International Union of Phlebology (UIP)
Level 5, 7 Help St
Chatswood NSW 2067 Australia
www.uip-phlebology.org

6th January 2023

Dear Medical Board of Australia,

The submission attached below is made by Professor Kurosh Parsi on behalf of the signatory group. It thoroughly expresses our concerns in relation to your classification of Varicose Vein treatments as 'minor' procedures in your October 1, 2016, publication *'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures'*.

Please direct all questions and correspondences to Professor Kurosh Parsi, the nominated point of contact by the signatory group. Please find Professor Parsi's contact details below.

Prof. Kurosh Parsi
MBBS, MSc(Med), PhD, LLM
FACD, FACP, FACLM
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UNIVERSITY OF NEW SOUTH WALES (UNSW)
[redacted]

We thank you for taking the time to review our submission and we look forward to hearing back from you.

[redacted]

Sydney Skin and Vein Clinic | Sydney Specialist Day Hospital

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6th January 2023

Medical Board of Australia

GPO Box 9958

Sydney, NSW, 2001

Dear Medical Board of Australia,

RE: Classification of Varicose Vein Treatments as 'Minor' by the Medical Board of Australia

We are writing in reference to the classification of varicose vein treatments as 'minor' by the Medical Board of Australia ('MBA') in their publication *'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures'* ('the Document'- Annexure 1) and appearing on the MBA website under *Definitions*.

The Board classifies cosmetic procedures as "Major" and "Minor" as below:

> ***Major*** *cosmetic medical and surgical procedures ('cosmetic surgery') involve* ***cutting beneath the skin****. Examples include; breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.*
>
> ***Minor*** *(non-surgical) cosmetic medical procedures* ***do not involve cutting beneath the skin, but may involve piercing the skin.*** *Examples include:* ***non-surgical cosmetic varicose vein treatment****, laser skin treatments, use of CO2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.*

Considering the current cosmetic surgery sector reforms to improve the safety of cosmetic procedures, we believe that the MBA's classification of *non-surgical varicose vein treatment* as 'minor' is an inaccurate reflection of the nature and known risks of these procedures. One important implication of such classification is that medical practitioners will not be obliged to give patients a cool-off period required for 'major' surgical procedures.

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1. The Aim of this Submission

This submission urges the MBA:

1. To strongly consider reclassifying non-surgical varicose vein treatments as 'major', and
2. To re-evaluate the definition "cutting beneath the skin" in relation to interventional endovascular procedures that involve introduction of instruments into blood vessels. Such procedures cannot be described as "minor". We propose the additional descriptor of "insertion of instruments, probes and catheters" should be included in the definition of "major" procedures.

2. Scope of Application

It is important to note that patients with chronic venous disease are classified into six stages of severity (CEAP classification)[1] where stage C1 (spider and reticular veins) may be deemed cosmetic. Stage C2 (varicose veins) is almost always associated with an underlying venous incompetence of the major superficial venous trunks and in the long term can lead to more advanced stages of venous disease (C3, oedema, C4 skin damage, C5-C6 leg ulcers). Stages C3-C6 are certainly not cosmetic but C2 (varicose veins) when not symptomatic and minor may be deemed cosmetic.

Table 1- CEAP Classification of Chronic Venous Disease

C1	Spider veins and reticular veins
C2	Varicose veins
C3	Oedema
C4a	Semi-reversible Skin changes- venous eczema, pigmentation
C4b	Irreversible Skin changes- lipodermatosclerosis, atrophie blanche
C5	Healed ulcers
C6	Active ulcers

[1] Lurie F, Passman M, Meisner M, Dalsing M, Masuda E, Welch H, Bush RL, Blebea J, Carpentier PH, De Maeseneer M, Gasparis A, Labropoulos N, Marston WA, Rafetto J, Santiago F, Shortell C, Uhl JF, Urbanek T, van Rij A, Eklof B, Gloviczki P, Kistner R, Lawrence P, Moneta G, Padberg F, Perrin M, Wakefield T. The 2020 update of the CEAP classification system and reporting standards. J Vasc Surg Venous Lymphat Disord 2020;8(3):342-352.

