From: Dilip Gahankari
Sent: Thursday, 28 May 2015 10:08 PM
To: medboardconsultation
Subject: Submission pertaining to Cosmetic Consultations

Dear Sir/ Madam

I wish to congratulate the Board for taking this step to seek consultations from the interested parties - in this largely unregulated zone of Cosmetic Surgery. As a Plastic Surgeon, based on Gold Coast, I am involved in such procedures for both local and remote (from Qld, other states and some over seas) patients. I believe, the proposed “cooling off”period is important but I do believe that it is not practical in the form, as Board has suggested. I am a member of Australian Society of Plastic Surgeons, but my opinion, does not necessarily represent the opinion of our society, and I request that this is considered as my independent opinion.

I hope the suggestions, that I have attempted to put forth in the attached document would be given due consideration.

With kind regards.

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From:

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[redacted]

Submission to Medical Board about reforms in guidelines and policies with regards to 'Cosmetic Surgery'.

The term cosmetic surgery is some what misinterpreted by consumers, clinicians and indeed by the health regulators.

A. Terminoplogy

Currently, it is my view, that there are two distinct types of "cosmetic procedures' –

The common stream between these two types is that these are performed with a understandable intent of improving the appearance or form and both the consumers and the clinicians are aware of this understanding.

Two types:

1. Procedures – which primarily are performed to enhance the appearance and there is no primary the physical disability, recognized developmental physical abnormality or there is intent of correction of disability occurred as a result of physical injury.
   Examples: Cosmetic breast augmentation, breast lift with or without implant augmentation, liposuction (or liposculpture) – including fat injections for cosmetic purposes, face lift or meloplasty, certain nose reshaping procedures, brow lift, certain upper eye lid and nearly all lower eye lid blepharoplasties, chin and cheek augmentations, other implant augmentations as for buttocks, calves and male chests etc.
   My suggestion is to categorise them as "C" procedures for 'cosmetic'.
2. Procedures which do have an intent of enhancing appearance and form, but also have medically (and Medicare) recognizable physical disability or symptoms and therefore, also have recognizable functional benefit.
   Examples are many: Breast reduction in females, male subcutaneous mastectomy and male breast reduction, Certain breast augmentations – such as for congenital abnormalities – like tuberous breasts, asymmetric breasts etc, mastopexy or lift in certain post-pregnancy severe breast ptosis, secondary recognizable physical issues related to previous implant surgery, abdominoplasty for recognizable physical symptoms (backache, rash, physical discomfort, ventral weakness etc), post-massive weight loss severe tissue laxity – correction procedures such as abdominoplasty,

body lift, brachiaplasty, thigh reduction etc, rhinoplasty for developmental or post-traumatic nose deformities and so on.
My suggestion is that these procedures may be terms as "CM" for 'Cosmetic Medical procedures'.

Submission about Cooling off period as in option 3:

I believe that it is an important issue to be discussed. I do support it in principles, however, I am opposed to the proposed commencement of the cooling off period "from the day of first face to face consultation".
I submit following reasons in support of my submission:

1. On global scale, electronic communication has been considered by our consumers, (including my cosmetic as well as my reconstructive and hand surgery patients) as a reliable source of communication, exchange of clinical data, pictures, consent forms etc. It must also be recognized, that many health practitioners including my self, use the electronic medium effectively within the ethical and clinical framework to exchange such clinical data for expedited opinions, clinical requests for investigations, second opinions, expert opinions and for post-operative follow ups etc. In my personal clinical practice as a Plastic Surgeon on the Gold Coast, the accident and Emergency physicians also find it easy to communicate to me even about relative emergency and trauma cases and the clinical outcome is much more efficient, reliable and is acceptable to referring health practitioners, consumers and my self. Many of my cosmetic patients, clients travel to Gold Coast from Brisbane, North Qld, and other states especially Northern Territory. I also treat over seas clients from New Caledonia quite frequently for 'CM' and 'C' type of procedures (as mentioned above). On Global scale, where travel medical procedures are routinely performed, it is practically impossible for clients or patients to travel more than a day earlier before the procedure. It must be realized that consumers these days, chose to travel not just for cosmetic procedures but for variety of other medical and surgical procedures. In fact, NHS in UK and some insurance companies globally, especially in US, 'out source' the clinical expertise for their clients over seas, for better service and of course for financial reasons.

