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A 'Wellbeing' Paradigm: A Concept-Based Study of Body Art and Regulatory Challenges

Nicola Glover-Thomas

Manchester University School of Law, The University of Manchester, Oxford Road, Manchester M13 9PL, UK; nicola.glover-thomas@manchester.ac.uk

Received: 1 September 2020; Accepted: 8 October 2020; Published: 15 October 2020

Abstract: In this paper, I trace the changing characterisation of health and consider the evolution of health within a shifting paradigmatic landscape. I argue that understanding health now encompasses the importance of wellbeing as a key determinant of longer-term good health. I use the case study of body modification and body art to explore this further. I argue that, while body modification and body art, as a means of self-expression and empowerment, is relatively easy to access, there are critical gaps in the regulatory framework that may undermine the notion of wellbeing and individual choice. I critique the Court of Appeal's decision in *R v BM*, [2018] EWCA Crim 560 which raises particular public interest concerns, but conclude that it is a missed opportunity in relation to how the law understands the promotion of 'self' within a model of wellbeing.

Keywords: autonomy; body art; health; healthism; regulation; wellbeing

1. Introduction

What do we mean by health? We tend to naturally think of health as a binary concept—we either have good health or poor health. We seek always to be in good health, and expect to be able to access support when our health is failing. However, this dichotomous approach does not allow for the nuances within the conceptual understanding of health. Models of health are conceptual frameworks or ways of thinking about and understanding health. In England and Wales, as with many other parts of the world, the biomedical model of health has reflected established and traditional approaches to health when illness is deemed dependent on primarily biological factors. Diagnosis and treatment were confined to biophysical analysis. However, by the mid- to late-twentieth century, a conceptual shift began to take place with the dominance of the biomedical model being challenged. Medical paternalism is no longer a ubiquitous feature of healthcare. In its place, greater focus has been given to the social interpretation of health where social, economic, and environmental determinants of health have been integrated into health policy development.[1] This paradigm seeks to reduce social inequalities by addressing equity of health access and to empower individuals and communities by providing skills, knowledge, and confidence to make positive health and lifestyle decisions. It urges a holistic approach to health and wellbeing.

Increasingly we are expected to take personal responsibility for our own health and to participate in preventive health strategies. Recent case law developments also underscore this move with judicial attitudes leaning more heavily towards patient rights and the diminishing role of medical paternalism.[2] In this paper, I trace the changing characterisation of health. I consider the evolution of health as a concept in the context of a shifting paradigmatic landscape and the impact this transformation has had

[1] (Marmot and Wilkinson 2005).
[2] See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

in practice. The definition of health has widened and is being interpreted in an increasingly expansive manner. I will argue that understanding health now encompasses the importance of wellbeing as a key determinant of longer-term good health. Wellbeing refers to 'diverse and interconnected dimensions of physical, mental, and social wellbeing that extend beyond the traditional definition of health. It includes choices and activities aimed at achieving physical vitality, mental alacrity, social satisfaction, a sense of accomplishment, and personal fulfilment'.[3] Therefore, wellbeing goes beyond the narrow confines of healthcare traditionally understood within the biomedical model of health and reaches out to other influencing lifestyle choices.[4]

I will explore this by adopting a case study approach. One area that has witnessed growing popularity in recent years and reflects this broader conception of health and wellbeing is the field of body modification and body art. Specifically, I will consider the largely overlooked question of how tattoos and body piercing fit within the wellbeing space. In this paper, I will chart the rise of body art in England and Wales and will critically assess the existing governance framework. I will argue that, while body modification and body art, as a means of self-expression,[5] is relatively easy to access and may offer a means of empowerment to those who wish to use it as a way of representing themselves to others, there are critical gaps in the regulatory framework that may undermine the notion of wellbeing and individual choice.

I will argue that, while the Court of Appeal's decision in *R v BM*,[6] a case that examines extreme body modification practices and the role of consent, raises particular public interest concerns and important ethico-legal issues, it largely overlooks important questions regarding how we understand the promotion of 'self and identity' within a model of wellbeing. I will conclude by suggesting that contemporaneous opinion about body art will continue to be shaped by external influences and that what is now deemed to be extreme may not be so in the future. How we balance the rights of individuals to self-expression while maintaining effective control over practices to reduce the risks remains an ongoing tension that has failed to be addressed so far.[7] The public interest will best be protected by legislative intervention to create a robust regulatory framework for the body art industry.

2. The Evolving Concept of Health

2.1. The Biomedical Model of Health

The 20th century witnessed several paradigmatic shifts in the governance of medicine and the health and wellbeing of people in the Western world. The traditional approach to medicine focussed on the notion that medicine should be driven by the maintenance and restoration of health, while palliating suffering.[8] In *Airedale NHS Trust v Bland*, Lord Keith observed '[t]he object of medical treatment and care is to benefit the patient. It may do so by taking steps . . . towards curing [illness]. Where an illness or the effects of an injury cannot be cured, then efforts are directed towards preventing deterioration or relieving pain and suffering'.[9] This 'biomedical model of health' is driven by biological analysis and pathological diagnostics. It is governed by the idea that the scope and role of medicine is understood and determined by the need to validate objectively medical intervention by evidence-based clinical data. The biomedical model of health is based on several entrenched assumptions, including the notion that the mind and body should be treated separately, that illness is triggered by a 'disease entity'[10] and

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3 (Naci and Ioannidis 2015).
4 (Glassner 1995).
5 (Sanders and Vail 2008).
6 [2018] EWCA Crim 560.
7 (Wicks 2016).
8 (Finnis 1993).
9 [1993] AC 789 (HL) *per* Lord Keith.
10 (Nettleton 1995).

that social and environmental factors are irrelevant when understanding the determinants of health and illness.

The biomedical model of health dominated healthcare for a long time and played a valuable role in prolonging life. The inception of the National Health Service (NHS) in 1948 brought with it revolutionary structural changes, and, in turn, this reinforced the paradigm. The medical profession and hospitals became the focus of healthcare provision. Medical paternalism thrived in this environment where the doctor was perceived as the person to solve the medical problem and the patient adopted a passive role.[11] Through the latter part of the twentieth century, as medical technology began to develop, pharmaceutical intervention improved, and diagnostic tools became much more widely accessible, medicine offered hope. This fuelled patient expectations both in terms of access to healthcare and the extent to which it could overcome ill-health.

