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Cosmetic gatekeepers: Negotiations of beauty and (re)shaping bodies by medical aesthetic practitioners

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ABSTRACT

Aesthetic practitioners who administer (non-)surgical medical cosmetic procedures play a central, and growing, role in the (re)shaping of predominantly women's bodies. This article focuses on how these practitioners negotiate their role as cosmetic gatekeepers – those with the medical and sociocultural skills, knowledge and tools - in (re)shaping the bodies of their client-patients. Adopting a reflexive thematic analysis of interviews conducted with aesthetic practitioners in the UK and the Netherlands, we identify three main themes. The first theme, *conceptualizing beauty*, describes the different ways in which aesthetic practitioners describe and negotiate the concept of 'beauty', including discussions of beauty as both subjective and objective. The second theme, *shaping bodies*, explores how practitioners consider why and how they (do not) suggest aesthetic procedures and how they (do not) see themselves as significant shapers of bodies and beauty. Finally, the theme of *cosmetic gatekeepers* examines the ways in which aesthetic practitioners provide boundaries in terms of how, when, why and on whom they (do not) perform procedures. Inherent to these discussions are constructions of the (non-) surgical 'other' and tensions between commercialism and 'medico-cosmetic' considerations that must be navigated by aesthetic practitioners. This article furthers explorations of how certain aesthetic appearances are (re) produced as desirable in increasingly expansive, diversified and normalized (non-)surgical cosmetic servicescapes.

1. Introduction

In 2023, approximately 35 million medical cosmetic procedures were performed worldwide, of which 19.2 million were non-surgical, such as injectable facial dermal fillers and botulinum toxin (ISAPS, 2024). Non-surgical cosmetic servicescapes have broadened significantly (Rodner et al., 2022). Evolving cosmetic technologies, the influence of visual social media like Instagram and TikTok on seeing (and selling) procedures (Berkowitz, 2017; Dowrick and Holliday, 2022), and increasingly diverse premises offering non-surgical treatments such as spas and beauty salons have driven demand for less invasive corporeal alterations. For example, estimates indicate that non-surgical procedures comprise approximately 70% of the UK's medical cosmetic market (Save Face, 2022). Furthermore, a 94% increase in injectable treatments occurred in the Netherlands between 2019 and 2022 (Decates et al., 2024).

Non-surgical medical cosmetic procedures represent an increasingly accessible and normalized route to continual transformation in neoliberal biomedicalized societies (Berkowitz, 2017; Pitts-Taylor, 2016). As such, aesthetic practitioners are key intermediaries in (re) producing 'desirable' appearances, serving as medical and cultural 'gatekeepers' with the skills, knowledge, and tools to alter bodies and function as purveyors of aesthetic taste (Menon, 2019). Despite this, existing scholarly literature has typically focused on the recipients of medical cosmetic procedures, especially their motivations for treatments (Bonell et al., 2022; Davis, 1995; Gimlin, 2007) and their quality of life afterward (Gimlin, 2007; Hermans et al., 2024; Kinnunen, 2010). Pitts-Taylor (2009, 2016) argues that existing discourse overly emphasizes client-patients' subjectivities in understanding medical cosmetic procedures. This framing neglects the complex, intersubjective nature of treatment processes that involve multiple actors, including aesthetic practitioners and their experiences, perceptions, and behaviors (Jones, 2008; Pitts-Taylor, 2009). Taking forward the idea of cosmetic 'gatekeepers', this study uses semi-structured interviews with practitioners to explore their conceptualizations of beauty, how these may guide consultations with client-patients, and how practitioners proceed (or not)

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with treatments. As non-surgical procedures become increasingly embedded in everyday, routinized beauty practices (Cook and Dwyer, 2017), we examine how aesthetic practitioners negotiate their role as cosmetic gatekeepers at an often uncomfortable medico-commercial juncture.

1.1. Medical cosmetic procedures: ethically fraught positionings

Medical cosmetic procedures occupy a contentious position in both medicine and feminist scholarship. Consumer-driven and widely – sometimes problematically – marketed, procedures are often considered contrary to key tenets of medical ethics, particularly beneficence and non-maleficence (Atiyeh et al., 2020; da Prato et al., 2024; Ramirez and Scherz, 2025). Critics argue that the medicalization of 'aesthetic flaws' propagates a 'pedagogy of defect' that frames deviations from a standardized ideal as requiring correction (Bordo, 2004; Edmonds, 2013; Widdows, 2018). Conversely, others view medical cosmetic procedures as agential body 'projects' (cf. Davis, 1995; Shilling, 2012), where pursuing physical enhancements reflects biopolitical demands for bodies to represent sites of 'wellness' (Pitts-Taylor, 2016). Ramirez et al. (2024) highlight the ethical uniqueness of medical cosmetic procedures where practitioners must balance (medical) professionalism, aesthetic judgment, client-patient expectations, and commercial interests. There are tensions to navigate where priorities may shift between medico-ethical considerations and business priorities (Hermans, 2022; Ramirez et al., 2024). Currently, there is a lack of unified guidelines for ethical medico-commercial conduct in this context, with client-patient selection and decisions to (not) offer treatments left mainly to individual practitioner discretion (Craddock et al., 2022).

1.2. Collaborative beauty? Relational dynamics in (re)shaping bodies

When (re)shaping bodies, aesthetic practitioners collaborate with client-patients to realize the latter's aesthetic aspirations. Therefore, power dynamics between the two are less 'straightforward' than in traditional medical consultations. Unlike the characterization of cosmetic surgeons as dominant (paternalistic) arbiters of beauty (cf. Blum, 2003), prospective client-patients often enter consultations with (firm) ideas and (some) knowledge about how they wish to alter their bodies (Gimlin, 2010). Indeed, Vlahos et al. (2022) emphasize that practitioners "must use their skills to understand consumers' visions of beauty and bring these to life" (p.126). This relationship necessitates building rapport and trust to negotiate and agree upon the possibilities and limits of what is aesthetically achievable (Aquino, 2020). Consultations can become fraught when aesthetic aspirations clash, and practitioners attempt to mediate desires or refuse treatment. Nash and Hermans (2025, p.39) note practitioners' "delicate balancing act" of (medical) professionalism and commercialism in establishing and maintaining aesthetic boundaries. For instance, some practitioners may exercise "aesthetic conservationism" and only agree to minimally (re)shape bodies in pursuit of a 'natural' outcome (da Prato et al., 2024, p. 4). In contrast, others may be more deferential to client-patients' desires and/or prioritize the pursuit of profit, even where a more radically augmented or adverse (i.e., distorted) outcome may result (Ramirez et al., 2024).

1.3. Gatekeeping beauty: avoiding the aesthetic 'other'?

Despite the normalization of non-surgical procedures , concerns about what constitutes an aesthetically 'successful' result persist. Regarding medico-ethical conduct, there are instances where aesthetic practitioners may 'conscientiously object' to procedures. Imposing aesthetic boundaries, practitioners may categorize those who seek 'excessive' or 'unnatural' results as (non-)surgical 'others' (Gimlin, 2010). Such representations have driven pathologizing discourse that equates undesirable aesthetic outcomes with psychological conditions, such as Body Dysmorphic Disorder (Pitts-Taylor, 2007). Furthermore, the surgical 'other' also refers to aesthetic practitioners who deliver undesirable results. In Gimlin's (2010) study, some cosmetic surgeons sought to mark themselves as more ethical and meticulous than their industry peers, sometimes refusing client-patients if the aesthetic outcome was perceived to be unachievable and/or unappealing and, on that basis, reputationally harmful. Though Minerva (2017) argues that medical cosmetic practitioners cannot morally refuse procedures simply because a client's aesthetic goals differ from their own, Saad (2018, p. 650) critiques this stance as 'patient preference absolutism', emphasizing the need for practitioners to balance "beneficence and autonomy". Again, the intersection of clinical judgment, patient autonomy, and commercial pressures highlight the tricky medico-commercial boundaries that aesthetic practitioners must traverse in cosmetic gatekeeping.

