Australasian Society
of Aesthetic Plastic Surgery

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2 June 2015

Dr Joanna Flynn AO
Chair
Medical Board Australia
By email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn

Re: Australasian Society of Aesthetic Plastic Surgery
Medical Board of Australia: Consultation on Cosmetic Surgical and Medical Procedures

The Australasian Society of Aesthetic Plastic Surgery (ASAPS) supports **Option 3** (three) outlined in the Medical Board's Consultation Paper and Regulation Impact Statement.

ASAPS is a professional organisation with approximately 250 members practicing predominantly in Australia and New Zealand. Its members consist of qualified Plastic Surgeons who hold a Fellowship of the Royal Australasian College of Surgeons (FRACS) or an equivalent qualification.

ASAPS members practice according to professional standards articulated by the Medical Board of Australia (the Board)[1], the Medical Council of New Zealand[2] and the Royal Australasian College of Surgeons (RACS)[3]. Many ASAPS members are also members of the Australian Society of Plastic Surgeons (ASPS) [4] or the New Zealand Association of Plastic Surgeons (NZAPS). ASAPS members must comply with ASPS Code of Practice.

The mission, values and objectives of ASAPS are to pursue a social agenda directed to providing patients with the best quality care carried out in a safe and nurturing environment. ASAPS realizes these aims through a process of world-class education for both its members and their patients. To facilitate this process, ASAPS has formed strategic partnerships with both the International Society of Aesthetic Plastic Surgery and the American Society for Aesthetic Plastic Surgery. Both of these organisations have similar membership criteria to that of ASAPS. These alliances provide ASAPS members with access extensive educational resources.

The result of these educational activities is to ensure that ASAPS members continually strive for excellence in skill, ethics and knowledge and innovation.

ASAPS regards technical competence to be of primary importance to the provider of aesthetic services. It is critical that aesthetic procedures are performed by adequately trained practitioners working to the highest standards.

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[1] Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia, March 2014
[2] Medical Council of New Zealand, Good Medical Practice, April 2013
[3] Royal Australasian College of Surgeons, Code of Conduct
[4] Australian Society of Plastic Surgeons, Code of Practice

ASAPS considers comprehensive training to be the backbone of a safe and effective aesthetic plastic surgical practice. However, ASAPS is also of the view that although world-class training is necessary, it is not sufficient in itself. Through the relationship that ASAPS members have with the RACS, they are also required to undergo continuous lifelong learning, audit, peer review and undertake to comply with the College's Code of Conduct.

ASAPS members are encouraged to embrace the highest ethical standards. They believe in empowering their patients by offering sound, well informed advice. They are committed to provide high levels of support during the preoperative, perioperative and postoperative phases of their patients' care.

ASAPS and its members are positioned at the cutting edge of the latest developments in aesthetic plastic surgery. They are the thought leaders in their field. ASAPS is responsible for setting the highest benchmark to ensure aesthetic surgery patients receive the best advice with which to inform their decisions.

Participation in the Consultation Process

ASAPS welcomes the opportunity to provide feedback to the Board in its Public Consultation Paper and Regulation Impact Statement (the Statement) on issues relating to:

- Medical practitioners who provide cosmetic medical and surgical procedures,
- The effectiveness of current regulation of medical practitioners providing these procedures,
- Whether additional safeguards are needed, and
- Feasible options in relation to medical practitioners who provide cosmetic medical and surgical procedures.

The remainder of this submission will focus on the specific questions raised in the Statement.

Consultation Questions

1 **Do you agree with the nature and extent of the problem identified in this consultation paper, for consumers who seek cosmetic medical and surgical procedures provided by registered medical practitioners?**

ASAPS is in broad agreement with the general principles outlined in the first section of the Statement.

In particular, the concerns raised by the major reviews into cosmetic surgery in Australia and internationally have considerable validity. The Statement correctly lists some of the characteristics of cosmetic medicine and surgery. Whilst acknowledging these attributes as being substantially accurate, ASAPS is concerned that there may be an overemphasis on many of the differences between aesthetic and therapeutic interventions. Any treatment that purports to effect an aesthetic outcome carries both risks and benefits in line with many other forms of medical and surgical therapy. It is in this regard that ASAPS in complete agreement

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with the position of the Medical Council of New Zealand (MCNZ) that "a medical practitioner's usual professional obligations apply regardless of the setting of the practice".[5] It is ASAPS view that providers of these services need to be adequately trained and have the requisite knowledge to ensure that patients are well educated and informed, that their expectations are comprehensively managed and that they have had the opportunity to make well-informed considered decisions.