The biomedical model of health has encouraged technological creativity.[12] Advances in technology and research in the twentieth century was at unprecedented levels. Without this conceptual framework driving the development of medicine, there may not have been the opportunity to understand how to diagnose illness and treat it. Common medical issues can now be effectively treated. Diseases that would once have killed can now be overcome. Life expectancy has risen, and with it, overall life quality has also increased though more age-related diseases are emerging.[13]

While the biomedical model of health has undoubtedly brought significant advantages, it has also been criticised for being too limited in its definition and has required considerable funding.[14] Healthcare is expensive.[15] It relies heavily upon professional healthcare workers, technology, and drugs. The need for medicine to specialise has accelerated as healthcare has become more complex. In turn, this has driven up the cost of professional training, technology, and equipment. Counterintuitively, the biomedical model of health has not promoted good health, because this narrow interpretation of health with its focus on biological analysis and treatment has not encouraged people to adopt healthier lives in order to prevent problems arising in the first instance.[16] Instead, focus is placed on reacting and treating a problem as it arises and ignoring the determinants that might cause it. This approach to healthcare does not account for terminal, incurable, or untreatable conditions. It also overlooks the influence of practical issues that influence the provision of healthcare. Not all 'wonder' drugs are affordable or validated by The National Institute for Health and Care Excellence (NICE), nor are all medical technologies available indefinitely. While this paradigm has laid down the groundwork for advances in medical science, it has also increased patient expectations regarding what medicine can achieve and paved the way for health inequalities to emerge.[17]

2.2. The Social Model of Health

There has been a gradual shift away from the biomedical model of health, and a refocusing upon a model of health which recognises that human interactions are complex and multi-dimensional.[18] The social model of health adopts a more expansive approach to health. It provides a conceptual framework where improvements in health and wellbeing are achieved by addressing the social, economic, and environmental determinants of health, as well as the biological ones.[19] It discourages medicine from having too much control. Biomedicine and medical science have a significant role to play in understanding health and responding to health needs, but it is not enough on its own, as political

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11 (Mildred and Schulz 1993).
12 (Wade and Halligan 2004).
13 (Eurostat n.d.).
14 (Alonso 2004).
15 (HM n.d.).
16 (Parsons 1951).
17 (Glover-Thomas and Fanning 2010).
18 (Engel 1980).
19 (The King's Fund n.d.).

decisions and processes also have an important impact on health and the social determinants of health. It seeks to address the broader determinants of health, such as gender, ethnicity, socioeconomic status, and the physical environment in which individuals live and work, as these have a deep relationship with health. This paradigm also seeks to reduce social inequalities by addressing the equity of access to the social determinants of health. Individual and community empowerment that is driven by skills, knowledge, and confidence to make positive decisions regarding health plays a central role. Ensuring individuals and communities have this knowledge is thought to encourage healthier behaviours to emerge.[20] Finally, improving access to healthcare is a significant health status indicator and the social model of health seeks to enhance available access where possible. The types of inhibitors to healthcare access include social factors, such as cultural and language barriers, economic and geographical factors, and education. One of the key objectives of this paradigm is to recognise the need for and support of inter-sectorial collaboration; making coordination better between health providers, government, and national policy development is central.

As the social model of health has become an increasingly accepted framework for health provision, the definition of health has been widened.[21] This definitional shift is not sudden; with the inception of the World Health Organisation (WHO) in 1946, health was defined as 'the complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[22] This definition embraces a broader, more holistic conception of health and wellbeing. Often, artificially constructed notions of health are broken down, and barriers between categories of health, for example, physical and mental health, are removed. The influence of the social–environmental domain upon the individual is acknowledged. Focus is placed on policy, education, and health promotion, while acknowledging the role of social change to advance health. This definition of health has facilitated a more proactive and wider role for health and social care workers and policy makers; enabling them to promote health 'not only [by defining] what is bad, but...also what is good'.[23] This definition bestows on medicine the ability to adopt an intrinsically expansive character and presents opportunities for the enhancement and development of new paradigms of health, including 'healthism',[24] the preventive health agenda, and wellbeing.

2.3. Healthism and the Preventive Health Agenda

The social model of health has given rise to an increasingly expansive understanding of medicine and its role in shoring up health and wellbeing. It now underpins much of contemporary health policy and practice in England and Wales. Our understanding of health now reaches far beyond traditional biomedical paradigms. Kennedy observes that illness is a deviation from the 'normal state', and that the notion of normality stretches far beyond traditionally perceived remits.[25] This expansion of normality 'is a product of social and cultural values and expectations', and deviation 'is a matter of social and political judgement'.[26] The social model of health encourages the exploration of 'the myriad of interactions and influences that emerge out of the complexities of human experience and the various inter-relationships of the mind, body and society'.[27]

The open-ended definitional reach of 'health' has come to underpin contemporary practice with the effect of healthcare drawing within many more activities beyond its traditional remit. Many conditions that were once accepted as 'a vicissitude of life' can now be resolved or at least mitigated by medical

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20 (NHS England 2017).
21 (Bircher and Kuruvilla 2014).
22 Constitution of the World Health Organisation, 22nd July 1946.
23 (Skrabanek 1994).
24 (Crawford 1980).
25 (Kennedy 1981).
26 I. Kennedy, The Unmasking of Medicine (Manchester: Granada Publishing, 1981) p. 3.
27 (Yuill et al. 2010).

intervention. At the other end of the spectrum, preventive action[28] and healthism[29] have also been increasingly embraced by the social model of health. Healthism is an axiom to describe personal practices and behaviours which are undertaken with the aim of preserving health, strengthening wellbeing, and preventing ill health[30]. It encourages healthy lifestyle behaviours, such as not smoking, participation in physical activities, and self-monitoring[31], including the increasing role of wearables.[32]

Central to healthism and the preventive healthcare agenda is the promotion of health. It seeks to achieve the fullest health possible by reducing health inequalities and promoting social justice and equity of health. As with the social model of health, healthism and the preventive health agenda seek to build public policy around the notion of better health for all. For example, in March 2016, the UK government employed direct action tactics when it announced that a tax on sugary soft drinks would be introduced from 2018[33], as part of a wider campaign against rising rates of obesity and type 2 diabetes. At the same time, subtler nudging techniques have also been deployed to encourage and coax people into healthier living.[34] However, responsibility and nudging, as prevention strategies, might ultimately be incompatible with the empowerment model that healthism is thought to encourage.

The healthism and preventive health model has pushed the frontiers of health further than either the biomedical or social models of health. It brings to the fore the rising tension between increasing demands for individual empowerment, control, and autonomy with the widening understanding of health and the intersection between healthy living, representations and practices of the body, medicalisation, and increasing state expectations of personal health responsibility.

2.4. Wellbeing—A Key Determinant of Good Health

To be responsible for our own health, the state relies on policies that encourage us to take the necessary steps to maintain good health. Healthy living and lifestyles, with no smoking, no obesity, good fitness, clean eating, and so on are regarded as the prudent routes to achieve good health and wellbeing. Healthism has emboldened us as patients: We are more independent, we do research, we seek out second opinions (sometimes from alternative non-traditional sources), we complain, and we are much more proactive in achieving the state's (and our own) ideal of what it is to be healthy.