Considering the above, non-surgical medical cosmetic procedures have come to signify the potential for continual corporeal malleability (Berkowitz, 2017; Pitts-Taylor, 2016). However, despite their popularity and normalization, such treatments remain at a contentious convergence of medicine and beauty. This study examines how practitioners negotiate aesthetic outcomes where their perceptions of beauty may vary from those of their client-patients and how undesirable outcomes are avoided. By providing boundaries on whom they will (not) treat, practitioners act as cosmetic gatekeepers who (re)produce valorized appearances in increasingly expansive, diversified, and normalized medico-cosmetic servicescapes.

2. Materials and method

2.1. Design

We conducted semi-structured interviews to develop an understanding of how aesthetic practitioners negotiate their role as gatekeepers in (re)shaping client-patients' bodies. For this research, semi-structured interviews were considered the most beneficial route to exploring individuals' approaches to their aesthetic practice. They allowed the conversation to be more candid and flexible than if we employed a different method, such as focus groups (Adams, 2015). Interviews can aid in understanding subjective experiences and perspectives and the sociocultural context influencing these, which was vital for our project (Holloway and Wheeler, 2009). After conducting and transcribing the interviews, we undertook reflexive thematic analysis (Braun and Clarke, 2006, 2021), which is grounded in relativist ontological and constructivist epistemological assumptions, meaning that we accept that 'reality' is not unequivocal and that knowledge generation is fundamentally subjective (Green and Thorogood, 2018; Hermans et al., 2024).

2.2. Participants and sampling strategy

Participants were recruited in the United Kingdom and the Netherlands. The sample was purposive due to the authors' locations, but these national settings offer interesting similarities and contrasts. For example, the overall beauty and personal care market is more extensive in the UK compared to the Netherlands (Statista, 2025a, 2025b). Yet, the Netherlands and the UK are located close together in the global top 30 of the estimated number of plastic surgeons per country (ISAPS, 2024). Moreover, in both countries, the number of – mainly, or even only, non-surgical – cosmetic procedures have grown substantially over the past years (Decates et al., 2024; Department of Health & Social Care, 2023; ISAPS, 2024).

Nevertheless, the UK and the Netherlands differ in their regulatory approaches to non-surgical procedures. In the UK, there is currently no regulatory framework that requires a specific level of qualification (medical or otherwise) for practitioners nor licensing of premises (Department of Health and Social Care, 2023; Nuffield Council on Bioethics, 2017). As a result, those from non-medical backgrounds, including beauty therapists and other aestheticians, can administer

non-surgical procedures (Zargaran et al., 2023). On the other hand, in the Netherlands, the title 'cosmetic doctor' – which covers those who perform non-invasive procedures - is protected and requires an additional two years of training. Exploring practitioner approaches to cosmetic gatekeeping across differing cultural and regulatory contexts may deepen comparative understandings of how (re)shaping bodies is negotiated. However, this comparison was not the primary aim of the research, and these differences did not influence the study design.

We recruited participants through several means, comprising active and passive strategies. The strategies were evaluated throughout, and we adopted new approaches when recruitment was slow, particularly in the UK (Negrin et al., 2022). Existing practitioner contacts were emailed, and targeted communications were sent to individuals and organizations (e.g., the UK's Joint Council for Cosmetic Practitioners). An online recruitment poster was also created and posted on social media sites (e.g., Instagram, Facebook, and LinkedIn). We aimed for maximal variation in aesthetic practitioners' experience, current position, and (non-)medical background.

Interviews were conducted online (n = 13) and offline (n = 2) between January and August 2024 and lasted 45–60 min. Conducting most of the interviews online posed considerable benefits for the research in enhancing access to participants where they were geographically dispersed (De Villiers et al., 2022). Additionally, following Jenner and Myers (2019), we found no significant difference in developing rapport or data quality because of differing interview formats. In total, 15 participants were interviewed (see Table 1). Acknowledging critical discussions around data and/or thematic saturation, especially in reflexive thematic analysis, we argue that codes and themes may continually be revised and expanded upon (Braun and Clarke, 2021). However, as we analyzed the first transcripts alongside conducting further interviews, we did see a recurrence of similar (types of) responses. Moreover, pragmatic saturation, alongside considerations and guidelines stipulated in previous research about code saturation versus meaning saturation (Hennink et al., 2017), played a role in deciding to stop recruitment. Lastly, we consulted Malterud et al.'s (2016) model for assessing appropriate information power in the data, evaluating the specificity of the study's aims and sample, case-by-case analysis, and the quality of dialogue to guide our decision to stop recruitment after 15 interviews.

2.3. Materials and procedure

A semi-structured interview guide was established to answer the research question (see Appendix A). This guide includes several topics from the broader project into aesthetic practitioners, comprising questions related to (1) the aesthetic practitioners' professional backgrounds and motivations to go into aesthetics; (2) rewarding/challenging elements of aesthetic practice; (3) the commercial nature of the aesthetics industry; and (4) conceptualizations of beauty and the role of aesthetic practitioners in shaping bodies and/or beauty. The latter topic, in particular, forms the focus for this article, with questions such as (a) how would you describe beauty?; (b) how do you see your position in shaping beauty?; and (c) how do your ideas of beauty inspire/guide your work?

Table 1
Overview of all interview participants.

Pseudonym	Current role	Professional background	Country
Melissa	CEO of aesthetic training company	Non-medical	UK
Oscar	Ear, nose and throat surgeon & Owner of aesthetics company	Ear, nose and throat surgeon	UK
Emma	Owner of aesthetics company	Nurse	UK
Simon	Aesthetic doctor	General practitioner	UK
Lisa	Prescribing nurse & injector at beauty studio	Nurse	UK
Ramona	Owner of aesthetics company	Dentist	UK
Amber	Aesthetic nurse	Nurse	UK
Jennifer	Owner of aesthetics company	Nurse	UK
Adrian	Aesthetic doctor	General practitioner	UK
Amir	Owner of aesthetics company	Nurse	UK
Pepijn	Cosmetic doctor	Cosmetic doctor	NL
Sanne	Dermatologist & cosmetic doctor	Dermatologist & cosmetic doctor	NL
Tijmen	Plastic surgeon & owner of aesthetics company	Plastic surgeon	NL
Joris	Cosmetic doctor	Dentist & cosmetic doctor	NL
Sebastiaan	Cosmetic doctor	Cosmetic doctor	NL

2.4. Data analysis

After completing each interview, the researchers and two student assistants transcribed the audio files verbatim, and pseudonyms were assigned to ensure data confidentiality. We adopted a reflexive thematic analysis (Braun and Clarke, 2006, 2021) to analyze the data. Using NVivo, the data analysis followed the six-phase process outlined by Braun and Clarke (2006, 2021). We undertook the analysis inductively (grounded in the data) as this study was exploratory, and our process for coding was open and organic, as opposed to following a specific coding framework (Braun and Clarke, 2021). Both authors engaged in data familiarization and noted observations for the first three transcripts, generating initial codes independently. These observations and initial codes were compared and discussed, identifying and agreeing initial themes together. Subsequent transcripts were assigned to be coded independently, with review and finalization of themes completed in collaboration, checking for consistency and coherence against the data (for the thematic map, see Appendix B).