It is widely accepted that aesthetic medical and surgical procedures are currently being performed by a range of practitioners who have a varied level of training and expertise and whose commitment to ongoing education and peer review can be difficult to determine. It is ASAPS view that a lack of transparency in this regard can generate confusion and potential misrepresentation in the minds of patients who seek cosmetic medical and surgical procedures. ASAPS believes that practitioners who perform cosmetic procedures need to be adequately trained and are subsequently subject to a rigorous governance process to ensure they comply with acceptable standards of continuing education, peer review and adherence to the highest ethical principles.

ASAPS agrees that a potential patient must be fully informed of the implications of the procedure and has had adequate time to consider these implications before they commit to treatment.

It is acknowledged that a patient under the age of 18 requires an even more considered approach to assist them to make a decision that, on balance, will be in their long-term interests. In the case of minors, the consent process will usually require the active participation of a parent or guardian. The RACS guidelines are very explicit about this.

The infrastructure and processes in private or stand-alone facilities vary considerably. ASAPS takes the view that properly equipped and managed facilities should provide no greater risk of poor patient outcomes when compared with public or collocated centres. This needs to be couples with robust policies regarding postoperative care, contactability and responsibility.

The data regarding a higher proportion of complaints directed at practitioners who perform cosmetic procedures is credible. However, ASAPS believes that this data needs to be stratified to determine which particular classes of practitioners attract disproportionate number of complaints.

Similarly, the data suggesting that some consumers are making rushed decisions is credible but this again requires stratification. ASPAS is committed to its members practicing surgery according to the highest ethical standards which precludes encouraging or allowing patients to make precipitative decisions.

ASAPS agrees with the Statement that the number of cosmetic procedures is likely to increase. This is being driven by a number of factors. On the demand side, the Statement

[5] Adams J and Thorn M, 'Doctors and interventions with well people', Chapter 25 in St George IM (ed), Cole's medical practice in New Zealand, 12th edn, Medical Council of New Zealand, Wellington, 2013.

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correctly identifies the process of 'normalisation' of cosmetic procedures. This process is determined predominantly by cultural and societal factors, many of which are socioeconomic. On the supply side we are seeing an increasing number of practitioners offering and increasing number of services. ASAPS is concerned that the number of new entrants into the aesthetic surgery space many result in many commonly performed treatments becoming commoditised. Should this be the case, many patients will choose their provider on price alone. Whilst keeping prices low is good for patients, ASAPS believes this should not be pursued at the expense of poorer outcomes in efficacy and safety. In ASAPS view, the public interest is best served by patients engaging reputable practitioners who have the requisite training and who make the necessary commitments to maintain their skills through ongoing education, audit and peer review. It is incumbent upon these practitioners to practice according to the highest ethical standards.

ASAPS does not make the claim that these attributes are limited to its members alone. However, it does consider that the attainment of standards comparable to those of which ASAPS expects of its members aspire is essential for the safe and effective provision of aesthetic medical and surgical services.

2 Is there other evidence to suggest that there is a problem with consumers making rushed decisions to have cosmetic medical and surgical procedures provided by registered medical practitioners without adequate information?

Patients would be unlikely to admit to this fact even when they felt there had been excessive pressure to make a decision. This information would only come from medical defence organisations.

3 Is there other evidence that consumers cannot access reliable information or are relying on inaccurate information when making decisions about these procedures?

There is a lot of information on the internet, about any procedure available both from here and overseas. It can be argued that in some cases there is too much. The problem for patients is determining its relevance, validity and bias.

4 Is there evidence that inappropriate use of qualifications and titles by medical practitioners may be misleading for consumers?

Anecdotally, patients are often surprised to hear their previous cosmetic surgeon had no formal surgical training.

5 Is there evidence that offers of finance for these procedures may act as an inducement for consumers to commit to a procedure before they have had adequate time to consider the risks?