As I have discussed above, the conception of health has evolved, and now a more holistic approach to good health is the desirable goal. Striving for wellbeing is no longer deemed extravagant or profligate in our expectations; for example, good mental health is supported and encouraged across various sectoral and institutional programmes, often with in-house counselling, yoga, and wellbeing agendas. The concept of wellbeing has often been likened to happiness. Jeremy Bentham[35] once famously argued that human happiness should be conceived as the fundamental principle of human conduct. He observed that happiness should direct and guide our life decisions and the state should have regard to happiness as the standard for improving society. While there are recognisable challenges with the way in which wellbeing is measured,[36] its value as a determinant of health is acknowledged.[37] Anand has observed that health is a 'special good' because it is directly constitutive of a person's wellbeing; and health enables a person to function.[38] It is argued later in this paper that this extended model of health should encourage a more holistic conception of health which should extend to body

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28 (Codagnone 2009).
29 (Zola 1977).
30 (Roberts and Weeks 2018).
31 (Glorioso and Pisati 2014).
32 (Metcalf et al. 2016).
33 (HM Revenue and Customs 2016).
34 (Quigley 2013).
35 (Bentham 1823).
36 (Kahneman and Krueger 2006; Stiglitz 2002).
37 (Kawachi 2001).
38 (Anand 2001).

modification and body art. While it is not suggested that all aspects of health should necessarily attract equal treatment or the same financial input in support of wellbeing, it is important to recognise a broader landscape of factors can play a fundamental role in an individual's good health and robust regulatory systems should be in place to maintain this.

3. Medicalisation, Patient Expectations and the Decision-Making Space

One of the effects of this paradigmatic shift is increasing levels of medicalisation where traditional and known domains of medicine have been stretched beyond customary lines. The right to self-determination and to 'lead our own lives rather than be led along them . . . '[39] is increasingly acknowledged by the case law. *Montgomery v Lanarkshire Health Board*[40] reinforces the notion of a patient's capacity for self-government and their ability to control their own life. Healthcare and lifestyle decisions have gradually been recognised as ones that can be undertaken with the view that an individual is capable of understanding the process and potential consequences. The social model of health urges a holistic approach to health and wellbeing.[41] Choices and decisions impact on all levels and facets of life and the determinants of health are recognised as going well beyond biomedical remits. This approach not only opens up the decision-making space to other actors beyond clinical professionals; it also provides further opportunities for greater involvement by the individual.

Healthism has boosted patient expectations regarding the role of medicine. With the emergence of healthism, many conditions have received medical labels and the 'normalisation' rhetoric[42] has become an emerging presence illustrated by the increasing breath of conditions deemed 'rectifiable'. The prevalence of these conditions and the increasing preoccupation given over to treating them has raised the public consciousness. Greater awareness of health and wellbeing concerns dislodge prejudice, bias, and ignorance that the general population might hold against a person or group. Legislative steps have achieved much to overcome prejudice and discriminatory behaviour, particularly in relation to disability.[43] However, the concept of normalisation acts as the vital tool to initially expose, indoctrinate, and train people to accept differences in a systematic way. For example, no longer is erectile dysfunction not discussed or acknowledged as a significant problem in men.[44] It is not accepted as a vicissitude of life, and, instead, drug therapy can be relied upon to solve the medical problem at least temporarily. While the landscape of possibility for medical intervention seems to be expanding, the opportunity for individual autonomy to be respected and recognised for those choices to be acted upon is also moving on a pace. Obtaining health and wellbeing assistance is no longer wholly the domain of the doctor's surgery. Pharmacies, dentists, clinics, and specialist shops are now often the frontline of care, offering a system of triage to both reduce demand on the NHS, but also to aid access to care and offer services that reach beyond what the healthcare system can and will provide. Getting your annual flu vaccine does not require a trip to the GP, while accessing low-grade, non-surgical cosmetic procedures, for example, dermal fillers, Botox, microdermabrasion, and laser treatment are easily accessible on the high street, if it can be paid for.[45]

Medicalisation as originally defined by Ivan Illich is the expropriation of health by the medical profession. Illich argued that the medical profession possessed 'the exclusive right to determine what constitutes sickness, who is or might become sick, and what [should] be done'.[46] Medicalisation leads to doctors acting as arbiters of health as it subjects an individual's medical complaints to 'Foucault's

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[39] (Dworkin 1993).
[40] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[41] (Engel 1977).
[42] (Fitzpatrick 2001).
[43] See, the Equality Act 2010.
[44] (McKinlay 2000).
[45] (Finch 2020).
[46] (Illich 1977).

medical gaze'.[47] While Rose's view that medicalisation is now only a 'cliché of critical social analysis' also fails to reflect accurately the current terrain. Rose argues that, while medicine might wish to step beyond the traditional boundaries of what is legitimate medical intervention, this desire is tempered by external constraints, including legal regulation and biomedical frameworks. However, the social model of health has brought with it a wider, more complicated array of actors in determining the nature of health. While in Illich's eyes it was the medical profession that posed a threat to health, and caused 'iatrogenic disease',[48] in the proceeding 40 years since Illich's seminal work was published, medical practice has changed radically. The model of health that is increasingly subscribed to sees a plurality of actors participating in health governance curtailing the 'medical profession's hegemonic power'.[49]

Judicial forays into the sphere of the doctor–patient relationship highlights its evolving nature. *Montgomery v Lanarkshire Health Board*[50] has reinforced the view that 'paternalism no longer rules'[51] with the Supreme Court's modernisation of the law of consent and the explicit introduction of a patient focused test in England and Wales. The right to self-determination is fully acknowledged in *Montgomery*[52] with a person's capacity for self-government and their ability to control their own life taking centre stage.[53]

4. Autonomy, Paternalism, and Broadening Perspectives of Health

Montgomery[54] brought fresh attention to the question of informed consent. It is the latest in a long line[55] of cases that marks a gradual sea change in judicial attitudes towards patient rights and the diminishing role of medical paternalism[56] in healthcare decision-making.[57] The decision has been characterised as supporting patient autonomy over medical paternalism[58] and highlights rising tensions between the professional discretion of doctors and patient choice. *Montgomery* reflects the growing social and legal movement away from the traditional paternalist paradigm towards greater shared decision-making, patient empowerment, and full information disclosure.[59] In 2015, the *NHS Five Year Forward View*[60] was published, setting out a vision for the future of healthcare and social care in England. It called for the health and care system in England and Wales to fully engage with people and communities, to build and sustain relationships where patients are partners, and to involve communities developing local health and care services. Traditional systems of healthcare where divisions between primary, community, and hospital care existed were to be set aside and replaced with new care models characterised by six principles. Care and support should be personalised and empowering; services should be created in partnership with communities; equality and narrowing health inequalities should be promoted; the role of carers should be identified, supported, and involved; wider stakeholders in healthcare and social-care provision should be key partners and enablers; and social action and volunteering should be recognised as key enablers. The role of doctors and medicine are relegated to a less dominant position while wider stakeholder groups are being given

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47 (Foucault 1963).
48 Illich, op. cit., n 58. 1977.
49 Glover–Thomas and Fanning, op. cit., n 18, p 28.
50 [2015] UKSC 11.
51 In *Chester v Afshar* [2005] 1 AC 134, Lord Steyn declared that: 'In modern law medical paternalism no longer rules and a patient has prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery', 16.
52 *Airedale NHS Trust v Bland* [1993] AC 789, 864 per Lord Goff of Chieveley.
53 In *R(Nicklinson) v MoJ* [2014] UKSC 38, Lord Sumption grounds autonomy in the 'moral instinct' that 'individuals are entitled to be the masters of their own fate', 208.
54 [2015] UKSC 11.
55 (Heywood 2015).
56 (Devaney 2005).
57 (Brazier and Miola 2000).
58 (Farrell and Brazier 2016).
59 *Glass v UK* (2004) EHRR 341 and *Tysiac v Poland* (2007) 45 EHRR 947.
60 (NHS England 2014).

increasing prominence in the process. These principles reflect the changing dynamic of the healthcare landscape where the pendulum has swung firmly towards a broader paradigm of health. Patients are not only the subject of the decision, but have considerable power in the direction of the decision.