2.5. Researcher characteristics

We acknowledge our constructionist approach, believing that researchers are a part of and shape all facets of the research process. Therefore, we disclose specific demographic information and positioning of the authors who conducted the interviews, performed the analyses, and reported the findings (Yardley, 2000). The first author, A1, is a white-European female in her early 30s with a Humanities and Social Sciences background. She has studied the sociocultural context surrounding cosmetic procedures for nearly a decade and considered undergoing various procedures. Yet, she is critical of the increased normalization of cosmetic procedures and the gendered nature of appearance practices. The second author, A2, is a white-British female in her mid-30s with a Social Sciences background and previously studied women's engagement with the digital landscape for aesthetic procedures. She has undergone non-surgical aesthetic procedures. A2 often reflects on the discursive complexities of being a client-patient while recognizing and critiquing aesthetic expectations. We were not asked about and did not discuss our positionalities with participants during the interviews. However, we recognize that our critical positions on medical cosmetic procedures may have influenced the study design and data interpretation.

2.6. Ethical approval

This project received ethical approval from the Faculty Ethics Committee at University of Southampton (ID 89667). Written consent was obtained from all participants prior to the interviews. Data was anonymized, and transcripts were stored on an institutional OneDrive that was accessible only to members of the research team.

3. Results

The analysis resulted in three main themes, which are further divided into themes and sub-themes. The first theme, **conceptualizing beauty**, discusses how participants described and negotiated the

concept of 'beauty', highlighting subjective and objective definitions. The second theme, **shaping bodies**, explores how aesthetic practitioners (do not) see themselves as significant shapers of bodies and beauty and why and how they (do not) suggest aesthetic procedures. Finally, the theme **cosmetic gatekeepers** examines how aesthetic practitioners provide boundaries regarding how, when, why, and on whom they (do not) perform procedures. Collectively, these themes emphasize the nuanced interplay between client-patients' corporeal desires and practitioners' aesthetic expertise and professional responsibilities. Together, the themes highlight the various intricate medico-cosmetic and commercial considerations that aesthetic practitioners must navigate when (re)shaping bodies.

3.1. Conceptualizing beauty

The first theme relates to ***beauty as a complex concept***, as participants struggled to define or express what they would think of as beautiful. Simon, for example, stated, "*it's very difficult to put into words because … when you sort of try to break it down into words, then you sort of, you kind of lose, you kind of take away from it*". Amber echoed this difficulty but alluded to ephemerality, arguing that conceptualizing beauty "*is difficult, it's not linear, and it changes from day to day even*". Nevertheless, after some initial deliberation, the aesthetic practitioners distinguished between ***beauty as/and subjectivity*** and ***beauty as/and objectivity***.

Reflecting Amber's statement related to the instability of beauty, participants described how beauty is subjective, relative, and/or changeable. Relatedly, Emma, Adrian, and Melissa all explicitly argued that 'beauty is in the eye of the beholder'. Acknowledging the subjective nature of beauty, some participants emphasized how – for them – beauty lies in a person's authenticity or individuality, which can refer to a person's appearance and/or personality. Sanne, for example, indicated how she *"[finds] beauty to be in an attitude… I can find it very charming and admirable that there are people who don't do anything [to their appearance] … and just say, 'yeah, this is how I am'"*.[1] Others also commented on the importance of people's acceptance, or even love, of themselves in conceptualizing beauty. Tijmen, for example, commented that "*the most beautiful beauty is in someone who, yeah, who just loves themselves… I think it is mainly about inner beauty that you radiate on the outside*".[2] A different way that some participants highlighted the subjectivity of beauty was by emphasizing it as a culturally dependent notion. Ramona pointed out how "*beauty is relative as well… depending on your context as well [as] where you are*". Adrian illustrated recalling recalled an instance when:

> I had this young lady fly in from Singapore for a treatment … And I remember she was asking for certain features… and it was very much away from the kind of European beauty standards … So that was a moment where I was like, actually, that's when you understand that every ethnicity, each group of people, their concept of beauty is so different.

However, despite this focus on subjectivity, relativism, and individuality, the aesthetic practitioners also argued that "*it's very personal … but there are of course some guidelines that are pretty uniform*"[3] (Sanne, emphasis added). These 'guidelines' were often rooted in science: as Simon specified, "*the objective way [of looking at beauty] is more sort of scientific and [has] to do with, for example, the aesthetic proportions that we have and, you know, and those kind of measurements*". Others also referred to these measurements, or the golden ratio, to determine "*a classic, ideal-shaped and featured face*" (Oscar). Taking a more critical stance regarding the uniformity of idealized aesthetic appearance, Amir recognized an entrenchment of beauty ideals in training spaces for practitioners:

> [You] can go to a lot of training companies that talk about 'the perfect ideal' in terms of the aesthetic model etc., which I'm not saying doesn't have its value… but you don't want to lose sight of, and certainly the client doesn't want to lose sight of themselves.

Relatedly, Emma more pointedly alluded to standardized notions of beauty as *"a big construct"*, specifically recounting occasions when she had attended aesthetics conferences where (mostly) male doctors presenting to (mostly) female aesthetic practitioners "*are telling us what those "beauty ideals"* [gestures air quotes] *are. It's so wrong*".

In sum, aesthetic practitioners noted various ways of conceptualizing beauty, often fluctuating between subjective and objective definitions. Sanne's quote highlights how practitioners may blend both factors in their decision-making. Interestingly, the interviews revealed minimal discussion about specific aesthetic features - beyond the concept of facial 'harmonization' - that are idealized, commodified, and marketed to consumers as beautiful. Instead, beauty was often described broadly and abstractly, referred to as 'beauty' or 'ideals.'

3.2. Shaping bodies

During the interviews, the aesthetic practitioners **reflected on their role as shapers of bodies and beauty**. Some distanced themselves from this arguing they only played a limited or even insignificant role. Joris, for example, argued that he has,

> a very limited role in this … There's just people who come to me and they have a wish for treatments and I see my task as figuring out what they want exactly and then to offer a realistic treatment plan and with realistic expectations [rather] than having a leading role in what they like. And actually, I don't think it's my job to, like, influence them in what they think is beautiful.[4]

Relatedly, Tijmen also argued, "*I think the trick is not to project my ideal image of beauty on to a client, but above all to try to understand what a client finds beautiful*".[5] Moreover, he questioned, "*who am I to say that something is [or isn't] right…?"* In a similar vein, Adrian argued, "*beauty for me could be very different from beauty to you … So, it's quite important to not superimpose my idea of beauty on the patient*". Correspondingly, some practitioners emphasized the importance - and challenges - of collaborating with client-patients to develop a shared understanding of aesthetic desires that align with what is non-surgically feasible. Amir, for instance, stated,

> [One] needs to be really quite clear and quite thorough about what can be achieved. This is not a one-sided conversation. It's about [the client-patient] understanding what I can achieve, and it's also about me understanding what they want to achieve, so that we're seeing eye to eye, and everything is balanced, and it is a challenge.

[1] Original quote: "Ik vind mooi ook in een hele uitstraling zitten… Ik kan het ook heel charmant vinden en heel bewonderenswaardig dat er mensen zijn die helemaal niks doen … en gewoon zeggen dit is he ik ben".

[2] Original quote: "Ik denk dat de mooiste schoonheid is bij iemand die gewoon ja, die gewoon van zichzelf houdt. Ja, weet je, en of dat dan met een uiterlijke schoonheid te maken heeft … het gaat denk ik vooral toch om de innerlijke schoonheid die je aan de buitenkant uitstraalt."

[3] Original quote: "Het is heel persoonlijk … Maar er zijn natuurlijk wel wat richtlijnen die wel redelijk uniform zijn".

[4] Original quote: "Ik vind denk ik dan heel beperkte rol in heb, want … ik ben geen influencer, Er zijn gewoon mensen die komen naar mij toe en die hebben een behandelwens en mijn taak zie ik meer in het heel erg uitvogelen wat zij nou precies willen en dan een realistisch ja behandeltraject aan te bieden en dan met realistische verwachtingen. Dan dat ik nou echt een soort van leidende rol heb in wat zij mooi vinden. En eigenlijk vind ik dat ook niet echt mijn taak om zeg maar hen te beïnvloeden in wat zij mooi vinden".