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3. Overview of Common Techniques and Modalities used in Treatment of Varicose Veins

To provide a background, the most common procedures currently used to treat chronic venous disease, including varicose veins, are grouped into the following three categories (Table 2):

Table 2- Overview of Common Techniques and Modalities used in Treatment of Varicose Veins

A - Surgical 1. Ligation and stripping 2. Stab avulsions 3. Ambulatory phlebectomy	INVASIVE Ligation, stripping and stab avulsions are typically performed in operating theaters under general anaesthesia. MINIMALLY INVASIVE Ambulatory phlebectomy may be performed in a procedure room using small incisions under local anaesthesia and may be classified as minimally invasive.
B - Non-Surgical - interventional 1. Endovenous Laser Ablation (EVLA) 2. Radiofrequency Ablation (RFA) 3. Cyanoacrylate Adhesive Closure (CAC) 4. Mechano-chemical Ablation (MOCA) 5. Catheter-directed Sclerotherapy (CDS)	MINIMALLY INVASIVE All Category B procedures are commonly classified as minimally invasive.
C - Non-Surgical - sclerotherapy 1. Ultrasound-guided sclerotherapy (UGS) 2. Direct-vision Sclerotherapy (DVS)	NON-INVASIVE All Category C procedures are commonly classified as non-invasive.

Procedures in Category A, except for ambulatory phlebectomy, are surgical procedures. Ligation, stripping and stab avulsions are typically performed in operating theatres under general anaesthesia and considered 'invasive'. Ambulatory phlebectomy may be performed in a procedure room using small incisions under local anaesthesia and may be classified as minimally invasive.

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Procedures in Category B involve making small incisions to insert various instruments including guidewires, catheters, laser fibres or radiofrequency probes in target veins and follow standard techniques employed in interventional radiology. These procedures are typically performed sterile and under ultrasound guidance. The instruments such as guidewires, catheters, n-BCA glue delivery systems or laser fibres are typically inserted in the patient's target vein in the ankle region (or another selected entry point) and advanced in the target vein to the groin (or another selected endpoint). An anaesthetic fluid (tumescent anaesthesia) may also be injected around the target veins to help improve treatment efficacy and prevent complications.

Category C procedures do not involve cutting or making incisions in the skin, but sclerotherapy, and in particular UGS, is associated with significant complications including gas embolism, stroke, deep vein thrombosis, anaphylaxis and cutaneous necrosis.

The aim of this submission is to make MBA aware that Category B and C procedures may result in significant complications and that the criteria of "cutting beneath the skin" is not appropriate to classify interventional endovascular procedures.

4. Category B Procedures - Invasiveness and Potential Serious Complications

4.1 Complications of tumescent anesthesia

The substantial amount of tumescent anaesthesia used in conjunction with endovascular procedures carries possible risk of local anaesthetic toxicity which may result in seizures and cardio-respiratory arrest, if not recognised early.

4.2 Complications of inadvertent targeting of critical surrounding structures

Suboptimal preoperative ultrasound mapping, intraoperative image guidance or poor procedural technique can result in inadvertent targeting of critical surrounding structures such as arteries and nerves. In rare occasions, other significant complications such as the catheter becoming glued to the treated vein have also occurred when procedures have been performed without the use of proper ultrasound guidance.

Nerve injury may also result from direct inadvertent puncture or through transmitted thermal damage from thermal-ablative methods such as EVLA and RFA. Nerve injury may be permanent and result in

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motor or sensory deficits, such as a foot drop. In addition, the various devices used to access the lumen of the vein, if handled poorly, can perforate the vein wall resulting in haematoma formation.

4.3 Complications of n-BCA glue

n-BCA glue injected into the vein during CAC has been reported to form foreign body granulomas and the procedure can be complicated by glue extrusion and hypersensitivity reactions.[2,3] This is reported to cause chronic infections, cellulitis and significant and extensive skin necrosis.[4]

4.4 Other potential complications of Category B procedures

Other potential significant complications of Category B procedures, although uncommon, include deep vein thrombosis, pulmonary embolism and infection.[5,6] Please refer to these footnotes for in-depth medical studies on the invasive nature and possibility of complications of Category B procedures.[7,8]

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[2] Parsi K, Kang M, Yang A, Kossard S. Granuloma formation following cyanoacrylate glue injection in peripheral veins and arteriovenous malformation. Phlebology 2020;35(2):115-123.