This rebalancing of decision-making power between the individual and state has also prompted questions regarding how far individual choices can and should be protected[61] and the scope to which consent offers sufficient defence to serious bodily harm.[62] Judicial commentary provides valuable insight, but before the decision of *R v BM*,[63] which I will analyse later in this paper, no qualifications or recognition has been given to the specific body modification and body art context. Courts have accepted consent as a defence to the infliction of harm in several contexts, including the tattooing of two boys aged 12 and 13,[64] the branding of a wife's buttocks with a hot knife,[65] the practice of minor operations undertaken by a suspended practitioner,[66] and injuries sustained through accepted reasonable sporting conduct.[67] Non-fatal offences, specifically (serious) bodily harm, covers a wide spectrum of conduct from minor to major harm. The offences are defined by two criteria: (1) the degree of harm suffered by the victim, and (2) the fault with which that degree of harm was caused by the defendant. Classification of offences within this spectrum can be difficult. The risk posed by some forms of physical intervention may vary considerably, and the extent of the damage, should it arise, can also be exceptionally difficult to assess. Actual bodily harm is any injury that interferes with the health and comfort of the victim that is more than transient or trifling.

In *R v Brown*,[68] a majority of the House of Lords, with Lord Mustill and Lord Slynn dissenting, concluded that consensual infliction of harm on another person for sexual gratification was not permissible; consent provided no defence against sections 20 (wounding) and 47 (actual bodily harm) of the Offences Against the Person Act 1861.[69] Accepting that consent could authorise the intentional wounding or actual bodily harm to oneself was deemed not to be in the public interest[70], and without good reason for the consent, it would not be a sufficient defence to a charge under Section 20 or 47 of the Act 1861.

Notwithstanding this, as noted above, judicial attitudes towards the role of consent in the infliction of harm has had a varied response, and it has been accepted that, even where some activities may give rise to harm, these forms of harm are permissible. Informed consent will legitimise harms that might be caused as a consequence of surgery, tattooing, body piercing, and violent sports. However, in the context of sadomasochism, Lord Mustill in *Brown* set the threshold just below actual bodily harm.[71] In *Brown,* the House of Lords held that consent would not be a defence where an act inflicted actual or grievous (serious) bodily harm upon others unless the harm was occasioned through (1) legitimate

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61 (Feinberg 1989).
62 (Tolmie 2012).
63 [2018] EWCA Crim 560.
64 *Burrell v Harmer* [1967] Crim LR 169.
65 *R v Wilson* [1996] Crim LR 573.
66 *R v Richardson* [1998] 2 Cr App R 200.
67 *R v Barnes* [2004] EWCA Crim 3246.
68 (1994) 1 AC 212.
69 Actual bodily harm means any injury which is designed to interfere with the health and/or comfort of the victim but must be of a transient or trifling nature (R v Miller [1954] 2 QB 282 at 292). A wound is caused when the skin, dermis and epidermis, is broken including the inner skin within the cheek, lip or urethra (*R v Smith* (1837) 8 C and P 173 and *R v Waltham* (1849) 3 Cox 442). Section 20 of the 1861 Act covers both wounding and also the infliction of grievous bodily harm (DPP v Smith [1961] AC 290; R v Cunningham [1982] AC 566).
70 The decision was largely based on the dicta of Lord Lane CJ in *Attorney General's Reference* (No. 6 of 1980) [1981] QB 715 that it is not in the public interest to permit people to cause each other actual bodily harm for no good reason. See also, *Laskey v United Kingdom* (1997) 24 EHRR 39.
71 The issue of consent in the course of sadomasochistic sexual activity was later considered in *R v Stein* [2007] VSCA 300 in which a participant died as a result of being gagged. The court held that, even if the victim had consented to a being restrained and gagged, his consent was invalid because there was no way for him to communicate his withdrawal once the gag was in his mouth.

surgical operations,[72] (2) consensual adornment procedures,[73] (3) properly conducted 'contact' sports, (4) dangerous pastimes, or (5) reasonable horseplay. This reasoning has since been questioned and criticised for being overly paternalistic[74], and in *R v Wilson*,[75] heterosexual activity that differed in nature, but was driven by similar motivations to those in *Brown*, was deemed lawful by the Court of Appeal.

The line between making choices that could undermine health and wellbeing, such as smoking or participating in a contact sport and choices made that are personal reflections of self and a representation of their body, such as, getting tattoos, other forms of body art, or consensual sexual activity which could also lead to harm, is a fine one. In *Wilson*, it was accepted that there was no aggressive intention on the part of the appellant when he branded his wife with a hot knife. He wished to assist his wife in what she regarded as the acquisition of a desirable piece of personal adornment. Consent between the parties was not questioned. The Court of Appeal recognised that there must be exceptions to the general proposition laid down in *Brown*. Where consensual acts are involved, such as tattooing or body piercing of a consenting adult, then it does not involve an offence under section 47, even though actual bodily harm is deliberately inflicted. 'For our part, we cannot detect any logical difference between what the appellant did and what he might have done in the way of tattooing. The latter activity apparently requires no state authorisation, and the appellant was as free to engage in it as anyone else'.[76]

At what point these choices should become subject to legal intervention is naturally difficult to identify. Why should consensual activity undertaken in private be subject to legal intervention, particularly when the increasingly dominant paradigm of individual empowerment and choice has emerged? The acts in *Wilson* were not seen as acts of sadomasochism, but rather as acts of personal adornment and an expression of love. However, in *R v Emmett*[77], the Court of Appeal held that the same rules as laid down in *Brown* applied to heterosexual participants in sadomasochistic sex acts. The defendant appealed against conviction after being involved in sexual activity which was said not to intentionally cause harm and to be consensual, though the acts presented a serious risk of harm. The acts involved the use of asphyxiation, using a plastic bag tied over the head of his partner, and the use of lighter fluid poured over his partner and set alight. It was held that these acts could not be lawfully consented to, and the conviction under section 47 Offences Against the Person Act 1861 was upheld: '[T]he point at which common assault becomes assault occasioning actual bodily harm, or at some higher level, where the evidence looked at objectively reveals a realistic risk of a more than transient or trivial injury, it is plain, in our judgment, that the activities [engaged] in by this appellant and his partner went well beyond that line'.[78] These activities presented actual and potential harm, and the risk of injury was at such a degree of unpredictability as to make it appropriate for the criminal law to intervene. 'This was not tattooing, it was not something which absented pain or dangerousness and the agreed medical evidence is in each case, certainly on the first occasion, there was a very considerable degree of danger to life; on the second, there was a degree of injury to the body'.[79]

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72 (Fovargue and Neal 2015).
73 *R v Wilson* (1996) 2 Cr App Rep 241.
74 (Baker 2009).
75 (1996) 2 Cr App Rep 241.
76 *R v Wilson* (1996) 2 Cr App Rep 241, *per* Russell L.J., 244.
77 [1999] All ER (D) 641 (CA).
78 *R v Emmett*, R v Emmett, [1999] All ER (D) 641 (CA), p. 8.
79 *R v Emmett*, op. cit., 8.