[5] Original quote: "Ik denk dat de kunst is om niet mijn ideaalbeeld van schoonheid op een klant te projecteren, maar vooral heel veel te proberen duidelijk te krijgen wat een wat de klant zelf mooi vindt".

Other participants referred to their role as (re)shapers in minimalist terms, with Simon asserting that his "*approach is very artistic and one which is very 'less is more'*", elaborating that this approach is "*where you're doing just the bare minimum of what needs to be done. I think that is a healthy way of doing aesthetics, which can promote the well-being of our patients, both physical and psychological*". Ramona similarly referred to artistry in creating 'natural' appearances, stating,

> It's like painting, isn't it? I can transform people's faces and make it look more harmonious, better looking skin condition and therefore they're perceived as healthier. My goal when I do my aesthetics treatments, it's not to change anyone's appearance in the sense to make them look like someone or have a specific augmentation, it is about balancing, and it's about making these people looking more natural and healthier.

Despite their aesthetic expertise, some aesthetic practitioners were **hesitant to suggest procedures.** Emma, for example, argued that it is essential for aesthetic practitioners not to make assumptions about client-patients' concerns as "*you don't want to add a concern to somebody's concerns already*". Amber similarly argued how she "*[leads] with what [her client-patients] say*" as she "*[doesn't] want to put words in their mouths so they then turn back at me later and say, 'you told me I had the rubbish skin?' Or, 'you told me I had to have this done'*". Some practitioners even argued that they sometimes dissuade client-patients from undergoing any procedures at all. Amir, for example, explained that he always indicates "*all available options… [including] that the options for some people definitely are not having any treatment and therefore I'm certainly not selling to them*". Emma similarly shared that "*when people come in and people say to me, 'what do I need?' I always say 'nothing'. You don't need anything*".

Where some practitioners were reticent to suggest procedures, others indicated they **would suggest procedures**. As Melissa put it, "*in fact, it's like going and having your hair cut, and your stylist recommending what would suit you – well, it's the same with aesthetics. I know some of it is medicine, but you're still recommending what you think is good for them… and they trust your opinion*". Several practitioners emphasized how recommendations follow their medical expertise and coincide with educating client-patients about physiology. Oscar, for instance, explained, "*I always talk through the physiology and aging process and what happens as we get older. The changes that you get to the skin and the fatty layer, the muscle, the bone, and then what different treatments are available to address each of those changes"*. Discussion of holistic facial features was also prominent in Simon's approach, particularly regarding proportionality and 'harmonization', where he stated,

> So, if you look at the face like a house, you want structure to be in place before you start changing doors and windows. So, the lips are like the door to the house and that would come only at the end. So, when patients come to me, and they want their lips done, but let's say they've got a weak chin or cheeks then, we would tend to focus on that, to begin with. And I'd explain, I'd get that house kind of analogy, and it's something they seem to understand because, of course, that restores harmony to the face.

He further highlighted that, as a practitioner, "*[you] look at the face holistically rather than just look at areas as such, so often patients will come to me for lips, but they'll end up with something else*".

In addition to the initial procedures that practitioners may recommend, several also mentioned how they would **suggest additional procedures**. Sanne, for example, indicated that she was wary of administering 'only' one zone of botulinum toxin or 1 ml of dermal filler, stating,

> So, I often try to motivate them, like' yeah take a bit more', then I inject a bit everywhere, even if that dose is a bit lower. Then at least you have balance… that's of course a bit commercial, 1 ml is €500, that's really expensive, but their 2 ml is €850, then I always explain, I say 'yes honestly €500 is just very expensive'… I say it as it is, that 2ml is €850 and that is not without reason … we can often make that difference with 2ml, giving you that wow effect. And that 1ml will certainly bring you something, but often just not enough.[6]

Similarly, Ramona stated "*I'm not pushy at all, so I always speak from the heart and if I think they will benefit from a treatment, I will tell them … if they say 'no', it's fine …. I don't force [them] into anything*". Reminiscent of this approach, Joris also described how,

> I will simply explain what the options are and the alternatives. And if I really see something in the face, for example… then I say, well, actually it would be very nice to add some cheekbone volume, or actually I would advise [to do] tear troughs for you, I'll show a photo, I won't go into it too much, because… I don't like to be pushy, but I'll just mention it. And often the result is that [when] someone has been with you for a while… then they still remember that you once said that and then they do it once and then they are happy with it.[7]

Aesthetic practitioners varied in their approaches to reshaping client-patients' bodies and navigating ethical and commercial boundaries. Some used a neutral consultation style, prioritizing client concerns, while others focused on mutual agreement for achievable outcomes. Some viewed their role as minimalistic 'artistry' to enhance natural features and wellbeing. Differences emerged in how proactively they suggested treatments, with some being cautious and others confidently recommending options, even where these deviated from client-patients' initial requests.

3.3. Cosmetic gatekeepers

As cosmetic gatekeepers, aesthetic practitioners **provide boundaries** regarding the procedures they choose (not) to perform and the client-patients they decide (not) to treat. The issue of providing boundaries was discussed in all interviews. However, participants acknowledged the **complexity** of this, with Pepijn arguing "*it's very difficult*" as the issue is interwoven with "*so many factors*".[8] This complexity highlights the unique 'medico-cosmetic' challenge to their work. Establishing boundaries often resulted in refusing treatment, which typically reflected broader considerations about (un)natural and (un)realistic aesthetic outcomes. Oscar argues, "*most of us medical practitioners with, you know, an ethical treatment practice will turn a lot of these patients down*". Moreover, some reflected on the potential reputational damage undertaking certain procedures could inflict, with Sebastiaan pointing out, "*there's also a bit of commercialism to it; I don't*

[6] Original quote; "Dus ook daar probeer ik heel vaak ze te motiveren van ja, doe dan ietsjes meer, maar dan prik ik je overal wat, al is die dosis dan iets lager. Dan heb je in ieder geval balans en een mooie stand van je wenkbrauwen. En dan weet ik gewoon zeker dat het goed gaat… kijk bij [kliniek] doen ze dat goed zo breng ik het dan, dat is natuurlijk wel een beetje commercieel, daar is 1 ml veel al € 500, Dat is echt duur, maar hun 2 ml is €850, dan leg ik altijd uit ik zeg ja, eerlijk € 500 is gewoon heel duur. Ik benoem het ook gewoon, zeg maar die 2 ml is €850 en dat is niet voor niks en Dat is Omdat wij vaak met twee ml net dat verschil kunnen maken waardoor jij dat wow effect hebt. En die 1 ml jou zeker wel iets gaan brengen, maar vaak nog net niet genoeg".

[7] Original quote: "Ik ga dan gewoon uitleggen wat daar de opties voor zijn en de alternatieven. En als ik echt iets zie in het gezicht bijvoorbeeld … dan zeg ik joh eigenlijk zou bij jou heel mooi zijn om wat jukbeen volume te doen, of eigenlijk zou ik bij jou traangootjes zou ik adviseren, laat ik een foto zien, ga ik daar verder niet te lang op in, want daar ben ik niet goed in … ik hou er niet van om opdringerig te zijn, maar dan noem ik het even. En vaak is dan het resultaat dat iemand een tijdje bij je is geweest, en een aantal behandelingen waar ze voor kwamen, dan hebben ze nog in hun achterhoofd dat je dat ooit hebt gezegd en dan gaan ze het een keer doen en dan zijn ze er blij mee".

[8] Original quote: ""dat is heel lastig… Het enige wat ik erover kan zeggen is dat het dus van heel veel factoren samenhangt".

want to be associated with that".[9] The practitioners pointed out several **ways in which they provide boundaries** to client-patients. Firstly, they may invoke their positional authority, with Tijmen stating, "*I have the right and the idea to say 'well I am in charge here, and I just won't do it'*"[10]. Additionally, Amber highlighted that the elective nature of procedures also helped enable a refusal: "*it's not life or death, it's not an emergency, and as practitioners we're in the more privileged position in that I can also elect to give it to them*".