[3] Parsi K, Roberts S, Kang M, Benson S, Baker L, Berman I, Bester LJ, Connor DE, Dinnen P, Grace J, Stirling A, Ibrahim N, Lekich C, Lim A, Matar L, Nadkarni S, Paraskevas P, Rogan C, Thibault PK, Thibault S, van Rij A, Yang A. Cyanoacrylate closure for peripheral veins: Consensus document of the Australasian College of Phlebology. Phlebology 2020;35(3):153-175.

[4] Sermsathanasawadi N, Hanaroonsomboon P, Pruekprasert K, Prapassaro T, Puangpunngam N, Hongku K, Hahtapornsawan S, Chinsakchai K, Wongwanit C, Ruangsetakit C. Hypersensitivity reaction after cyanoacrylate closure of incompetent saphenous veins in patients with chronic venous disease: A retrospective study. J Vasc Surg Venous Lymphat Disord 2021;9(4):910-915.

[5] O'Banion LAA, Siada S, Cutler B, Kochubey M, Collins T, Ali A, Tenet M, Dirks R, Kiguchi MM. Thrombotic complications after radiofrequency and cyanoacrylate endovenous ablation: Outcomes of a multicenter real-world experience. J Vasc Surg Venous Lymphat Disord 2022;10(6):1221-1228.

[6] Spreafico G, Kabnick L, Berland TL, Cayne NS, Maldonado TS, Jacobowitz GS, Rockman CR, Lamparello PJ, Baccaglini U, Rudarakanchana N, Adelman MA. Laser saphenous ablations in more than 1,000 limbs with long-term duplex examination follow-up. Ann Vasc Surg 2011;25(1):71-8.

[7] Teter KA, Kabnick LS, Sadek M. Endovenous laser ablation: A comprehensive review. Phlebology 2020;35(9):656-662.

[8] Australasian College of Phlebology. Endovenous Laser Ablation. Diagnose and treat superficial venous incompetence with Endovenous Laser Ablation under Ultrasound Guidance. 2010. https://www.phlebology.com.au/standards accessed 28/11/2022.

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5. Category C Procedures - Potential Serious Complications

Category C procedures, namely sclerotherapy, are minimally invasive as they require injections of sclerosing agents into the target veins. The sclerosing agent used is most commonly a detergent but may also be a chemical irritant or osmotic agent. The administration can be performed under ultrasound guidance (UGS) or without ultrasound guidance (DVS). The sclerosant can be administered as a liquid or as a foam that is created upon mixing the liquid agent with gas. Known complications include tissue necrosis, intra-arterial injection, nerve damage, anaphylaxis, deep vein thrombosis and pulmonary embolism.[9] However, more severe complications of stroke either due to paradoxical clot embolisation or venous gas embolism have also been reported.[10]

6. Inadequacy of the Current Definition

With consideration to the nature of the three categories of varicose vein treatments, the MBA's generalised categorisation of all varicose vein treatments as 'minor' cosmetic procedures is contradictory to the MBA's definition of 'minor' procedures in the *Document* and is an inaccurate reflection of the practical nature and risks of these procedures.

In Category B procedures classified as "minor", wires, catheters, laser fibres or other instruments are inserted and advanced "*beneath the skin*". Similarly, liposuction is classified as "major" but also involves insertion of instruments "beneath the skin" via small incisions.

The risks and complications that may occur with Category B and C procedures, including stroke, deep vein thrombosis and anaesthetic toxicity, are severe risks comparable to those anticipated in major procedures. As such, we strongly urge the MBA to review the current classification to categorise Category B procedures as "major" and include the additional descriptor of "insertion of instruments, probes and catheters" in the definition of "major" procedures.

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[9] Cavezzi A, Parsi K. Complications of foam sclerotherapy. Phlebology 2012;27 Suppl 1:46-51.

[10] Parsi K. Paradoxical embolism, stroke and sclerotherapy. Phlebology 2012;27(4):147-67.