5. Case study—Body Art, Tattooing, and Body Piercing

5.1. Body Art—The Reinforcement of 'Self'?

Reliance on the exceptions articulated in *Brown* to ensure an act is lawful depends upon clear and uncontested notions of harm. However, how are we to categorise actions where individuals seek to express themselves through various forms of body art?[80] Body art or body modification is the deliberate altering of the human anatomy or physical appearance for aesthetic purposes. What drives a person to undertake forms of body modification is often deeply complex. Tattoos or piercings may be used as a means of articulating a separate identity. This may be particularly common in developing young people seeking to detach themselves emotionally from their families as they grow older. For others, use of body modification may be about working through or controlling difficult personal experiences, whereby the choice of tattoos or piercing is about taking back control. Having a tattoo or getting a tongue piercing may be a simple case of being 'on trend' and belonging,[81] or body modifications could be purely an art form.[82]

For many, use of body art reinforces a sense of self or identity and promotes wellbeing.[83] Body art and modification can be achieved through a number of different routes, including cosmetic surgery, which includes facial contouring, such as, rhinoplasty; facial rejuvenation, such as facelifts; and body contouring, such as liposuction and breast augmentation.[84] Cosmetic surgery is lawful if performed by a licensed doctor in England and Wales who is listed on a Specialist Registrar.[85] If expectations around consent are met, standards of information disclosure are achieved, and the patient's needs and vulnerabilities are considered, cosmetic surgery would fall within the recognised medical exception in Lord Slynn's category-based rationale in *Brown*.[86][87]

As body art in the form of tattooing and body piercing has become increasingly popular in the United Kingdom, the range of procedures available has expanded rapidly. With more extreme procedures becoming available, concerns have risen over the risks to recipients and the standards of care provided by body art practitioners.[88] There is currently limited data on the prevalence of tattoos in England and Wales. However, it is thought up to 35% of those between the ages of 30 and 39 have tattoos, with an estimated one in five people in the UK having at least one.[89] This increase in interest is also reflected in the significant rise in the number of tattoo parlours in the UK. In 2014, *The Guardian* found that, between 2004 and 2014, there was a 173% rise in parlours.[90] There is no comprehensive data for the UK on the prevalence of body piercing, either, but one small study undertaken by Bone et

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80 (Bibbings and Alldridge 1993).

81 The motivation for body modification has been subject to considerable sociological, psychoanalytic and personal experience narratives, which extends beyond the remit of this paper. For further discussion, see: (Brain 1983; Pitts 2003).

82 For example, ORLAN (Mireille Suzanne Francette Porte) is a French contemporary artist who has acquired fame through her work with cosmetic surgery in the early to mid-1990s.

83 A sense of self is related to our perception of ourselves and an awareness of who we are. For a detailed discussion, see, (Vartanian 2009).

84 (Griffiths and Mullock 2017).

85 General Medical Council Guidance on cosmetic interventions http://www.gmc-uk.org/guidance/ ethical guidance/28687.asp. See also, See the Royal College of Surgeons webpages: http://www.rcseng.ac.uk/surgeons/surgical-standards/-practices/csic/main-areas-of-work.

86 *R v Brown*, op. cit. n 80, p 227. Surgeries that are designed to modify the body for non-therapeutic, but religious purposes may well be supported by Article 9 of the ECHR, which guarantees respect for religious freedom. However, some argue that non-therapeutic circumcision of male infants and young boys violates the child's right to bodily integrity under Article 8 of the Convention. See (Fortin 2009).

87 While cosmetic surgery offers an important route through which some may seek to enhance their wellbeing, this facet of body modification is outside the scope of this paper. This important issue has been considered elsewhere, see, for example: (Widdows and MacCallum 2018).

88 Tattooists must be registered under the Local Government (Miscellaneous Provisions) Act 1982, Part VIII, but there is no registration scheme in place for body modification and no training or qualifications system is in place for either.

89 (Henley 2010).

90 (Wood and Butler 2014).

al. in 2008 estimated that body piercing, other than of the earlobes, in the general adult population in England, was 10%.[91]

Body art and the use of tattoos and piercings have existed for a long time. Decorating the human body in various forms is often used as a permanent representation of membership to a club, religious group, and secret society. Tattoos and body piercings have been used as a marker to identify people and to bring people together. They also provide a means of permanently depicting something of importance in an entirely personal and unique way. For example, the popularity of the Manchester worker bee tattoo as a means of demonstrating solidarity following the Manchester Arena attack became an international representation of support.[92]

5.2. Types of Body Art and Body Modification

Body art includes a wide range of procedures undertaken on the human body. It commonly involves tattoos and body piercing, but there is growing interest in other forms of body art, including subdermal implants, scarification, shaping, scalpelling, scleral tattooing (the practice of tattooing the white part of the human eye), corset piercing, and tongue bifurcation or forking. Tattooing historically was linked to particular socioeconomic groups, criminals, sailors, and working men's groups. However, tattoos and other forms of body modification are increasingly common across many more population groups, and as they have become more accessible, the stigma surrounding them has been reduced. Body piercing has gradually shifted away from traditionally accepted practices. Piercing of the earlobes has been practiced across the globe for thousands of years, but over the last 40 years, the practice of piercing has become more widespread, with multiple piercings becoming common, including nose, lip, and tongue piercings. Nipple, genital, and navel piercings have also become more popular for a variety of reasons, including increased media attention, celebrity endorsement, and contemporary music and art depicting body modification.

5.3. Body Art—The Risks

For many, tattoos and body piercings are positive actions, but there are both physical and psychological risks and complications associated with them. Many forms of body art will be irreversible, either because the intervention is permanent or scarring remains. Often, body piercing will leave scarring whether the jewellery is removed or not. For tattoos, the use of permanent ink will make it difficult to remove the tattoo in its entirety, should there be a change of heart in the future.

A primary medical challenge with any tattoo or piercing is the risk of infection. Both forms of body art involve the piercing of the skin, and with this, there is always some risk. Ensuring the body art practitioner meets industry standards and uses autoclave-sterilized instruments reduces this risk. Effective aftercare guidance during the healing process is also essential. However, this relies upon there being robust industry standards in place and that enforcement strategies are developed and maintained. Despite basic steps to protect against infection, the popularity of multiple piercing of the ear, which involves higher ear-piercing puncturing through the cartilage, increases the risk of auricular perichondritis[93], and with this comes greater need for hospital care and longer-term healthcare intervention. Risk of localised infection around the tattoo or piercing site can be high if appropriate hygiene standards are not met and allergic or toxic reactions to various substances used on or in the skin is always a potential risk. However, the risk of transmission of blood-borne viruses, for example Hepatitis B, Hepatitis C, Hepatitis D, or HIV, presents serious and long-term health consequences which will have significant repercussions. It is therefore important that practitioners

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91 (Bone et al. 2008).
92 (Perraudin 2017).
93 (Santhanakrishnan and Bhat 2017).

operate within a system of safe working and good infection-control practices are followed at all times, so that both clients and practitioners are protected.