Generally, a distinction can be made between **procedure-related refusals** and **patient-related refusals.** Amongst the **procedure-related refusals,** firstly, practitioners mentioned they would not perform procedures they perceived to be 'unnecessary'. Reflecting on what would be deemed unnecessary, Simon argued, "*unnecessarily [treating] is when patients come and … they want to go beyond what I would consider normal*". Secondly, procedures that were deemed 'excessive' – often injectable Brazilian Butt Lifts (BBLs) or large quantities of dermal fillers in the lips – were frequently refused by the participants. In fact, some of the participants suggested counter-treatments to resolve 'excess' filler as opposed to further augmentation: *"[young ladies] want more filler, and it's 'you don't need any more, you know, in fact, we need to do some revision, because this is just not natural'"* (Amber). Ramona pointed to a similar scenario, emphasizing, "*you will have overfilled faces that will come in and say, 'I want more', and you have to have the difficult conversations, 'I'm sorry you don't need any more'*". Finally, practitioners critiqued particular cosmetic procedures, mostly trendy treatments "*not backed up by research*" (Oscar) or procedures "*where the risks are so great that [they] do not outweigh the advantages you can expect from [a procedure]"*[11] (Tijmen).

Regarding **patient-related refusals**, practitioners had a clear idea of who they did (not) accept for procedures. Firstly, practitioners declined client-patients with 'unrealistic' expectations of procedures, like people presenting pictures of their desired outcomes without regard for their facial shape or structure. For instance, Jennifer commented that social media has led to "*a lot of young girls [coming] in, and I've had to say, 'that's not a good look', you know? You know, everybody looking the same, everybody having the same lips no matter what size your face is… that's not good*". Moreover, practitioners assessed the physical health of prospective client-patients, advising no treatment where their lifestyles may result in lessening efficacy of treatments, with Emma stating, "*I've turned people away who are heavy smokers, are really interested in the sun, and I'm just like 'you're going to be throwing your money away'*". Alongside physical health, the (presumed) mental health status of people proved to be a prominent reason for refusing treatment. As Lisa argued, "*we have a responsibility to protect mental health … you get a gut feeling if someone is teetering and it's our responsibility to say 'I'm really sorry, I'm not going to treat you'*". Similarly, Pepijn indicated how, when he "*finds himself sitting opposite someone who's completely down"* he first tries to ascertain what is going on for someone, arguing that "*the most wonderful [thing] I find is to figure out together with someone that I am not the one to help that person, but that someone else needs to help that person*".[12]

Naturally, the provision of boundaries and refusal of client-patients have specific **implications**. Most practitioners discussed the issue of client-patients 'clinic hopping' to locate somebody else to perform the procedure they had refused. The rapid expansion of medico-cosmetic servicescapes means there is increased competition for client-patients, therefore finding an alternative practitioner may not prove difficult. Practitioners from both the UK and the Netherlands emphasized concern about the widespread availability of treatments. However, in the case of the UK especially, clinic hopping could additionally result in undergoing treatment from a practitioner with poor or minimal training. Oscar lamented, "*the really sad thing is, [client-patients] will go off to find the same treatment somewhere else with someone who's not an ethical injector and will happily go and treat them for a couple of hundred pounds in their pocket*". Some practitioners discussed how they **adapted their boundaries** to avoid people undergoing (bad) procedures at unscrupulous clinics. Pepijn, for example, explained, "*I'm going to do it … now because I know, or I'm afraid, that if I say no [someone] will go around the corner and then I'm afraid it will be too much*".[13] Moreover, Pepijn also indicated that his provision of boundaries depended on his emotional state: "*it depends on how I feel that day… if I have a beaten-down day then I think fuck it, I'll do it. But when I feel strong … then I will put a lot of time and energy in explaining to someone why I won't do something*".[14] Others, like Adrian, noted compromise, meeting the client-patient 'part way' to their desired outcome, especially during ethically tricky cases:

> [There] will be people […] that'll come in and their idea of beauty is quite on the peripheries of normal. So those are the ones that you navigate quite carefully because 'how about rather than lifting the tip of the nose so high, how about we go halfway today, let's reassess in six weeks, come back in and then actually, if we need to lift it more, let's try that'.

Yet, some practitioners indicated they did not feel compelled to (attempt to) stop clinic-hopping if they could **stick to their boundaries**. Amber, for example, commented, "*some of the young ladies, they're not interested, they want to continue, and that's fine by me; they just won't have their work done by me. I have a strong ethos that I'm not going to do anything out of my comfort zone for a patient*". Reflecting a similar sentiment, Lisa stated, "*I have many a time been told 'well I'm just going to get it done elsewhere', and my argument is 'ok, I'm not going to plead with you, all I can do is educate you as to my reason why'*", concluding, "*I can't force [them] to listen to me, but I can go to sleep at night knowing that I've done what I was supposed to do*".

Refusing treatments also has a monetary impact, which complicates matters. Monetary pressures differed slightly between practitioners who ran their clinics, or worked as freelancers, and those who worked for larger clinics, or as part of a clinical chain. Emma, who ran her aesthetic clinic, explained the financial precarity of running a small enterprise, stating, "*it's always a tricky one because it's a difficult balance of this is my income and I do need to pay the bills*". From the perspective of working in a larger corporate structure, Sebastiaan reflected that in an *"organization where there's someone, a controller, three countries away, who is looking at the finances and who says, hey this week you've made 6 % less on Botox, why's that? That immediately creates a completely different atmosphere, a different pressure*".[15] This pressure reflects a broader concern with

[9] Original quote: "Het is ook zo, en daar komt ook een stukje commercie achter, ik wil daar niet mee geassocieerd worden".

[10] Original quote: maar dan heb ik ook gewoon het recht en het idee om te zeggen ja ik ben hier de baas en ik ga dat gewoon niet doen. Ja, want ik voel me daar niet prettig bij

[11] Original quote: "zaken waarvan we echt menen dit gaat te ver, daarvan zijn de risico's zo groot dat dat niet opweegt tegen de voordelen die je ervan verwacht, ja dan doen we het gewoon niet".

[12] Original quote: "Als ik iemand tegenover mij tref, die dus helemaal in zak en as zit … dan vind ik het heel erg interessant om eerst te achterhalen waar dat vandaan komt en soms zelfs eerst op dat vlak te helpen voordat ik fysiek iets ga doen. En het allermooiste vind ik dan om er samen achter te komen dat ik niet degene ben die diegene moet helpen, Maar dat iemand anders diegene moet helpen."

[13] Original quote: Ik ga het nu bij jou doen omdat ik weet, of bang ben, dat als ik nu nee zeg, dan ga je om de hoek, en dan ben ik bang dat het veel te veel wordt.

[14] Original quote: Dus als ik een, ja een murw geslagen dag heb dan denk ik fuck it, ik doe het wel. Maar Als ik me heel sterk en krachtig voel, ja, dan ga ik gewoon veel tijd en energie steken in iemand om uit te leggen waarom ik het niet ga doen.