Therefore, insisting on face to face consultation to start the 'cooling off' period seems like going back to traditional days, where the clients are expected or assumed to have their procedures done by the practitioner in the town at a drivable distance.

2. In same context as in no 1., the costs estimate provided in the AHPRA model is very fallacious in my opinion. Although, there is a mention as follows:

The Board acknowledges that there would be further impact and a cost (for travel and time) for consumers in rural and regional areas who may need to travel to metropolitan areas to access these types of procedures. It should be noted that any additional cost for consultations is low compared with the overall cost of cosmetic procedures. Prices vary, but many cosmetic

surgical procedures are more than $2,000 and several types of surgeries are over $10,000 for a single procedure. Based on the fees quoted, an initial consultation for a consumer having major cosmetic surgery is less than a three per cent (3%) increase in the total cost incurred. Whether a fee is charged or is absorbed into the total cost of the procedure is at the discretion of the practitioner.

3.

Clients or consumers of 'C' or 'CM' categories of procedures travel for various reasons such as

i. Cost of having these procedures may be less elsewhere
ii. Local expertise may be unavailable or unreliable or simply unaffordable
iii. Local expertise may be very limited and not accessible in the time frame that clients or consumers may desire.
iv. Post-procedure care giver (family, friend support) may be available elsewhere – where surgical expertise is also available and affordable. All anesthetic or medical patients Australia wide are recommended at least 24 hrs of attendance by an adult and this is not always possible for clients working away from family.
v. Word of mouth, published data, internet, ease of communication, better clinical opinion and dialogue than available locally.
vi. FIFO workers working in remote communities or mines have limited time frame for their procedures and find it difficult to come twice for consultations – even though they are otherwise happy.

Many of clients or consumers of C and CM procedures are of working age group and most are young and in relatively early phase of their work career. For these clients, even if they are keen and well researched, it is difficult to find time during day hours to attend the 'consultation" just to satisfy the criteria of "cooling off period" even though, they would have had their first consultation prior weeks or months earlier, however the surgery was not scheduled at the time.

As I mentioned, the cost estimates quoted in Board's recommended proposal do not seem to take into account the – loss of leave, work hours, travel time compensation, cost of staying in hotel for a night or more just for a Day's consult and other expenses associated with travel. These expenses for a North Qld patient coming to Gold Coast just for a day, for a consult just "to comply' with "cooling off period' would be approximately a thousand dollars or more, not including the additional cost of consultation, taxi or commute etc.

I therefore suggest that:

1. The 'cooling off ' period should be <u>'opt out'</u>. There needs to be a mechanism whereby the clients can chose to waive the cooling of period by signed or electronic implicit declaration, that they consciously waive this period

and specific reasons can be mentioned such as

suggested: examples – prohibitive cost, conscious decision of having surgery at a short notice for specific "reasons".

- The cooling off period alternatively could be accepted as a period from the first documented correspondence between the consumer and health provider and an email evidence must be reproducible by the health provider with implicit consent from the clients. Again the clients should have the 'opt-out' option. As it is well known that the documented date in email is not likely to be forged by the practitioner.
- I also suggest that the information sheet and blank consent forms for the procedure, that the clients are going to sign up after face to face consultation may be emailed to them at the first clinical decision making communication, so that the clients have a reasonable (there is of course still some chance that the face to face consult may necessitate change or modification of this consent, depending on assessment) knowledge of risks and complications that they would be signing off on when they see the practitioner in person.
- Another suggestion is that the "cooling off" period could be "waived" for patients travelling beyond a certain distance – say 50 or 100k – which is acceptable to Board as a safe travelling distance just for consultations. Any body else seeking procedure with a particular surgeon (for whatever reasons as mentioned in detail above) beyond this distance could be given an option of seeking a consult a day prior – so that this can be achieved within their limited hotel stay, that they could comfortably afford.

I hope these suggestions are found clinically relevant and practical in the current age and would still incorporate safe guards for patients seeking cosmetic surgery (for both "C" and "CM" types as above) .

I would be happy to provide more input if asked, with regards to these suggestions.