5 June 2015

Dr Joanna Flynn AM
Chair
Medical Board Australia
G.P.O. Box 9958
Melbourne VIC 3001
By email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn,

re: Medical Board of Australia - Public consultation - Cosmetic medical and surgical procedures provided by medical practitioners

Reference: 1.3.8.9

The ASA thanks the Medical Board of Australia for the opportunity to contribute to the consultation process on this matter. The ASA welcomes the comprehensive 'Public consultation paper and regulation impact statement', March 17th 2015, that highlights concerns in this area. In general the ASA agrees with option three with some qualifications and would like to make specific comments in relation to anaesthesia and office based surgery.

Response to consultation questions:
(Qu. 1-8) Firstly, the ASA agrees with the description of the problem as outlined in the consultation paper and therefore agrees and responds affirmatively to consultation questions one through to eight.

Option One:
Maintaining the status quo does not address the quality and safety concerns relating to recent morbidity and mortality in this area of practice.

Option Two:
(Qu.13-16) Providing more high quality, peer reviewed, accurate, plain language statements and information in a timely fashion to patients would be considered necessary to obtain informed consent. Any costs involved in providing this information are an indispensable part of the clinical process.

Option Three:
Qu. 17.1 The ASA supports a mandatory cooling off period and would agree with the Australian Society of Plastic Surgeons recommendation of minimum 10 to 14 days.

Qu. 17.2, 17.5, 17.6 The ASA considers that cosmetic procedures in patients under 18 years of age to modify or enhance physical appearance are not appropriate unless these procedures are in the best medical or psychological interests of the patient. The medical practitioner is responsible to make this assessment and obtain the appropriate consent. The ASA does not support a three month cooling off period, nor does it support a mandatory referral to a psychiatrist or psychologist for every patient unless clinically warranted.

Qu. 17.3, 17.4 The psychological assessment and referral if clinically warranted is considered part of the clinical consultation.

Qu. 17.7 The ASA agrees that the medical practitioner who is to perform the procedure should have a 'face to face' consultation before scheduling the procedure or prescribing schedule 4 injectables.

Qu. 19-21 The ASA would agree that the benefits from adopting Option Three in terms of reducing morbidity, mortality, reducing complaints, improving quality, safety and patient satisfaction would offset any costs involved. These costs should be considered a necessary part of the clinical episode.

Option Four: Qu. 22-24. Option Three seems more appropriate.

Specific Anaesthesia Considerations:

1. Facilities, staffing and equipment. ASA position statement 14: 'Anaesthesia for office based surgery'(2011)

    a. The ASA maintains that any cosmetic medical procedure must be performed in a facility which has the appropriate equipment, staff, governance and complies with standards for quality and safety. Hospitals and Day Surgery facilities have well defined standards. The ASA has developed guidelines for office based surgery and anaesthesia.

2. Local anaesthesia and or sedation.

    a. There seems to be a misconception that if a procedure is performed under local anaesthesia or sedation, the equipment, staff and standards required may be less rigorous. This is incorrect. (Rao, et al 1999). The appropriate equipment, staff and protocols to deal with complications and emergencies including local anaesthetic toxicity, resuscitation, and cardiopulmonary arrest must be provided. The ASA endorses the ANZCA "Guidelines for Health Practitioners Administering Local Anaesthesia" PS37 (2013) and the related "Anaphylaxis Management Guidelines ANZAAG-ANZCA (2013)

    b. Misconception of safe local anaesthesia doses. Local anaesthesia toxicity and adverse reactions depend on several factors including the physiochemical and drug characteristics of local anaesthesia selected, total dose, route of administration, speed of administration, patient factors including lean body mass, atopy and allergy profile, comorbidities, drug interactions, and co-administration of adjuvants such as adrenaline. (McLeod et al, 2009) The medical practitioner is responsible for selecting and administering the appropriate local anaesthetic in the correct dose for that patient. The Association of Anaesthetists of Great Britain and Ireland has released a safety guideline regarding the management of severe local anaesthetic toxicity. (2010)

    c. The facility must have the appropriate equipment and staff to monitor the patient during, and after local anaesthetic injection for adverse reactions. The ASA endorses the ANZCA Professional Statements PS18 "Recommendations on Monitoring during Anaesthesia" (2013) and PS04 "Recommendations for the Post-Anaesthesia Recovery Room" (2006)

    d. Sedation. The ASA would advise that if sedation is used, the guidelines described in Australian and New Zealand College of Anaesthetists Professional Statement 09 "Guidelines

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on Sedation or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures" (2014), be followed. These guidelines give specific advice about definitions, aims, patient preparation, patient assessment, staffing, facilities, equipment, specialized equipment for inhalational sedation, technique and monitoring, oxygenation, medications, documentation, recovery and discharge, training and audit. Specifically, the medical practitioner performing the procedure cannot be also be administering the sedation.

3. Patient Management

a. The ASA is particularly concerned about the appropriate post operative monitoring and care being provided for cosmetic patients. (Grazer & de Jong 2000)

4. Training, experience, qualifications, titles.

a. The ASA supports open disclosure of the training, experience, and significance of qualifications and titles.

5. Duplication of guidelines.

a. The ASA acknowledges the Medical Board of Australia 'Good Medical Practice: A code for conduct for doctors in Australia'.

b. Any future guidelines would need to be developed in conjunction with this code to avoid the potential for duplication and confusion with multiple guidelines.

6. Despite advances in resuscitative medicine, prevention of local anaesthesia toxicity and complications of sedation and anaesthesia, remains the best way to protect patients.

Yours sincerely,

Dr Guy Christie-Taylor
President: Australian Society of Anaesthetists

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References:

1. ASA position statement 14: 'Anaesthesia for office based surgery' ASA (2011)

2. Professional Statement 09 "Guidelines on Sedation or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures" ANZCA (2014),

3. Rao RB, ElySF, Hoffman RS. Deaths related to liposuction. New England Journal of Medicine 1999; 340(19): 1471-1475

4. ANZCA "Guidelines for Health Practitioners Administering Local Anaesthesia" PS37 (2013) and the related documents

5. PS18 "Recommendations on Monitoring during Anaesthesia" (2013)

6. McLeod GA, Butterworth J, Wildsmith JAW 'Chapter 5 Local Anaesthesia Toxicity' pages 114-132; Cousins and Bridenbaugh's Neural Blockade: Lippincott Williams & Wilkins, at Wolters Kluwer (2009)

7. The Association of Anaesthetists of Great Britain and Ireland has released a safety guideline regarding the management of severe local anaesthetic toxicity. (2010)

8. "Anaphylaxis Management Guidelines ANZAAG-ANZCA (2013)

9. PS04 "Recommendations for the Post-Anaesthesia Recovery Room" (2006)

10. Grazer FM, de Jong RH. 'Fatal outcomes from liposuction: Consensus survey of cosmetic surgeons.' Plast reconstr Surg 2000;105: 436-448

11. Medical Board of Australia 'Good Medical Practice: A code for conduct for doctors in Australia'. *Good Medical Practice: A Code of Conduct for Doctors in Australia — July 2009 1*

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