[15] Original quote: "Heb je een bedrijf waar op kantoor drie landen verderop iemand zit een controller die financieel kijkt en die zegt, Hé, deze week heb jij 6 % minder omgezet op de botox, hoe komt dat? Dan creëert dat meteen weer een hele andere sfeer, een andere druk".

practitioners performing procedures against their will, either for direct financial recompense or to satisfy corporate profits. Tijmen, for example, also related how, at a different clinic,

> *you just did what came in … even though you sometimes thought, Jesus, do I really have to do that? … Of course, you decide what you do and don't do. But yes, if, let's just say, five times a week someone comes in who wants that, then you can't just say 'go home' five times. At a certain point, the boss also says 'I don't know, but you send everyone away again'*[16]

Pressure to perform procedures also resulted from client-patients' (perceived) position of consumer power, which impacted some regarding their professional identity. Sanne, for example, explained that "*as a doctor, you are extremely vulnerable … [Client-patients] can start a whole smear campaign against you on Instagram. You are so vulnerable; you feel that sometimes, [to] the point that you think I'll just give in*".[17] Sebastiaan also reflected on this "*position of dependency*", arguing, "*you really feel that if someone says I would like this and that is my choice, and I pay for it … then you just need to perform*".[18] He further related this to the emphasis on 'serving people' in medical school and fulfilling a "*moral duty*" to provide care. Relatedly, many of the practitioners emphasized that the **final decision** (not) to undergo particular procedures **rests with the client-patients,** with Sebastiaan emphasizing client-patients' '*self-determination'* and Joris arguing, "*I see myself more as someone who has to do something safely than that I have to sort of sit on my seat in an ivory tower and say what [people] can and can't do [or] want, so then yes, I agree if it can be done safely*".[19]

Cosmetic gatekeeping involves intersecting medical and commercial considerations among aesthetic practitioners, who varied in establishing boundaries. Procedures deemed aesthetically 'unnecessary', 'unnatural', or 'excessive' were often grounds for refusing treatment, as were clients perceived as physically or mentally unsuitable. However, practitioners acknowledged client-patient agency and consumer power, knowing those turned away might seek alternative providers. For some, this awareness sometimes tempered their (initial) instinct to refuse. Additionally, for some, commercial pressures to maintain client turnover complicated the balance between their (medical) professional and commercial identities, highlighting the nuanced complexity of cosmetic gatekeeping.

4. Discussion

This study aimed to explore how aesthetic practitioners negotiate their role as cosmetic gatekeepers who (re)shape client-patients' bodies in evolving and normalized non-surgical medico-cosmetic servicescapes. There are several noteworthy points discussed here. Importantly, we explore how practitioners' perceptions of beauty influence the cosmetic procedures they choose (not) to perform and on whom. Inherent to these discussions is how practitioners construct the (non-)surgical 'other', which guides their deliberations. Correspondingly, we examine how practitioners assert their aesthetic expertise while they also (aim to) collaborate with client-patients. Finally, we discuss how practitioners construct ethical 'medico-cosmetic' practice, particularly when navigating (preference for) client-patient refusal. We highlight the broader implications for an expanding industry with no standardized guidelines for ethically approaching procedures (Craddock et al., 2022). This study contributes qualitative insights into practitioners' experiences of cosmetic gatekeeping and everyday negotiations of aesthetic aspirations, possibilities, and limits.

4.1. Defining beauty: constructing the 'natural', avoiding the 'other'

Positioned as aesthetic intermediaries in (re)producing 'desirable' appearances (Menon, 2019), practitioners offered a mixture of subjective and 'objective' notions of beauty, with most emphasizing that both considerations influence their practice. On the one hand, beauty was associated with authenticity and individuality. Some practitioners thus posited that 'inner' beauty would radiate out, but conversely, beautifying the outer body could also benefit a person's confidence and overall wellbeing (cf. Davis, 1995). Aligning 'inner' beauty to match an external façade reflects an enduring Western notion equating beauty with virtue and moral goodness (Gupta et al., 2016). Extending the idea of alignment, some practitioners advocated enhancing 'natural' appearances to indicate health, a commodified virtue in neoliberal societies that necessitates visual signs of 'wellness' (Berkowitz, 2017; Pitts-Taylor, 2009). Non-surgical procedures increasingly form part of biomedicalized imperatives that promote ongoing corporeal transformation as necessary "self-care" (Pitts-Taylor, 2016, p. 160). As such, practitioners are a route to achieving the convergence of beauty and wellness.

Conversely, beauty was defined 'objectively' using measurements like the golden ratio to achieve a 'harmonized' aesthetic. However, such 'objective' approaches raise concerns regarding bodies that may be measured as divergent (Atiyeh et al., 2020; da Prato et al., 2024; Edmonds, 2013). After all, (when) do such deviations warrant cosmetic intervention where beauty has become an 'ethical ideal' (Widdows, 2018)? In addition, cultural and ethnic variations in beauty challenge the appropriateness of facial measurements (Arian et al., 2023), though only a couple of practitioners acknowledged cultural diversity in their definitions. Some practitioners critiqued homogenized approaches, highlighting how professional spaces like training and conferences may reinforce narrow 'constructs' of beauty. Criticism of the medical cosmetic industry for propagating standardized beauty ideals is prevalent in medical and feminist literature (Ramirez et al., 2024; Bordo, 2004; Edmonds, 2013). However, although practitioners acknowledged their discomfort with some elements of the professional, cultural, and commercial contexts in which they operate, there was little elaboration on how they might challenge the dominance of these standards in their practice, aside from showing respect for individual anatomy.

There was more consensus among practitioners regarding what features were *not* considered aesthetically desirable and should be mediated - or avoided - through meticulous gatekeeping to prevent a significantly altered appearance. Congruent with Gimlin's (2010) findings, practitioners constructed (non-)surgical 'others' to evaluate potential client-patients and as a gauge for the credibility and ethical standards of their industry peers, cautioning against 'unnatural', 'excessive', and 'unrealistic' (outcomes of) cosmetic procedures. Occasionally, practitioners' aesthetic judgment clashed with prospective client-patients' desires ("not natural") or in the assessment of their current aesthetic state ("overfilled faces"). Menon (2019) notes that cosmetic gatekeeping involves an interplay between both medical and cultural elements. We echo in our findings that practitioners' aesthetic sensibilities, combined with their (technical) expertise, guided them in (not) (re)shaping bodies.

[16] Original quote: "je [deed] gewoon wat er binnenliep, dat werd gedaan. Terwijl je ook wel eens dacht, Jezus, moet ik dat nou echt gaan doen? Moet ik hier nou echt die dikke volle protheses in gaan proppen, tja …. Natuurlijk bepaal je uiteindelijk altijd zelf wat je wel en niet doet. Maar ja, als daar ik noem maar wat in een week tijd 5 keer iemand binnenkomt die dat wil, dan kun je niet 5 keer zeggen: ga maar weer naar huis, dan zegt de baas ook op een gegeven moment ook van ja, ik weet niet maar, ja jij stuurt iedereen weer weg."

[17] Original quote: "Je bent als arts echt ontzettend kwetsbaar… Ze kunnen op Instagram weet ik veel een hele hetze tegen je beginnen. Je bent echt heel kwetsbaar, dat voel je soms wel dat punt dat je dan denkt, ik geef maar [toe]".

[18] Original quote: "dat is ook een heel andere afhankelijkheidspositie … voel je ook bijvoorbeeld heel erg het gevoel dat als iemand zegt, Ik wil dit graag en dat is mijn keuze en ik betaal ervoor dat je dan het idee hebt van … dan moet jij eigenlijk zo gaan presteren".

[19] Original quote: "ik zie mezelf meer als iemand die iets veilig moet doen dat dat ik een soort van op een-in een ivoren toren op mijn zetel moet gaan zitten en zeggen wat zij wel of niet mogen moeten [en] willen, dus dan ja, dan ga ik erin mee als het veilig kan".

