, and we should not allow surgeons off the hook, because they are complicit in promoting what cannot be other than a damaging stereotype for women. They should reconsider the ethics because, as we have heard, these implants are not long-term implants. They have a shelf life and women will inevitably need to have them replaced on numerous occasions if they have them fitted as teenagers, or else they will need significant reconstructive surgery at a later date if they choose not to continue with the same size of implant.

The British Association of Plastic, Reconstructive and Aesthetic Surgeons and the British Association of Aesthetic Plastic Surgeons both claim that they always put patient safety first, but I do not feel that that is the case when we see repeated examples of the type of practice that we have heard about on our forum; I will not repeat the quotes that we have already heard from my right hon. Friend Mr Dorrell. In practice, there is a consistent failure to tell women about the long-term implications of having breast implants, and I want to see the General Medical Council investigate the entire ethical basis of the industry and issue some very firm guidance.

I close by raising the issue of a register. I hope that the Minister can update us on plans for the future, so that we do not again see women left at home—sometimes for weeks—suffering from extreme stress because they do not know whether the implant that they have had fitted is one of the implants that we are concerned about. A register would allow proper long-term monitoring of side-effects.

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Does the Minister accept that if someone has a gold filling, for example, for which they paid a top-up on the NHS, if that gold filling fails, the NHS will still treat them, rather than expecting them to take responsibility for having the gold filling replaced in the private sector? There is a precedent. Again, I make the point that we must put women first in this situation and not subject them to two operations.

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