While tattooing and body piercing has become increasingly popular, it has been identified as particularly prevalent among adolescents and young people.[94] While body modification and art may, for some, provide a true representation of identity and 'self',[95] given the potential risks involved, effective governance is critical to ensure the notion of wellbeing and individual choice is not undermined.

6. Regulating Body Art

So, to what extent is body art and body modification regulated in England and Wales? Before answering this question, some consideration should be given to the type of regulatory regime and theory that dominates many areas of medical law. Regulatory design plays an important role in both the justification and success of regulation, yet 'regulation' itself remains difficult to define.[96] For the purposes of this paper, regulation is a mechanism to prohibit, control or require specific conduct. Most lawyers are familiar with regulatory instruments that use command-based mechanisms and rules to exert control on behaviour. Failure to comply with these rules results in some form of sanction. A command and control regulatory framework benefits from relative clarity where there is knowledge and understanding of the legal standard that should be achieved, information about the mode of legal enforcement and the extent of regulators' roles in the enforcement process. However, this certainty within command and control frameworks is also heavily criticised for its relative rigidity and inability to evolve easily—a problem that is particularly evident in the health law sphere.[97] However, despite this, regulatory regimes are evaluated on the basis of the outcomes they achieve. One way of undertaking this assessment is to adopt a welfarist approach. Welfarism is a type of consequentialism that identifies wellbeing as the 'sole intrinsically morally relevant feature of outcomes'.[98]

Welfarism features clearly within the sphere of medical regulation. Acts and omissions to act are scrutinised and assessed with the patient's wellbeing and best interests in mind. While this approach necessarily opens up questions about the balance of paternalism and autonomy, another key feature of the regulation debate within health is driven by risk[99] and an increasingly risk-adverse society.[100] Why and when should governments introduce legislation to regulate behaviours?

Regulation is used to reduce and avert risk and, importantly, maintain its repetition through sanctions. Haines argues that regulation offers an important avenue for solving problems for communities that are deemed at risk. Where risk is perceived to exist, this incentivizes governments to legislate and to tighten regulatory frameworks in order to be seen to be doing something proactive to reduce the likelihood of political support being lost (political risk). Regulation may contain and reduce risk by using an actuarial approach whereby risk is managed by calculating the risk through quantitative assessment of the evidence (actuarial risk). Alternatively, regulation may be used to reassure the public when they feel vulnerable to risk (sociocultural risk).[101] Irrespective of the driver to reduce and manage risk in the health arena, the increasing evidence of risk aversion suggests that governments are regulating in response to this.[102] Body modification techniques are beginning to witness increasing levels of risk. Extreme body modification practices, such as scleral tattoos, are introducing risks that are less predictable and quantifiably more impactful if the procedures were

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94 (Mayers et al. 2002)
95 (Cipolletta et al. 2010).
96 (Ogus 1994).
97 (Latin 1985).
98 (Adler 2010).
99 (Glover-Thomas 2011).
100 (Haines 2012).
101 (Haines 2017).
102 (Farrell et al. 2013).

to go wrong. An effective regulatory framework can aid compliance in terms of requiring more robust training requirements and qualifications, better controls over advertising and insurance. All of these are 'realistically achievable'.[103] Within the context of this paper, the question this leads us to is: what is the justification for the regulation of body art and modification, what would be the optimal legal response and what are the outcomes being sought?

To say that regulation of the body art industry in England and Wales is patchy with little direct and national regulation in place would not be unwarranted. In 2013, Sir Bruce Keogh believed the sector was 'a crisis waiting to happen' and called for an urgent need for systematic and mandatory regulation.[104] Children are offered some protection under the Tattooing of Minors Act 1969, which imposes a statutory minimum age of 18 years for permanent tattooing, unless carried out for medical reasons. When this is contravened, the offence sits with the person who carries out the procedure, rather than the person seeking the tattoo.[105] Consent is not a defence, though where the practitioner had good reason to believe the person was over 18 years of age, this may be sufficient.[106]

For skin piercing, there are no minimum age requirements and the regulatory framework is localised relying on area licensing models. In the *Tattooing and Body Piercing Guidance and Toolkit* produced by Public Health England and The Chartered Institute of Environmental Health in 2013, it states that 'the ... law allows children under the age of 18 to consent to cosmetic body piercing provided they are sufficiently mature to understand the nature of the request'.[107] Implicit within this statement is that the body art practitioner should be able to assess a young person under the age of 18 as to their maturity.[108] This is a subjective assessment that can be very hard for the practitioner to make and is determined on a question of fact. Ensuring sufficient information is provided to allow a client to make a decision in an informed way is essential and is important in the assessment of a person's maturity when under the age of 18.[109]

Local authorities are given scope to state minimum age requirements and safe practice systems for these procedures.[110] However, reliance on model byelaws has stymied the development of nationwide standards of compliance and competence setting. Instead, local and regional guidance have been developed by different agencies in a rather haphazard manner, and through an environmental health and health protection perspective rather than derived from meeting national health and social care standards. There is inconsistency of approach with some local authorities setting no minimum age restrictions, with some setting particular prohibitions on the type of cosmetic piercing for those under 18 or 16 years old, some allowing most procedures when accompanied by parental consent, others allowing any skin piercing above the waist for all over the ages of 16 or 18, and others prohibiting all types of genital and nipple piercing.[111]

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[103] Farrell, A. M., S. Devaney, T. Hervey, and T. Murphy. 2013. Regulatory 'desirables' for new health technologies. Medical Law Review 21: 1–10, at p. 2.

[104] (Keogh 2013).

[105] Tattooing of Minors Act 1969, section 2.

[106] When an offence is committed, the police will enforce the legislation with fines up to £1000.

[107] (Public Health England and The Chartered Institute of Environmental Health 2013).

[108] This principle was established by *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 where the House of Lords observed that the child's voice should be listened to when they reach sufficient understanding to be capable of making up their own mind.

[109] Though the legal requirements for body piercing are very limited in England and Wales, it is a matter of good practice to ensure the client signs a declaration of age and a consent form prior to any work being commenced. Consent will only be valid if full information regarding the nature of the process and potential problems involved is disclosed. Informally, for those under the age of 16, adults with parental responsibility are required to sign the consent form. While not a formal indemnity device, the practitioner relies upon it as the primary means of protection.

[110] Under section 120 of the Local Government Act 2003 cosmetic piercing and semi-permanent skin-colouring businesses have been added to the existing powers under the Local Government (Miscellaneous) Provisions Act 1982 to regulate ear piercing, tattooing, acupuncture and electrolysis by requiring registration and observance of byelaws. Local authorities in London already had these powers under private legislation, the London Local Authorities Act 1991 and the Greater London Council (General Powers) Act 1981.