Finance usually takes some time to arrange. Patients need to find their own finance as it is outside the proscribed codes of conduct for practitioners to offer it.

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6 Is there other evidence of disproportionate numbers of complaints or adverse events for consumers who have had these procedures?

ASAPS is of the view that the genesis of many complaints stem from mismanaged patient expectations. Managing expectation is an important part of the consultation process. This is why it is important for the surgeon to conduct the consult, not some patient advisor. It is noted the guidelines proposed by the Board do not stipulate that the surgeon should consult directly with the patient. Only the surgeon can adequately assess the patient, advise and then, if appropriate, plan an operation. Expectation can then be managed prospectively. ASAPS believes that any "guidelines" need to ensure that the surgeon consults directly with the patient and not delegate this important duty to a non-medical advisor.

7 Is there other evidence to identify the magnitude and significance of the problem associated with cosmetic medical and surgical procedures provided by registered medical practitioners?

The Medical Defence organisations and APHRA would have this information when complaints spill over from the practice.

8 Is there other evidence that the current regulation of medical practitioners who provide cosmetic medical and surgical procedures is not adequately protecting the public and not providing clear guidance on the Board's expectations of practitioners?

ASAPS understands that no data has been collected this issue.

9 Does the Board's current code of conduct and the existing codes and guidelines of the professional bodies provide adequate guidance to medical practitioners providing cosmetic medical and surgical procedures?

The codes and guidelines articulated by the Board and the RACS provide adequate guidance. ASAPS views many of the problems articulated in the Statement arising from poor compliance with these guidelines.

10 How effective are existing professional codes and guidelines in addressing the problem identified by the Board?

The RACS codes and guidelines explicitly address the problem identified by the Board. The problem is that not all providers adhere to these guidelines as they are not members of the RACS**.**

11 Do you agree with the costs and benefits associated with retaining the status quo as identified by the Board?

Not entirely. The cost-benefit analysis correctly identifies a range of practitioners with a range of qualifications. The analysis holds only if a range of competencies is tolerated.

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12 Are there other costs and benefits associated with retaining the status quo that the Board has not identified?

The major cost is to patients who will have difficulty determining which class of practitioners have the necessary qualifications to meet their needs.

13 Would consumer education material be effective in addressing the problem? If so, how could it be designed to ensure it is effective and kept up to date and relevant?

Consumer education material can be very effective. The material needs to address three specific issues:

i. Education about the procedures, although by necessity general, needs to be factual and unbiased. It needs to be complementary, not a substitute, to the doctor-patient consultation.
ii. Patients need to be informed about their specific health-care provider. In particular, they need to be aware of the practitioner's training and compliance with an ongoing, robust governance structure.
iii. Patients need to be aware of the Boards expectations of medical practitioners. This sets patients' expectations as to what constitutes acceptable conduct. It also protects scrupulous practitioners from succumbing to unreasonable patient requests.

14 Who do you think is best placed to design consumer education material about cosmetic medical and surgical procedures provided by medical practitioners?

i. Consumer education material relating to specific procedures and treatments are best designed by practitioners who are experts in their fields, perhaps with input from education professionals. The most effective way to do this is through professional bodies where expertise resources can be pooled.
ii. Information about the practitioners training and ongoing compliance with acceptable professional standards should be produced by the professional organisations or the relevant educational bodies such as the RACS. The same information would then be used by the Board to enable registration.
iii. The material outlining the Board's expectations is best designed by the Board in consultation with the RACS.

15 Who should pay for the development of consumer education material?

The practitioners, through their professional bodies should pay for the material outlined in i and ii. The Board should pay for material outlined in iii.

16 Are there any other costs and benefits associated with providing consumer education material that the Board has not identified?

ASAPS views aesthetic procedures as having an equivalent status to any other medical or surgical intervention. The provision of scientifically robust unbiased information takes precedence over any commercial concerns.

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The trend is for patients to seek information, often prior to an initial consultation. ASAPS considers the wide availability of patient education material to be desirable.

17 The Board seeks feedback on elements for potential inclusion in guidelines:

17.1 Should there be a mandatory cooling off period for adults considering a cosmetic medical or surgical procedure (other than for minor procedures)? If so, is seven days reasonable?