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Thank you for taking the time to review our submission. Should you require further clarification, please do not hesitate to contact us at our nominated point of contact, Professor Kurosh Parsi.

On behalf of signatory professional societies and craft groups,

Prof. Kurosh Parsi	**Mr Thodur Vasudevan**	**Dr Lisa Marks**	**Dr Mark Malouf**	**Dr Chris Rogan**
President	President	President	President	President
International Union of Phlebology (UIP)	Australia and New Zealand Society for Vascular Surgery (ANZSVS)	Australasian College of Phlebology (ACP)	Australia and New Zealand Society of Phlebology (ANZSP)	Interventional Radiology Society of Australasia (IRSA)

Annexure 1- *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures.*

Medical Board of Australia

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

1 October 2016

MBA1608 03

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

Introduction

These guidelines have been developed by the Medical Board of Australia (the Board) under section 39 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law).

The guidelines aim to inform registered medical practitioners and the community about the Board's expectations of medical practitioners who perform cosmetic medical and surgical procedures in Australia. These guidelines complement *Good medical practice: A code of conduct for doctors in Australia (Good medical practice)* and provide specific guidance for medical practitioners who perform cosmetic medical and surgical procedures. They should be read in conjunction with *Good medical practice*.

Who do these guidelines apply to?

These guidelines apply to medical practitioners registered under the National Law who provide cosmetic medical and surgical procedures.

Definitions

Cosmetic medical and surgical procedures are operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.[1]

Major cosmetic medical and surgical procedures ('cosmetic surgery') involve cutting beneath the skin. Examples include: breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.

Minor (non-surgical) cosmetic medical procedures do not involve cutting beneath the skin, but may involve piercing the skin. Examples include: non-surgical cosmetic varicose vein treatment, laser skin treatments, use of CO_2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.[2]

Surgery or a procedure may be medically justified if it involves the restoration, correction or improvement in the shape and appearance of body structures that are defective or damaged at birth or by injury, disease, growth or development for either functional or psychological reasons.[3] Surgery and procedures that have a medical justification and which may also lead to improvement in appearance are excluded from the definition.

The medical specialty of **plastic surgery** includes both **cosmetic surgery** and **reconstructive surgery**. **Reconstructive surgery** differs from **cosmetic surgery** as, while it incorporates aesthetic techniques, it restores form and function as well as normality of appearance. These guidelines apply to plastic surgery when it is performed only for cosmetic reasons. They do not apply to reconstructive surgery.

How will the Board use these guidelines?

Section 41 of the National Law states that an approved registration standard or a code or guideline approved by the Board is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the profession.

These guidelines can be used to assist the Board in its role of protecting the public, by setting and maintaining standards of medical practice. If a medical practitioner's professional conduct varies significantly from these guidelines, the practitioner should be prepared to explain and justify their decisions and actions.

Serious or repeated failure to meet these guidelines may have consequences for a medical practitioner's registration.

1 Definition adapted from the Medical Council of New Zealand's *Statement on cosmetic procedures* (2011) and the Australian Health Ministers' Conference *Cosmetic Medical and Surgical Procedures – A National Framework* (2011).

2 Definitions adapted from the Medical Council of New Zealand's *Statement on cosmetic procedures* (2011).

3 Definition from *Cosmetic surgery guidelines* (Medical Council of New South Wales, 2008).

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

Providing cosmetic medical or surgical procedures

1. Recognising potential conflicts of interest

1.1 Medical practitioners must recognise that conflicts of interest can arise when providing cosmetic medical and surgical procedures and must ensure that the care and wellbeing of their patient is their primary consideration.

2. Patient assessment

2.1 The patient's first consultation should be with the medical practitioner who will perform the procedure or another registered health practitioner who works with the medical practitioner who will perform the procedure. It is not appropriate for the first consultation to be with someone who is not a registered health practitioner – for example, a patient advisor or an agent.

2.2 If the first consultation is with another registered health practitioner, the patient should have a consultation with the medical practitioner who will perform the procedure, before scheduling the procedure.

2.3 The medical practitioner who will perform the procedure should discuss and assess the patient's reasons and motivation for requesting the procedure including external reasons (e.g. a perceived need to please others) and internal reasons (e.g. strong feelings about appearance). The patient's expectations of the procedure should be discussed to ensure they are realistic.

