Public consultation - Submission

Regulation of medical practitioners who provide cosmetic medical and surgical procedures

9 December 2022

Your details
Name: [redacted]
Organisation (if applicable): Avant Mutual
Are you making a submission as? • An organisation • An individual medical practitioner • An individual nurse • Other registered health practitioner, please specify: • Consumer/patient • Other, please specify: • Prefer not to say
Do you work in the cosmetic surgery/procedures sector? • Yes – I perform cosmetic surgery • Yes – I provide minor cosmetic procedures (e.g. Botox, fillers, etc.) • Yes – I work in the area but do not provide surgery or procedures (e.g. practice manager, non-clinical employee) • No • Prefer not to say
For medical practitioners, what type of medical registration do you have? • General and specialist registration – Specialty (optional): • General registration only • Specialist registration only – Specialty (optional): • Provisional registration • Limited registration • Non-practising registration • Prefer not to say
Do you give permission to publish your submission? • Yes, with my name • Yes, without my name • No, do not publish my submission

Avant Submission to the Medical Board of Australia's Public consultation on the Regulation of medical practitioners who provide cosmetic medical and surgical procedures

General comments

Avant is a member-owned doctors' organisation and Australia's largest medical indemnity insurer, committed to supporting a sustainable health system that provides quality care to the Australian community. Avant provides professional indemnity insurance and legal advice and assistance to more than 82,000 healthcare practitioners and students around Australia (more than half of Australia's doctors). Our members are from all medical specialties and career stages and from every state and territory in Australia.

We assist members in civil litigation, professional conduct matters, coronial matters and a range of other matters. We have a Medico-legal Advisory Service that provides support and advice to members and insured medical practices when they encounter medico-legal issues. We also provide medico-legal education to our members with a view to improving patient care and reducing medico-legal risk.

We agree that there needs to be better regulation in the area of cosmetic medical and surgical treatment. There are challenges across the cosmetic surgery industry that remain, despite reviews and regulatory and legislative changes that have taken place over the last two decades.

Not all practitioners in this industry are practising in a way that causes harm to patients. Many practitioners provide appropriate care to patients who are satisfied with the outcomes.

Solving the problems requires a system-wide approach and should be done on a national basis. It is broader than regulating the conduct of individual practitioners.

Whilst we understand that the short timeframe for the consultations is a requirement of Health Ministers, many of the issues raised in the three draft documents are complex. A detailed consideration is not possible within the time allowed. We are concerned changes will be made without proper debate and deliberation.

For example, there are a number of practical and medico-legal concerns raised by the proposal to make it mandatory for a patient to have a referral from a general practitioner for major cosmetic medical and surgical procedures (cosmetic surgery). These concerns need to be resolved before any change comes into effect.

Given the scale of the changes in all three draft documents, we encourage the Medical Board to engage in a thorough education campaign for practitioners and patients to ensure widespread awareness of the changes.

More broadly, Avant confirms its support for regulatory change in this area. We welcome further consultation on any of the issues raised in our submission.

Feedback on draft Registration standard

This section asks for feedback on the *Draft Registration standard: Endorsement of registration for cosmetic surgery for registered medical practitioners.*

The details of the requirements for endorsement are in the draft registration standard.

1. Are the requirements for endorsement appropriate?

Avant supports training accredited by the Australian Medical Council (AMC), education and professional development programs and minimum standards for practitioners involved in cosmetic surgery practice. The AMC and the Medical Board of Australia are best placed to determine these appropriate minimum standards.

2. Are the requirements for endorsement clear?

For the most part, yes. However, it is unclear what criteria the Board will use to determine whether a practitioner holds a qualification that is "substantially equivalent to, or based on similar competencies to, an approved qualification". The draft registration standard does make it clear that the practitioner bears the onus of establishing equivalency, but it is not clear what information will be required from the practitioner to do this and how it will be established to satisfy the Board. The absence of that guidance may lead to a greater administrative burden on the Board in assessing and determining applications, and managing appeals, and therefore we recommend some guidance be provided by the Board for practitioners in due course.

For clarity, we recommend that item 1 in the list on page 2 under the heading "What must I do?" could be amended to read "1. hold registration as a medical practitioner *in Australia*, and' [suggested additional words in italics]. We assume from the draft registration standard that this is the intention.