4.2. Beauty (by practitioner) standards? Relational dynamics in aesthetic negotiations

Practitioners generally viewed (re)shaping bodies with client-patients as a collaborative, co-productive effort, relying on empathy, rapport, and trust to explore and agree on aesthetic goals (Aquino, 2020; Vlahos et al., 2022). However, practitioners varied in what collaboration looked like. Reflecting neoliberal, consumerist ideologies of client-patients as agential, knowledgeable consumers (cf. Braun, 2009; Gimlin, 2007), some practitioners viewed themselves as (mere) performers, not supposed to superimpose their aesthetic idea(l)s, but rather as neutral executors of procedures, with the sole caveat that these would have to be safe. However, it was not specified what this 'safety' entailed. Other practitioners were keen to emphasize their artistic and minimalist influence on alterations. The intersection of artistry with (non-)surgical proficiency has been widely discussed elsewhere (Berkowitz, 2017; Fraser, 2003; Parker, 2010), and here, in keeping with the bio-medicalized pursuit of holistic facial 'health', it resulted in discreet outcomes over "specific augmentation". Most of the practitioners in this research extolled 'aesthetic conservationism' (da Prato et al., 2024), which was reflected in their negotiations with client-patients.

Variance in practitioners' approaches to (re)shaping bodies was also evident in their treatment recommendations. Some were reluctant to engage in the commercial side of aesthetics despite the financial advantages of doing so, reticent because they were wary of 'adding' to client-patients' aesthetic concerns. Conversely, others proactively utilized their expertise to suggest initial or additional treatments, which occasionally resulted in client-patients undergoing an entirely different procedure than initially intended and/or leaving with additional procedures to consider. The latter approach shifts towards Blum's (2003) conceptualization of aesthetic practitioners as arbiters of aesthetic ideals. Although practitioners claimed to avoid a 'pushy' commercial approach even where they recommended procedures, Ramirez et al. (2024, p. 5) advise caution in suggesting treatments as it can reveal "previously unrecognized anxieties" in client-patients. There is potential for body-image harm from seemingly 'innocuous' observations or suggestions from practitioners exercising their aesthetic expertise, raising concerns about imposition of aesthetic idea(l)s, even where practitioners may not realize it.

4.3. Labyrinthine considerations: navigating ethical 'medico-cosmetic' conduct

Cosmetic gatekeeping involves complex deliberations regarding ethical 'medico-cosmetic' practice. Practitioners perceived these navigations as ethically labyrinthine, balancing corporate pressures and client-patient management. Most emphasized adherence to values of beneficence in curating 'natural' enhancements and non-maleficence in avoiding the (non-)surgical 'other' (Gimlin, 2010). The latter sometimes resulted in treatment refusal. A refusal was often seen as an ethical medico-cosmetic decision, even if it led client-patients to seek procedures from potentially less scrupulous practitioners focused on financial gain rather than the interests of the client-patient. Boundaries of refusal, however, were sometimes flexible. Even in cases where refusal of treatment was the preferred option for practitioners, procedures may still be performed in light of various justifications, such as preventing client-patients obtaining (bad) procedures elsewhere, deference to client-patients as agential and paying consumers, or corporate pressures (Gimlin, 2007; Jones, 2008). Some practitioners struggled to detach from a physician's 'moral duty to treat', with one noting he might reluctantly provide treatment when emotionally drained, highlighting how emotional capacity affects negotiations tied to (medical) professional identities (Kerasidou and Horn, 2016).

The boundaries of refusal for non-surgical procedures varied, influenced by practitioners' constructions of (un)desirable aesthetic outcomes and often impacted by commercial pressures they may face, making deferring to medical ethics alone insufficient in cosmetic gatekeeping. To address this, Ramirez and Scherz (2025) emphasize shared decision-making to empower both client-patients and practitioners. While shared decision-making is essential, the authors emphasize that practitioners should decline a procedure if it does not align with medico-ethical best practice. Herein lies an issue. Despite some practitioners stating that they did not superimpose their notions of beauty on client-patients, refusing procedures – for instance, to avoid an 'obvious' appearance of artifice - may inadvertently impose a vision of acceptable beauty based on the *practitioner's* conceptualizations of aesthetic (un) desirability (Menon, 2019; Minerva, 2017). This raises questions about *who* determines appropriate boundaries of 'naturalness' versus 'artifice', and *when* this warrants a refusal.

With that said, there are no easy solutions, especially given the increasingly competitive marketplace, the ephemerality of diverse beauty trends in a saturated visual culture (Kuipers, 2022), and the lack of unified professional practice guidelines specific to medical cosmetic procedures (Craddock et al., 2022; da Prato et al., 2024). What a specific 'medico-cosmetic' framework could look like and how this would most effectively balance patient autonomy (to receive treatments), practitioner autonomy (to refuse treatments), and commercial pressures (to sell treatments)? Currently, ethical medico-cosmetic conduct represents a complex and often individualized balancing act of (medical) professionalism and commercialism.

5. Conclusion and future directions

In this study, we explored aesthetic practitioners' nuanced approaches to cosmetic gatekeeping. This research has added important qualitative insights, particularly regarding the interplay between constructions of (un)desirable aesthetic outcomes and how practitioners navigate ethical medico-cosmetic practice at a fraught nexus of medicine, beauty, and commercialism. The specific focus on non-surgical procedures in this research is an important strength, as previous qualitative research into practitioners' lived experiences mainly focuses on surgical cosmetic procedures. The growing popularity of non-surgical procedures necessitates understanding how aesthetic practitioners navigate their roles in ever-expansive medico-cosmetic servicescapes where these interventions are accessible, largely non-permanent, and typically less skill-intensive than surgical options.

In conclusion, practitioners' multifaceted approaches are summarized in three themes. Firstly, aesthetic practitioners' conceptualizations of beauty were complex and often cautiously articulated, illustrating variable interpretations that inspired the gatekeeping in which practitioners engaged. Secondly, this variance continued into practitioners' approaches to (re)shaping bodies, highlighting not only differences in relational approaches but also the extent to which they were (un) comfortable with commercialized aspects like recommending (initial, alternative, and additional) procedures. Lastly, cosmetic gatekeeping involved differences in how practitioners established and enforced ethical 'medico-cosmetic' boundaries, constructing the (non-)surgical 'other' as grounds for treatment refusal. However, some practitioners adapted their boundaries for medico-commercial reasons, even where refusal was preferable. Cosmetic gatekeeping comprises labyrinthine medico-commercial considerations, and this research highlights practitioner experiences, perceptions, and behaviors of navigating a 'fragmented' sector with oscillating medicine and business priorities (Craddock et al., 2022; Hermans, 2022).

We included a diverse sample of aesthetic practitioners from (non-) medical backgrounds across different national contexts. Interestingly, cosmetic gatekeeping had minimal differences between the UK and the Netherlands. Participants in both national contexts exhibited similar approaches to beauty, body (re)shaping, and concerns about 'unethical' practitioners. The primary distinction lies in regulatory perspectives: in the UK, an 'unethical' practitioner extends to include un(der)trained practitioners (Craddock et al., 2022; da Prato et al., 2024). This lack of

variation prompts questions for future research regarding gatekeeping differences among practitioners predominantly from non-medical backgrounds; our sample included only one non-medical practitioner, who voiced concerns about un(der)trained individuals in the UK. Additionally, expanding the focus to regions beyond North-West Europe may yield further insights, particularly regarding how client-practitioner dynamics influence cosmetic gatekeeping across diverse cultural contexts. Lastly, it is important to note that cultural diversity in aesthetics was only explicitly mentioned by a couple of the practitioners, and this warrants further examination in a Northwestern European context. Transnational beauty ideals flow easily, as highlighted by Menon (2019), and therefore, practitioners' aesthetic considerations on this point would be a valuable addition to work on non-surgical cosmetic gatekeeping, especially.

Notably, while this study focused on the experiences of aesthetic practitioners, whose narratives around performing medical cosmetic procedures have often been overlooked in favor of the experiences of client-patients, a natural complement to this research would be to explore the client-patients' experiences of working collaboratively on realizing aesthetic outcomes with their chosen practitioner(s). This would elucidate strategies of resistance or negotiation employed by client-patients in response to medical professionals regarding the feasibility of the transformation. Understanding how client-patients discuss their aesthetic desires with practitioners is crucial for insights into their perceptions of non-surgical procedures and how they develop aesthetic competencies for effective negotiations as these interventions become more integrated into everyday beauty practices (Vlahos et al., 2022). Building upon this, there are also possibilities for ethnographic observation of negotiation processes between client-patients and aesthetic practitioners. Such research would further enhance understandings of relational dynamics in practice and provide insights into how aesthetic possibilities and limits are agreed or resisted by both parties.