2.4 The patient should be referred for evaluation to a psychologist, psychiatrist or general practitioner[4], who works independently of the medical practitioner who will perform the procedure, if there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

2.5 Other than for minor procedures that do not involve cutting beneath the skin, there should be a cooling off period of at least seven days between the patient giving informed consent and the procedure. The duration of the cooling off period should take into consideration the nature of the procedure and the associated risks.

2.6 The medical practitioner who will perform the procedure should discuss other options with the patient, including medical procedures or treatment offered by other health practitioners and the option of not having the procedure.

2.7 A medical practitioner should decline to perform a cosmetic procedure if they believe that it is not in the best interests of the patient.

3. Additional responsibilities when providing cosmetic medical and surgical procedures for patients under the age of 18

3.1 The Board expects that medical practitioners are familiar with relevant legislation of the jurisdiction in relation to restrictions on cosmetic surgery for patients under the age of 18.

3.2 The medical practitioner must assess and be satisfied by the patient's capacity to consent to the procedure.

3.3 The medical practitioner should, to the extent that it is practicable, have regard for the views of a parent of the patient under 18, including whether the parent supports the procedure being performed.

3.4 Before any major procedure, all patients under the age of 18 must be referred for evaluation to a psychologist, psychiatrist or general practitioner[5], who works independently of the medical practitioner who will perform the

4 Referral to a general practitioner excludes referral to general practitioners who provide cosmetic procedures.

5 Referral to a general practitioner excludes referral to general practitioners who provide cosmetic procedures.

procedure, to identify any significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

3.5 For minor procedures, referral for evaluation by a psychologist, psychiatrist or general practitioner[6], who works independently of the medical practitioner providing the procedure, is not required for patients under the age of 18, unless there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

3.6 For the patient under the age of 18, there must be a cooling off period between the informed consent and the procedure being performed:

- for minor procedures, the cooling off period must be a minimum of seven days
- for major procedures, the cooling off period must be a minimum of three months.

3.7 The patient should be encouraged to discuss why they want to have the procedure with their general practitioner during the cooling off period.

4. Consent

4.1 The medical practitioner who will perform the procedure must provide the patient with enough information for them to make an informed decision about whether to have the procedure. The practitioner should also provide written information in plain language. The information must include:

- what the procedure involves
- whether the procedure is new or experimental
- the range of possible outcomes of the procedure
- the risks and possible complications associated with the procedure
- the possibility of the need for revision surgery or further treatment in the short term (e.g. rejection of implants) or the long term (e.g. replacement of implants after expiry date)
- recovery times and specific requirements during the recovery period
- the medical practitioner's qualifications and experience
- total cost including details of deposits required and payment dates, refund of deposits, payments for follow-up care and possible further costs for revision surgery or additional treatment, and
- the complaints process and how to access it.

4.2 Informed consent must be obtained by the medical practitioner who will perform the procedure.

4.3 Other than for minor procedures, informed consent should be obtained in a pre-procedure consultation at least seven days before the day of the procedure and reconfirmed on the day of the procedure and documented appropriately.

5. Patient management

5.1 The medical practitioner who will perform the procedure is responsible for the management of the patient, including ensuring the patient receives appropriate post-procedure care.

5.2 If the medical practitioner who performed the procedure is not personally available to provide post-procedure care, they must have formal alternative arrangements in place. These arrangements should be made in advance where possible, and made known to the patient, other treating practitioners and the relevant facility or hospital.

5.3 When a patient may need sedation, anaesthesia and/or analgesia for a procedure, the medical practitioner who is performing the procedure must ensure that there are trained staff, facilities and equipment to deal with any

6 Referral to a general practitioner excludes referral to general practitioners who provide cosmetic procedures.

emergencies, including resuscitation of the patient.

5.4 There should be protocols in place for managing complications and emergencies that may arise during the procedure or in the immediate post-procedure phase.

5.5 Written instructions must be given to the patient on discharge including:

- the contact details for the medical practitioner who performed the procedure
- alternative contact details in case the medical practitioner is not available
- the usual range of post-procedure symptoms
- instructions for the patient if they experience unusual pain or symptoms
- instructions for medication and self-care, and
- dates and details of follow-up visits.