No. The process of obtaining informed consent requires the practitioner to ensure that patients have had an adequate opportunity to digest information and to ask questions. This often requires more than a single consultation. Best practice in the informed consent process will provide a better outcome for patient and practitioner compared to an imposed mandated time interval.

17.2 Should there be a mandatory cooling off period for patients under the age of 18 who are considering a cosmetic medical or surgical procedure? If so, is three months reasonable?

No. ASAPS recognises the special significance of performing procedures on minors. These are clearly articulated in the RACS Code of Practice. In addition to the issues outlined in question 17.1 it must be noted that the consent process will necessitate involvement of a parent or guardian.

17.3 Should medical practitioners be expected to assess patients for indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure?

Yes. This is an important component of aesthetic surgical practice.

17.4 Should medical practitioners be expected to refer these patients to an independent psychologist or psychiatrist for evaluation?

Referral will depend upon the clinical need following assessment by the aesthetic practitioner.

17.5 Is it reasonable to expect that registered medical practitioners refer all patients under the age of 18 to an independent psychologist or psychiatrist for evaluation before a cosmetic medical or surgical procedure is performed, regardless of whether legislation exists (as it does in Queensland via the Public Health Act 2005)?

No. It should depend upon the clinical need.

17.6 Should there be further restrictions for patients under the age of 18 who seek cosmetic medical and surgical procedures?

It should be up to the practitioner in conjunction with the patient and parent or guardian to determine that the patient fully understands to long-term implications of

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treatment. An ethically competent aesthetic plastic surgeon will understand this as a natural consequence of their professionalism.

17.7 Should a medical practitioner be expected to have a face-to-face consultation (in person, not by video conference or similar) with a patient before prescribing schedule 4 prescription only cosmetic injectables? If not, why?

This is a difficult situation. Electronic consultation is a legitimate and important component of good medical, particularly for patients who live in remote areas. This is encouraged in some jurisdictions.

The ASAPS position is that aesthetic medicine and surgery should not be treated as a category separate to mainstream medicine. However, ASAPS is also mindful of the fact that some treatments are performed by non-medical practitioners in facilities that are not hospitals or doctors rooms (e.g. beauty salons). Under these circumstances, a doctor may be available through electronic consultation with the sole purpose of formalising prescription of injectables. ASAPS views this situation as undesirable.

18 Are there other elements not included in the draft guidelines at Attachment B that could be included?

Yes. Training alone is a necessary but insufficient requirement of a competent aesthetic practitioner. The practitioner also needs to commit to ongoing education and peer oversight.

19 Do you agree with the costs and benefits associated with guidelines with explicit guidance (option 3) as identified by the Board?

In general. Explicit guidelines would essentially duplicate professional society guidelines.

20 Are there other costs and benefits associated with guidelines with explicit guidance (option 3) that the Board has not identified?

If the intention is to use the code of conduct of professional societies to regulate practitioners who are not members of any society it would be expedient to ensure all practitioners are members of professional societies and be comprehensively regulated by those bodies. Societies would, however, need the right to deal with their members in a robust fashion for reported transgression, or APHRA would need to work closely in disciplinary cases.

21 Would the benefits of guidelines with explicit guidance (option 3) outweigh the costs, or vice versa?

Probably. However, ASAPS does not hold the view that a mandated cooling off period will lead to better outcomes compared to comprehensive consultation with the surgeon combined with relevant printed information

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22 Do you agree with the costs and benefits associated with guidelines which are less explicit (option 4) as identified by the Board?
In general.

23 Are there other costs and benefits associated with guidelines which are less explicit (option 4) that the Board has not identified?
No.

24 Would the benefits of guidelines which are less explicit (option 4) outweigh the costs, or vice versa?
ASAPS considers the current guidelines (Medical Board and RACS) to adequately cover:

- Informed consent.
- Sensitive management of minors.

25 The Board seeks feedback on the cost estimates and assumptions underlying the consumer scenarios (Attachment C).
No surgery should be performed without consultation with the surgeon as the main source of assessment and information.

26 Are there other options that the Board has not identified?
Issues of scope of practice and enforcement of current guidelines.

27 Which option do you think best addresses the problem of consumers making rushed decisions to have cosmetic procedures without adequate information?
ASAPS is of the view that Option 3 best addresses the problems assumed in Question 27.

Yours sincerely

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President

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