We support the position that there are no provisions for grandparenting of practitioners who have been performing cosmetic surgery but do not have the required qualification for endorsement.

The draft registration standard also refers to clinical registries, which will be compulsory and require practitioners to submit data about complications and adverse outcomes, as well as other details not listed. The draft registration standard does not explain the purpose of introducing these registries, or the basis upon which it would be compulsory for practitioners to contribute data to the registries. If clinical registries are to be introduced, there should be further detail provided about the information intended to be collected on these clinical registries. In the meantime, we suggest that the term "complication" should be defined or explained. For example, it should be made clear whether or not the clinical registry should capture the number of revision procedures a practitioner has performed, for their own patients and for patients referred to them for the revision procedure.

The proposed clinical registry/registries should be created in accordance with the Australian Commission on Safety and Quality in Health Care's (ACSQHC) Framework for Australian clinical quality registries. This should include reference to the "Legislation and regulation relating to clinical quality registries" final report. In particular, it would be important to ensure that all proposed clinical registries are declared quality assurance activities in accordance with Part VC of the *Health Insurance Act 1973* (Cth) (and/or the equivalent relevant state and territory legislation), and therefore subject to qualified privilege. A statement regarding this should be included in the endorsement registration standard. As a matter of principle, we would be concerned if the data contributed to the registry could be used as the basis of disciplinary action against individual practitioners rather than a mechanism for improving the quality of healthcare.

We support the recommendation that all major cosmetic procedures should be done in accredited facilities. In addition, Avant strongly supports national consistency in the regulatory framework, noting the work currently being undertaken by the ACSQHC. Avant agrees that cosmetic surgical procedures be performed in licensed facilities.

3. Is anything missing?

As outlined in our response to question 2, there is some additional information that could be included in the endorsement registration standard. These are:

- Further guidance from the Board regarding how it will assess whether a practitioner's qualification is substantially equivalent to an approved qualification;
- Detail regarding the information to be included in the proposed clinical registries, which should be created in accordance with the ACSQHC's 'Framework for Australian clinical quality registries'; and
- Confirmation that the registries will be quality assurance activities in accordance with Part VC of the *Health Insurance Act 1973* (Cth) or other relevant state or territory legislation.

We appreciate that it may be more appropriate to outline some of the information recommended in separate documents to the endorsement registration standard itself. If that is the case, we recommend that the registration standard should refer to those separate documents to ensure that all practitioners are aware of those documents and are able to readily access that information.

We also recommend that the endorsement registration standard confirms that medical practitioners must hold appropriate indemnity insurance for all procedures performed. This could be a brief reference to the "Registration Standard: Professional Indemnity Insurance Arrangements" and the need for practitioners to be "insured or indemnified for every context" in which they practise.

Feedback on draft revised Cosmetic Guidelines

This section asks for feedback on the Board's proposed changes to its 2016 *Guidelines for medical practitioners who perform cosmetic medical and surgical procedures.*

The details of the revised guidance are in the draft revised Cosmetic Guidelines.

4. Are the proposed changes to the Cosmetic Guidelines appropriate?

We agree that the Cosmetic Guidelines are due for review given they were issued in 2016. The proposed changes to the Cosmetic Guidelines address a number of areas that we agree should be strengthened and medical practitioners and their patients would benefit from the inclusion of more detail, as outlined in our submissions to the 'Independent review of the regulation of medical practitioners who perform cosmetic surgery' (Independent review).

The key to the successful implementation of the revised Cosmetic Guidelines will be in ensuring doctors are aware of and adhere to them. It is important that the Guidelines are disseminated and promoted continually or at regular intervals.

Avant is aware that some medical practitioners consider that "Guidelines" are not binding on practitioners. Especially in light of the change in wording from "should" to "must" throughout the draft Cosmetic Guidelines, the Board could consider renaming them as a "code" or similar, or making clear comments regarding the professional consequences if medical practitioners practise contrary to the Cosmetic Guidelines.

5. Does splitting the guidance into sections for major and for minor cosmetic procedures make the guidance clearer?

Yes, this makes the guidance clearer, in terms of practitioners knowing the different obligations that apply to the two different categories of procedures.