Lastly, the role of social and/or business pressures on practitioners is worrying, as these could (and did at times) negate the practitioners' (initial) decision not to treat client-patients. Future research would need to establish the prevalence of these concerns among practitioners and then reflect on ways to address them. Regarding commercial pressures to sell procedures, a call to action from professional and regulatory bodies representing aesthetic practitioners may stimulate guidance and initiatives that support practitioners in redressing the balance between ethical medico-cosmetic judgment and corporate aspirations. There may also be scope for additional training to assist practitioners in navigating ethical medico-commercial practice. Such a call to action would likely be somewhat easier to co-ordinate in the Netherlands. However, in the UK, where aesthetic practitioners are dispersed across different (non-)medical professions and regulatory bodies, with some not being associated with any professional organizations, attempting to implement initiatives presents an impossible challenge until a coherent regulatory framework is implemented.

CRediT authorship contribution statement

Anne-Mette Hermans: Writing – review & editing, Writing – original draft, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation. **Rebecca Nash:** Writing – review & editing, Writing – original draft, Software, Resources, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Appendix A. Interview Guide

Introduction

- Check: questions beforehand
- Check: consent form signed and stored
- Introduce researcher + project
- Interview etiquette – e.g., confidentiality of data; no right/wrong answers but interest in personal experiences and perceptions; can stop the interview at any moment.

Professional background

1. Can you tell me about your professional background; how would you describe your role?
   a. What does your role entail?
   b. How did you become a cosmetic practitioner?
   c. What were your main motivators to move into this profession?
   d. What are the most rewarding/challenging aspects of being a cosmetic practitioner?
2. Bridge - As a cosmetic practitioner, I imagine that aesthetics and beauty play an important role. How would you describe beauty [next part]

Constructing beauty + gatekeeping and shaping beauty in others

3. How would you describe beauty?
   a. What do you think is 'beautiful'?
   b. How do you see your position in shaping beauty?
      i. Both individual + collective level
   c. How do your ideas of beauty inspire/guide your work?

Commercial nature of work

4. As a cosmetic practitioner, you operate within a commercial field. How do you experience this?
   a. Do you consider yourself an entrepreneur?
   b. How/why/in what way(s)?
   c. How do you use your experience/qualifications/background in positioning yourself as a cosmetic entrepreneur?
   d. What do you think of the commercial nature of the field?

e. What are the (dis)advantages of this?
f. How do you see the position of cosmetic procedures in medicine?

5. In a competitive market, how do you build and maintain relationships with clients?

End

6. Is there anything that has not been discussed yet but that you feel is important for the focus of this research?
7. Thank you and asking whether participant would like to be notified of outcomes of study

Appendix B. Thematic map

Main theme	Theme	Sub-theme	Definition	Illustration from data
Conceptualizing beauty	Beauty as complex concept		Participants describe their struggles in conceptualizing how they see 'beauty'	"I think it's very difficult to put into words because … when you sort of try to break it down into words, then you sort of, you kind of lose, you kind of take away from it" (Simon)
	Beauty as/and subjectivity		Participants describe how beauty is subjective, relative, and/or changeable	"Beauty is indeed very relative" (Tijmen)
		Beauty through authenticity or individuality	Participants discuss how beauty can be found in a person's authenticity or individuality. This can relate either to a person's appearance or personality.	"I find beauty to be in an attitude… I can find it very charming and admirable that there are people who don't do anything … and just say, yeah this is how I am" (Sanne)
		Beauty as culturally dependent	Participants point out that beauty is not universal, but rather is dependent on various (socio)cultural notions which differ across groups and regions.	"I had this young lady from Singapore … [who] was asking for certain features… that's when you understand that every ethnicity, each group of people their concept of beauty is so different" (Adrian)
	Beauty as/and objectivity		Objective measures	"Scientifically we know very well what beauty is. Then it's symmetry and you have the golden ratio that Michaelangelo already used" (Sanne)
Shaping bodies	Suggesting procedures		Participants discuss whether, and how, they suggest particular procedures, which may be *alternatives* or *additions* to what patients initially asked for.	"In fact, it's like going and having your hair cut and your stylist is recommending what would suit you. Well, it's the same with aesthetics" (Melissa)
		Reluctance suggesting procedures	Participants discuss their reluctance to suggest procedures, sometimes also advising against procedure, positioning themselves as *keepers of natural beauty* and/or arguing that *less is more*.	"You need to understand what [your clients] concern is, so you don't make an assumption about what I think the concern is… You don't want to add a concern to somebody's concerns already" (Emma)
	Reflections on role as shaper of bodies		Participants reflect on the role(s) they have in shaping patient-clients' bodies. This also includes a denial of, or distancing from, the notion that cosmetic medical professionals play a role in shaping or reinforcing particular beauty norms.	"I think the trick is not to project my ideal image of beauty onto a client, but above all to try to understand what a client finds beautiful" (Tijmen)
Cosmetic gatekeepers	Providing boundaries	Complexity of providing boundaries	Participants indicate the complexity of providing boundaries to patient-clients.	"It's very difficult … The only thing I can say is that it depends on very many factors" (Pepijn)
		Procedure-related refusals	Participants discuss procedure-related reasons for refusing to perform particular procedures. These reasons include (a) *perception of 'non-necessity';* (b) *perception of excess*; and (c) *criticism particular procedures,* which may inflict *reputational damage*	"Sometimes it's the case that I personally don't support a procedure … I don't want to be associated with that" (Sebastiaan)
		Patient-related refusals	Participants discuss patient-related reasons for refusing to perform particular procedures. These reasons include (a) *unrealistic expectations*; (b) *physical health of patients*; and (c) *mental health of patients*.	"We have a responsibility to protect mental health … you generally get a gut feeling if someone is teetering and it's our responsibility to say 'I'm really sorry, I'm not going to treat you'" (Lisa)
		Ways to provide boundaries	Participants discuss the various ways in which they provide boundaries to patient-clients, including (a) *positional authority* and (b) *dissuasion through financial means*.	"I think that's the key thing: it's elective, it's cosmetic, it's not life or death, it's not an emergency. And as practitioners we're in the more privileged position in that I can also elect to give it to them" (Amber)
		Implications of providing boundaries	Participants discuss the implications of providing boundaries, namely (a) *patients going elsewhere*, and, relatedly, (b) the *financial impact* this may have	"Some of the young ladies … they want to continue and that's fine by me, they just won't have their work done by me… There are plenty of other practitioners that don't have the same ethos, and they'll go and find them" (Ramona)
		Boundaries as flexible and changeable	Participants describe that boundaries can be flexible and changeable, depending on several factors, namely (a) *professionals' reluctance of patient-clients going elsewhere*; (b) *the work environment*; and (c) *practitioners' position and/or emotional state.* Also, participants discuss instances where they performed *procedures against their will.*	"Eventually you get the realization, yeah if I don't do it … then they'll go [to clinics where they do anything]. And well, if it has to be done and they really want it, and we've discussed it thoroughly a second time, then yes, well, then it must happen with us" (Tijmen)
	Client final decision		Participants indicate that patient-clients (must) make the final decision (not) to undergo a cosmetic procedure. These convictions reflect a *focus on serviceability; a (desired) state of neutrality*; and *neoliberalist ideology.*	"I very much believe in self-determination. So in that sense I think that the decision has to be with the person, primarily I think that the decision needs to be with the patient" (Sebastiaan)

Data availability

Data will be made available on request.

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