6. Provision of patient care by other health practitioners

6.1 The medical practitioner is responsible for ensuring that any other person participating in the patient's care has appropriate qualifications, training and experience, and is adequately supervised as required.

6.2 When a medical practitioner is assisted by another registered health practitioner or assigns an aspect of a procedure or patient care to another registered health practitioner, the medical practitioner retains overall responsibility for the patient. This does not apply when the medical practitioner has formally referred the patient to another registered health practitioner.

7. Prescribing and administering schedule 4 (prescription only) cosmetic injectables

7.1 Medical practitioners must know and comply with the requirements of their state or territory drugs and poisons (or equivalent) legislation for schedule 4 (prescription only) cosmetic injectables. For example, requirements relating to permits, supply, storage and transport.

7.2 Medical practitioners must not prescribe schedule 4 (prescription only) cosmetic injectables unless they have had a consultation with the patient, either in person or by video. Remote prescribing of cosmetic injectables by phone or email (or equivalent) is not appropriate.

7.3 If the 'prescription only' cosmetic injectable is administered by another registered health practitioner who is not an authorised prescriber, the prescribing medical practitioner must be contactable and able to respond if required.

8. Training and experience

8.1 Procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure and deal with all routine aspects of care and any likely complications.

8.2 A medical practitioner who is changing their scope of practice to include cosmetic medical and surgical procedures is expected to undertake the necessary training before providing cosmetic medical and surgical procedures.

9. Qualifications and titles

9.1 A medical practitioner must not make claims about their qualifications, experience or expertise that could mislead patients by implying the practitioner is more skilled or more experienced than is the case. To do so is a breach of the National Law (sections 117 – 119).

10. Advertising and marketing

10.1 Advertising material, including practice and practitioner websites, must comply with the Board's *Guidelines for advertising of regulated health services*, the current *Therapeutic Goods Advertising (TGA) Code*, any TGA guidance

on advertising cosmetic injections and the advertising requirements of section 133 of the National Law.

10.2 Advertising content and patient information material should not glamorise procedures, minimise the complexity of a procedure, overstate results or imply patients can achieve outcomes that are not realistic.

11. Facilities

11.1 The Board expects that medical practitioners are familiar with relevant legislation, regulations and standards of the jurisdiction in relation to facilities where the procedure will be performed.

11.2 Procedures should be performed in a facility that is appropriate for the level of risk involved in the procedure. Facilities should be appropriately staffed and equipped to manage possible complications and emergencies.

12. Financial arrangements

12.1 The patient must be provided with information in writing about the cost of the procedure, which should include:

- total cost
- details of deposits required and payment dates
- refund of deposits
- payments for follow-up care
- possible further costs for revision surgery or additional treatment, and
- advising the patient that most cosmetic procedures are not covered by Medicare.

12.2 No deposit should be payable until after the cooling off period.

12.3 The medical practitioner should not provide or offer to provide financial inducements (e.g. a commission) to agents for recruitment of patients.

12.4 The medical practitioner should not offer financing schemes to patients (other than credit card facilities), either directly or through a third party, such as loans or commercial payment plans, as part of the cosmetic medical or surgical services.

12.5 Medical practitioners should not offer patients additional products or services that could act as an incentive to treatment (e.g. free or discounted flights or accommodation).

12.6 Medical practitioners should ensure that they do not have a financial conflict of interest that may influence the advice that they provide to their patients.

Acknowledgements

The Board acknowledges the following organisations' codes and guidelines, which informed the development of the Board's guidelines:

- Australian Health Ministers' Advisory Council's Clinical, Technical and Ethical Principal Committee Inter-jurisdictional Cosmetic Surgery Working Group (2011) *Supplementary guidelines for cosmetic medical and surgical procedures*
- Australian Society of Plastic Surgeons (2015) *Code of practice*
- Medical Council of New South Wales (2008) *Cosmetic surgery guidelines*
- Medical Council of New Zealand (2011) *Statement on cosmetic procedures*.

Review

Date of issue: 1 October 2016

The Board will review these guidelines at least every three years.