[111] Under the Sexual Offences Act 1956, girls and boys under the age of 16 cannot legally give consent to intimate sexual contact under any circumstances, consequently piercing of nipples and genitalia (for girls) or genitalia (for boys) can be regarded as

Currently, as a result of this patchwork of guidance and localised regulatory practices, any attempt to engage body art practitioners with existing regulatory models and the development of nationwide standards has proved difficult. There are currently no nationally recognised accredited training courses or agreed competencies, standards for practice, agreed knowledge and skills frameworks, or arrangements for monitoring, and reporting of professional competence are all currently absent.[112] Under statute, local authorities are responsible for regulating and monitoring businesses offering cosmetic body piercing (including ear piercing), permanent tattooing, semi-permanent skin colouring (micropigmentation, semi-permanent makeup, and temporary tattooing), electrolysis and acupuncture.[113] These procedures involve a degree of skin piercing, thereby carrying the potential risk of skin infections, allergic or toxic reactions to various substances used on or in the skin, and transmission of blood-borne viruses.[114] Failure to obtain a license or register premises where these body art procedures are carried out will result in statutory breach and result in a criminal offence being committed.[115]

Why is a national regulatory system necessary? Having an appropriate system of regulation will offer better protection to both recipients and providers of body modification ensuring least harm is caused and any risks mitigated. Currently, regulation and the legislative frameworks concerning body modification across the whole of the UK are disparate and inconsistent. Legislation needs to be formalized to enable better guidance for local authorities and other involved agencies so as to determine the most effective means of achieving good risk management. Current registration practices are no longer fit for purpose, particularly with the exponential rise in demand for body modification.

R v BM—A Missed Opportunity?

In *R v BM*,[116] the appellant was charged with three counts of inflicting grievous bodily harm contrary to Section 20 of the Offences Against the Person Act 1861. The question presented to the Court was whether the defence of consent was available to an individual who caused serious bodily harm when performing body modifications on another. The case concerned an appellant who was a professional tattooist and body piercer. Over recent years, he had extended his services to include 'bodily modifications' of various kinds. The appellant had removed a client's ear, removed another client's nipple, and divided a further client's tongue to achieve a reptilian-like effect. The appellant was not a medically qualified professional, though no concerns were raised in court regarding the premises and its sterile conditions. All of these modifications were carried out without anaesthetic. The clients sought out the services of the appellant and consented to the different procedures. The consent provided was accepted by the court as valid and informed. The case instead turned on whether consent could provide a defence for these counts on the indictment. It was found by the Court of Appeal that there was no good reason why body modification of this nature should be placed in a special category of exemption from the general rule laid down in *Brown*.[117] Consent to injury provided no defence to

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an assault. Evidence that such contact was for sexual gratification would be required in order to constitute an indecent assault. The Female Genital Mutilation Act 2003 states that certain procedures in respect of female genitals are illegal unless carried out for medical reasons.

112 The Tattoo and Piercing Industry Union is recognised as the only professional body for tattoo and body piercing practitioners in the UK.

113 Local Government (Miscellaneous Provisions) Act 1982, section 14(2), section 15(2), section 4(7) and section 15(7). This legislation does not apply when the procedures are carried out under the supervision of a medical practitioner—see sections 14(8) and 15(8).

114 The Local Government (Miscellaneous Provisions) Act 1982, as amended, is concerned with the minimisation of infection and controlling practitioner behaviour and premises hygiene to meet this objective. Local authorities are responsible for regulating and monitoring premises which carry out body art procedures through compulsory registration and licensing. Registration provides lawful authority to undertake the specified tasks and local authorities may also supplement the registration scheme with bye laws directed, in particular, at cleanliness and hygiene.

115 Local Government (Miscellaneous Provisions) Act 1982, as amended, section 16.

116 [2018] EWCA Crim 560.

117 Compare *R v Brown* (1994) 1 AC 212 with *R v Wilson* (1996) 2 Cr App Rep 241.

the person who inflicted that injury if the violence caused actual bodily harm or more serious injury. Consequently, the Court of Appeal held that consent of the defendant's clients to the removal of an ear and nipple, and the division of a client's tongue did not provide him with a justification for removing body modification from the ambit of the law of assault. Unlike surgery, which falls clearly within the exceptions laid down in *Brown*, as the procedures in *BM* were neither carried out by a medically qualified practitioner, nor were for medical purposes, the surgery exception was not met. The question in *BM* was whether there was sufficient justification for a further exception to be created that would allow for consent to bodily harm done during extreme body modification procedures. The Court of Appeal concluded that no adequate justification could be found. Lord Burnett of Maldon outlined four reasons: inherent within the criminal law is a protective, paternalistic role, which includes protecting people from themselves; associated with all body-modification procedures is the risk of unintended and unwanted injuries; such procedures have no material social benefit and could instigate further risk; and the decision to extend the exceptions allowing consent to act as a defence to bodily harm is a task for Parliament rather than the judiciary.

There was an unwillingness to extend the established boundaries allowing consent to act as a defence without good reason. The protection of practitioners undertaking extreme body modification procedures was not deemed to be in the public interest. However, the line between the reasoning in *BM* and *Wilson* is a fine one. In both cases, the procedures undertaken left permanent, irreversible marks. In both cases, it was accepted by the court that consent had been informed and freely given by the clients and wife concerned. The only factual difference was in the status of the appellants. In *Wilson*, the husband had undertaken his wife's wishes, while, in *BM*, the procedures were carried out by a paid body art practitioner. The contractual nature of the relationship between BM and his clients was not an issue of interest, yet, in *Wilson*, the loving private relationship between Wilson and his wife and his desire not to hurt her was given particular emphasis. The risk of harm arising out of the procedures undertaken in *BM* was also of particular focus in the reasoning in the case. In *BM*, Lord Burnett of Maldon observed that the removal of body parts could give rise to significant risk. For example, it was noted that ear removal presents a 'moderate to severe … [risk of] … hearing loss and injury to the facial nerve and would not be a procedure undertaken by a plastic surgeon for aesthetic reasons'.[118] It was also noted that nipple removal and tongue splitting would generally not be justifiable surgical procedures. Tongue splitting, in particular, brought particular risks, notably heavy blood loss and breathing problems if the tongue swelled following the procedure. Despite the risk, it is contended that in *Wilson* there was recognition of an important objective beyond the protection of physical health—the importance of wellbeing and the ways in which this can be enhanced.

This paper argues that *BM* represents a missed opportunity to conceptualise health more broadly and to recognise the importance of individual wellbeing as a determinant of good health. The defendant in *BM* was characterized as someone who operated beyond the scope of his license to practice. The consent of his clients was not deemed relevant nor able to legitimize the defendant's action. No efforts were made in the judgment to consider the reasons for the individuals to seek out the body modifications that they did. However, on several occasions, tacit references were made, indicating a lack of judicial understanding regarding these decisions.[119] This failure to grapple with the motivation of the clients delimited the opportunity for judicial recognition of a broader conception of health. The notion of body modification was not deemed to be sufficient to extend the exceptions to the general rule laid down in *Brown*. These exceptions were justified because they might 'produce a discernible social benefit' and it would be 'regarded as unreasonable for the common law to criminalise the activity if engaged in with consent'.[120] However, with health increasingly being recognised more

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[118] *R v BM*, op. cit., n 1, p 13.
[119] *R v BM*, op. cit., n 1, p 43.
[120] *R v BM*, op. cit., n 1, p 40.

comprehensively, *BM* provided an opportunity to acknowledge that 'discernible benefit' can be derived and experienced by those who desire these forms of modifications and body art.