From a practical point of view, the duplicated numbering is confusing and we recommend the numbering continue throughout the document rather than restarting under the section for minor (non-surgical) cosmetic medical procedures. It will be useful for any education campaign associated with the roll-out of the revised Cosmetic Guidelines to have clear continuous numbered sections.

6. Are the draft Cosmetic Guidelines and the Board's expectations of medical practitioners clear?

We support the increased detail in the draft Cosmetic Guidelines which makes the Board's expectations of practitioners clearer. A number of the proposed changes are in accordance with recommendations made in Avant's submissions to the Independent review. We have set out further recommendation on the draft Cosmetic Guidelines below.

Definitions
We recommend that the definition for 'Major cosmetic medical and surgical procedures ('cosmetic surgery')' be amended to include additional wording to make it clear that cutting of the skin includes laser-cutting. We consider that all non-clinically indicated injections to genitalia should be included as major cosmetic medical and surgical procedures given the risk associated with those procedures is more aligned to major procedures. In referring to liposuction as one of the examples, the definition should also make it clear that this includes all volumes of liposuction regardless of the state or territory legislative requirements for facilities.

The terminology in the first paragraph of the definitions refers to “normal bodily features” which is subjective and potentially problematic language. We suggest a term such as “non-pathological” may be an appropriate alternative.

We support the inclusion of examples in the definitions; however, we recommend that both definitions be amended to include a sentence along the lines of “The list of examples is not exhaustive”. It would also be beneficial to have an associated document that lists the procedures under ‘major cosmetic medical and surgical procedures’ in one column, and ‘minor (non-surgical) cosmetic medical procedures’ under a separate column. There would need to be a process and adequate resourcing for keeping that document up to date.

Assessment of patient suitability
We understand the rationale of proposing that all patients must have a referral from a general practitioner when seeking cosmetic surgery (section 2.1). However, we consider that there should be further information regarding the purpose of the referral and clear guidance regarding the role of the general practitioner in providing that referral. We have commented further about this proposal in question 7 below.

We support the requirements that a medical practitioner performing both major and minor procedures consider the patient’s expectations of the procedure (sections 2.2 (major procedures), and 2.1 (minor procedures)) and their psychological suitability for the proposed procedure (sections 2.3 and 2.2 respectively), noting that this is the same for any medical or surgical procedure. We understand that using a validated psychological tool for screening for Body Dysmorphic Disorder (BDD) would likely be within the scope of skills of a medical practitioner performing cosmetic surgery, noting that the most likely tool would be the Body Dysmorphic Disorder Questionnaire. However, section 2.3 also refers to other underlying psychological conditions, with no other examples and therefore would benefit from further clarity and guidance for practitioners regarding this requirement.

Consent
We support the proposals regarding the content of the discussion with patients and the provisions of information to patients, and the level of detail provided in this section. Dissemination of and education about these requirements will be crucial to ensuring compliance with this section in particular.

We support the approach taken in section 5.3 of the proposed Cosmetic Guidelines regarding the process for obtaining consent for use of images or videos.

Patient management
We support the requirements set out in section 6 regarding patient management, in that the medical practitioner who performs the procedure is responsible for the patient’s care and that if not available post-procedure, they must nominate a suitably qualified delegate. We also support the proposal that the treating medical practitioner has admitting rights to an appropriate hospital in case post-operative admission is required. This proposal improves the quality, safety and professionalism of healthcare in this area.

In relation to proposed section 6.2 and the involvement of a nominated delegate, any formal arrangement with a nominated delegate should include an agreement about how complications or adverse outcomes are identified or entered into a clinical registry.

We support section 6.3 in addressing requirements for practitioners performing surgery in a location that is not their primary place of practice. We defer to clinical expertise regarding the appropriate length of time for the practitioner to be available after the procedure and consider that 24 hours after conclusion of the procedure should be the minimum requirement. We consider that the section could also provide guidance on how long the patient should be advised to remain in the area where the procedure was performed, to address the situation where the patient has travelled for the procedure not the practitioner.

7. Do you support the requirement for a GP referral for all patients seeking major cosmetic surgery?

We note that the Independent review reported that cosmetic surgery is an area where general practitioners are not involved in recommending treatment or directing patients to appropriately qualified medical practitioners.