The importance of 'artistic engagement and the psychological and biological manifestations' of the connection with good health has become the focus of considerable research.[121] Much of this work currently focuses upon the impact of art on an individual either as an observer or producer of creativity.[122] The human skin presents an alternative, yet deeply personal canvass for some. Health psychologists highlight the ways in which art therapy can be harnessed to deal with emotional injury, help with self-reflection and understanding, reduce symptoms, and carve out new behavioural patterns.[123] I argue that body art and modification should be seen in a similar vein; another mode of creative expression that, for some, could have significant psychological and physiological impacts, enhancing wellbeing and overall good health. Acceptance of the definition of health being more than the absence of disease[124] and the shift towards a much more holistic and proactive health paradigm should spur the courts to actively engage with a whole-person approach to good health and its sustenance.

7. Conclusions

The legal controls in place for piercing and tattooing offer a less-than-perfect system of regulatory governance and raise their own questions about whether these controls are sufficiently robust to protect individual health and wellbeing. For those seeking a more extreme form of body art or body modification, the issue of regulatory oversight presents an even greater challenge and is now subject to the gaze of the criminal law. Currently, the rules regarding piercing and tattooing are strictly defined as 'the insertion into the skin of any colouring material designed to leave a permanent mark' and does not directly cover the methods adopted for more extreme body art. Local authorities have oversight responsibility of premises which operate within the definition under the legislation, but those that undertake broader practices may slip through this system overseen by local authorities. For now, *R v BM* provides clarity regarding the legal position of extreme body-modification procedures, but it has not engaged with the wider question of how we better monitor and regulate activities that some might undertake in order to improve their wellbeing.[125]

Consent does not protect the practitioner when undertaking extreme body modification procedures on clients as they are deemed to be against the public interest. However, the line between body adornment, which has become 'normalised', and more extreme body art has become blurred. As body art continues to become more prevalent and reflects cultural norms, for those people who regard body art as more than a trend, but a statement of self and identity, the push for more extreme body modification may likely increase.

In *BM*, the procedures undertaken highlighted how close some of these procedures are to surgery. Piercing the skin for jewellery is notably different from having a functional body part removed altogether. The removal of the client's ear required the use of a scalpel, and, if undertaken for medical purposes in a hospital, it would have been accompanied by anaesthetic. The client had, nonetheless, consented to the procedure and wished it to be done for the purpose of fulfilling their wishes. Thus, how individual choice regarding body art is protected appears dependent upon risk of harm and, importantly, on existing sociocultural norms.

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[121] (Stuckey and Nobel 2010).
[122] (Staricoff and Loppert 2003).
[123] (Stickley et al. 2017).
[124] WHO, op. cit., n 23.
[125] In the future, more extreme forms of body modification may be better scrutinised by requiring psychological assessment before it can be carried out, adopting a similar approach to transgender surgery, which requires a diagnosis of gender dysphoria by a psychologist and continued review and management by a gender-identity-development unit. Adopting this more rigorous approach would act as a more effective gatekeeper to ensure recipients are fully committed to the procedure and understand the risks.

The influence of these norms and social mores marks the gradual dominance of the social paradigm of health. Over the last half century, focus has shifted away from the preoccupation with how the body works and how to fix it biomedically. Recognition that the determinants of health and wellbeing are multi-factoral has not only shaped health policy in England and Wales, but has had an impact upon how individuals understand their own health and the control they have over it. Healthism has encouraged personal responsibility over health and lifestyle choices. It has also nudged us to participate in preventive healthcare strategies to improve our overall health projections. These paradigmatic changes have had a transformative impact upon the way in which health and wellbeing is perceived both at individual and organisation levels. Medical paternalism no longer dominates; where medicine has lost ground, a plurality of health and wellbeing stakeholders have stepped in. With the paradigmatic shifts in health and wellbeing, no single profession fully monopolises. The health and wellbeing industry is increasingly comprised of many specialist services, both traditional and alternative. We, as patients and clients, have become empowered; choice, autonomy, and control have moved into the lexicon of healthcare.

As the definition of health expands further and incorporates the amorphous notion of wellbeing, 'fixing' people can no longer be achieved through the biomedical route alone. The social model of health requires a deeper understanding of people and the determinants of health and wellbeing. It forces us to confront difficult questions, including, for instance, what makes us happy? For some, body art and body modification, in one form or another, provide this. These procedures offer a route which enables the portrayal of themselves in the way they wish. It boosts their sense of self. Making choices about what tattoos or piercings to have and where, and how they wish to represent themselves to others empowers them. The social model of health acknowledges the complex array of factors that influence health.

The governance framework of the body-art industry is currently inadequate. Regulation is viewed through an environmental health lens, taking little account of the considerations normally attendant in the health sphere. Consent is at best mechanistic where some, though not all, practitioners rely upon a consent form to confirm the client's willingness.[126] Information disclosure regarding risks appears dubious and is likely inconsistent across the industry. The criminal law has so far been the designated safety net. However, the reasoning in *Brown*, *Emmett*, and *BM* disregards the tension between the right to choose and protection in the public interest. The nuances are more pronounced in *Wilson*, though the particular relationship between the appellant and the recipient of the body art underpinned much of the analysis.

So, what would a properly regulated body art industry look like? Prohibition on the grounds of public interest ignore the desire for self-expression and empowerment. Such an approach also belittles the human condition and the complexity of what wellbeing is and what identity looks like. Instead, a regulatory system needs to be introduced that sets national standards and requires practitioners to obtain nationally recognised qualifications. Reliance on training within independent studios at local level without national benchmarks creates silos of knowledge that should be shared, while also concealing inadequate and potentially dangerous practice. Given the development of procedures being undertaken, as well as the new techniques and new trends emerging, practitioners should be integrated into a national framework of continuing professional development. Currently, body art is seen as a service industry where individuals can pay for services requested. When things go wrong, breach of contract or negligence may be the primary mechanism for financial redress. However, neither of these routes serve to protect all people from receiving inadequate care. There is currently an unwillingness within the criminal law to recognise the broader health and wellbeing components within the body art and modification industry. Instead, the reasoning in *R v BM* indicates a preference for shutting down the idea that body art and modification should be seen as an exception to the general principle laid

[126] (McKinney et al. 2005).

down in *Brown*. Currently, the choice about where to acquire body-art services is dependent on local knowledge and sheer luck that the practitioner is competent.

If the paradigmatic shift towards a social model of health which harnesses healthism and wellbeing is to be fully realised, these tensions cannot continue to be ignored. Prohibition and protection in the public interest may continue to be effective for extreme body modification procedures, but sociocultural norms will continue to evolve and push forwards. Contemporaneous opinion about more extreme body art will continue to conflict and be shaped by external influences. What is currently deemed extreme may not be so in the future. Legislative intervention to create a regulatory framework for the body art industry that goes beyond environmental health concerns is a pressing need. It would be short-sighted to ignore this.

Funding: This research received no external funding.

Conflicts of Interest: The author declares no conflict of interest.

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