The proposed change recognises that general practitioners have a crucial role in coordinating a patient's care. A patient's regular general practitioner is well-placed to include up to date and accurate information in the patient's referral, including relevant medical history, existing medical conditions and current medications. The medical practitioner performing the cosmetic surgery could then report back to the general practitioner regarding the procedure, enabling the general practitioner to have accurate information about the patient's medical history in return. The proposed change would also put general practitioners in a position to have a conversation with patients considering cosmetic surgery. This could be beneficial to the general practitioner, to the medical practitioner performing the surgery and to patients, as well as supporting the delivery of safe and quality healthcare.

However, we have some concerns about the practical implementation of the proposal and the implications for general practitioners. These include questions regarding how general practitioners can or should manage requests from patients. For example:

- If the patient nominates the name of the practitioner to whom they would like the referral, is the general practitioner expected to determine whether the practitioner requested by patient is general registrant, specialist registrant, and/or has the endorsement for cosmetic surgery?
- What is the role of the general practitioner in advising patients of the medical practitioner's qualifications, experience, and endorsement status?
- Will the referring general practitioner have to outline alternatives to each patient, including alternative medical practitioners, alternative treatments and the option of no procedure?
- Will the referring general practitioner be expected to discuss with the patient their views about whether or not the procedure requested by the patient is indicated?

The draft Cosmetic Guidelines state that the medical practitioner performing the surgery is responsible for assessing the patient for psychological conditions but we anticipate that the referral may cause the medical practitioner performing the surgery to assume or believe that such an assessment has been done by the general practitioner as part of the groundwork to providing the referral.

Based on our experience, we anticipate that some general practitioners will be reluctant or uncertain about their role in providing a referral for a patient considering cosmetic surgery. General practitioners may feel that they do not have the requisite level of knowledge to discuss the appropriateness of the procedure the patient is considering, even as an initial discussion. Equally, some general practitioners may feel obliged to provide a referral for a patient simply because they requested it.

There is potential for there to be complaints to Ahpra and healthcare complaints entities from patients who do not agree with a decision by their general practitioner to refuse to provide a referral. This may lead to an increase in 'low-level' complaints to Ahpra, the Health Care Complaints Commission (NSW) and the Office of the Health Ombudsman (Queensland) and therefore increase the demand on the resources of these bodies.

The provision of a referral may also lead patients to assume or expect that a Medicare rebate would be available for the consultation/treatment by the cosmetic practitioner. We note that the draft Cosmetic Guidelines include that the medical practitioner performing the cosmetic procedure must let the patient know that there is no Medicare rebate for their treatment, but does this extend to the general practitioner? If so, this would only practically occur after the patient had seen the general practitioner and this may result in increased patient dissatisfaction regarding costs.

If the patient proceeds with surgery and is dissatisfied or there was a complication, there is potential for the referring general practitioner to get drawn into any claim or complaint about that.

There would also need to be further clarity regarding the general practitioner's role in follow-up and ongoing management after surgery. The provision of a referral from a general practitioner may lead the medical practitioner who performed the surgery to consider it appropriate to refer the patient back to the general practitioner for follow up that should be done by them. This could lead to further complications, and patient dissatisfaction regarding outcomes.

It is also important to consider this proposed change in the context of the existing burden on general practice and whether this could lead to an exacerbation of the shortage of availability of general practice consultations.

We would need responses to these concerns before being able to consider this proposal in detail. These issues need to be resolved and should be done so after consideration of the medico-legal risks and the views of appropriate bodies.

8. Do you support the requirement for major cosmetic surgery to be undertaken in an accredited facility?

Yes. Avant strongly supports national consistency in the regulatory framework, and we support the performance of cosmetic surgical procedures in accredited facilities. National consistency of the requirements for accreditation and licensing would also lessen the opportunity for patients to choose the location for their procedure influenced by these requirements.

We acknowledge that the ACQSHC is currently working on review of the applicable legislation in this area. Changes to legislation are more difficult to achieve than changes to guidelines. In our submission to the Independent review into cosmetic surgery, we suggested that the Guidelines should be amended to include:

- Guidance on the types of facilities where procedures can be performed, including licensing and staffing requirements.
- A requirement that all anaesthesia, sedation and analgesia for cosmetic surgery should be provided in accordance with ANZCA guidelines and position statements, particularly PG09(G).

Regulating the conduct of cosmetic surgery in licensed facilities, including requirements for anaesthesia, is important to ensure quality of care and enhance patient safety. We note that the draft Cosmetic Guidelines address the need for practitioners to discuss the type of anaesthesia with their patients and ensure appropriate staff are available (see sections 6.4 and 6.8). However, this does not stipulate the types of facilities or type of anaesthesia and we consider this should be included in the Guidelines.

9. Is anything missing?

As outlined in our response to questions 5-8 inclusive above, there are a number of areas of the draft Cosmetic Guidelines that require further consideration or consultation.

Additional comments

This section asks for feedback on guidelines for advertising cosmetic surgery.

The Board's current *Guidelines for medical practitioners who perform cosmetic medical and surgical procedures* (2016) include a section on 'Advertising and marketing'.

The Board is proposing standalone *Guidelines for medical practitioners who advertise cosmetic surgery* because of the influential role of advertising in the cosmetic surgery sector.

The details of the advertising guidance are in the draft Advertising Guidelines.

10. Is the guidance in the draft Advertising Guidelines appropriate?

To some degree, yes. Advertising of cosmetic surgery is subject to the same regulation as all other areas of practice. In general, the broader advertising requirements for anyone advertising a regulated health service can be confusing for medical practitioners, and are of variable effectiveness in regulating practitioners' conduct. We support the Medical Board and Ahpra continuing to work together on enhancing the guidance and education for medical practitioners and others about their obligations when advertising a regulated health service.

We note the comments in the report from the Independent review regarding the particular practices associated with advertising for cosmetic procedures. Therefore, additional separate Guidelines for cosmetic surgery advertising are likely to benefit practitioners in understanding their professional obligations and application of the legal prohibitions regarding advertising. We therefore support there being additional guidance for advertising cosmetic surgery.

The Independent review report found that many health consumers were unaware of the Ahpra public register as a resource. The proposed requirement that practitioners must include their registration number and type of registration will not of itself increase public awareness of the register. Consumer testing could be undertaken to assess whether or not this change will address the knowledge gap. Also, we recommend that the proposed change should be accompanied by education about the public register.

We support the approach to use of images in section 4. We consider that the requirement in section 4.3 not to use sexualised images or gratuitous nudity images should apply to all images and not just before and after images.

11. Are the draft Advertising Guidelines and the Board's expectations of medical practitioners clear?

We support the use of examples, for example in section 2.3, and encourage further use of examples in the Guidelines and in the education and resources to support the Guidelines.

Avant supports Ahpra's current regulatory approach to advertising, particularly the 'check and correct' focus to encourage advertisers to be aware of their obligations and educate themselves and ensure compliance. However, monitoring and regulating advertising, in this industry where advertising has a significant influence on patients, requires substantial resources. We acknowledge that Ahpra has established a specific unit for cosmetics, and note there would be an ongoing need for this area to be adequately resourced to properly monitor and regulate advertising.

12. Is anything missing?

The Board's draft Advertising Guidelines state that they apply to "medical practitioners registered under the National Law who advertise cosmetic surgery. Medical practitioners are responsible for their advertising, so they need to check any content produced by others on their behalf and ensure it is compliant."

Despite the preamble on page 2 of the draft Advertising Guidelines, there is potential for confusion as to how these obligations relate to the legal prohibitions in section 133 of the National Law and Ahpra's 'Guidelines for advertising a regulated health service'. If the new draft Guidelines are introduced, there would need to be a widespread and thorough education campaign for practitioners and for consumers.

In addition to new Advertising Guidelines from the Board in this area, there are opportunities for greater cooperation between the ACCC, the Medical Board and Ahpra to raise awareness of the broader obligations on practitioners and practices under the *Competition and Consumer Act 2010* and Australian Consumer Law.

If the draft Advertising Guidelines are introduced, we recommend that there be a substantial education campaign for practitioners to inform them of the new requirements. There should also be a period of at least three months after the requirements are announced and before they come into effect, to enable practitioners to check and correct their advertising to ensure compliance.

13. Do you have any other comments about cosmetic surgery regulation?

For all three draft documents, we note that the proposed review period is every five years. Given the pace of relevant developments to date, we recommend that this review period be no longer than every three years.