Your details

Name: [redacted]

Organisation (if applicable): The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

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): Obstetrics & Gynaecology
- 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- No, do not publish my submission

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?

RANZCOG is of the view that the requirements for endorsement are appropriate. However, noting the paucity of any specific endorsement requirements, RANZCOG proposes mandating a baseline approved qualification, along with currency of practice and participation in continuing medical education.

Furthermore, it is suggested that three main qualification areas to be identified: surgical, substantial surgical and non-surgical training.

2. Are the requirements for endorsement clear?

Yes. RANZCOG confirms that the requirements for endorsement are clear.

3. Is anything missing?

It is noted that that endorsement is provisional upon confirmation of currency of professional indemnity insurance. In addition, this provisional endorsement is given subject to the Medical Defence Organisation approving insurance for the type of cosmetic surgery the candidate intends to perform (i.e., within the applicant's scope of practice).

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?

Yes. RANZCOG confirms that the proposed changes to the Cosmetic Guidelines are appropriate.

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

Yes, RANZCOG is of the view that splitting the guidance into sections for major and for minor cosmetic procedures makes the guidance clearer.

However, it is noted that there are some major procedures that may involve minimal cutting beneath the skin, but have a significant aesthetic or psychological consequences, particularly in the event of complications or poor aesthetic outcome. For example, many forms of facial surgery or genital surgery may not involve significant incisions but any complications leading to aesthetic deforming (either objective or subjective) can have extreme consequences for patients.

Another instance is where a minor degree of cutting to the nose that results in infection and damage to the covering skin which can lead to permanent deformity that will be almost impossible to rectify. Thus, RANZCOG proposes that the Guidelines clearly specify that some body areas (face, genitals) are particularly vulnerable to permanent deformity in the case of surgical complication or 'misadventure'. Moreover, it is flagged that these permanent deformities can lead to serious psychiatric injury. Therefore, in RANZCOG's view, the significance of the procedure should not be deemed 'minor' simply by virtue of the degree of incision involved. Whilst patient autonomy may allow for decisions to be made, patients may be completely ignorant as to the potential consequences.

To this end, RANZCOG proposes that some 'minor procedures' to be placed in a special category-to become either 'major surgery' or as a 'special kind of minor surgery'.

It is further recommended that these procedures to be clearly defined, assessed and completed by, appropriately qualified surgical specialists rather than non-surgically trained medical practitioners.

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

Yes, RANZCOG confirms that the draft Cosmetic Guidelines and the Board's expectations of medical practitioners are clear.

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

No, RANZCOG does not support the requirement for a GP referral for all patients seeking major cosmetic surgery.

RANZCOG feels that GP referral has a multitude of issues as explained below:

Firstly, many patients do not have a general practitioner as a 'regular doctor'. Many patients will attend a single clinic, seeing many different doctors, or attend many different clinics seeing 'bulk-billing' services. Therefore, RANZCOG is of the view that the patient-doctor relationships in such situations are insufficient to allow considered assessment, prior to referral. Furthermore, if a doctor elects not to provide a referral, a motivated patient may seek alternative health care provider who will be willing to provide the same.

Secondly, it creates a duty of care for a GP to refer a patient for a surgery that the patient is seeking, and whereby the surgery has not been recommended by the GP. In RANZCOG's view, it is not feasible for a GP to refer a patient appropriately for surgery when the patient themselves are not sure exactly what the surgery will be. For instance, the patient may be seeking a surgery such as 'rhinoplasty', however, upon attending the surgeon, the patient may be guided towards a major procedure such as a full facelift. This may be recommended as an appropriate option to maximize the effect of the rhinoplasty, nevertheless, will result in a degree of surgery that is not anticipated by the GP. As such, this will impose a duty of care upon the GP for a referral that results in surgery and complications not anticipated and not recommended by the GP. Moreover, the complications may not surface until after the completion of the surgery, whereby there is a possibility that the patient may never return to the GP.

Thirdly, RANZCOG is of the view that the proposed GP referral for cosmetic surgery places an unnecessary and undue burden upon an already stressed specialty – general practitioners. It is a common understanding that patient access to GP care is already challenging due to various systemic issues. For instance, patients may have longer waiting periods to obtain a GP appointment - the issue may be worse for rural and remote patients. Thus, filling up patient appointments with consultations for cosmetic reasons may be perceived as 'unfair' or 'unreasonable'.

It is further noted that cosmetic surgery is not a part of the medical care that the GPs are trained to provide. They will not be aware of the potential consequences for the patient, until the complexity and complications of surgery are clear. In addition, it is flagged that the consultation time to appropriately counsel patients will be much longer than a standard or a long consultation. Moreover, the timing will place an undue financial and professional onus on GPs, to simply have a cursory discussion and sign off the referral. Besides, a determined patient will not be deterred by a non-referral or a recommendation contrary to their wishes. Thus, RANZCOG is of the view that a screening test for Body Dysmorphic Disorder (BDD) is appropriate. It is further suggested that the BDD need not be included in a GP consultation, as it could be carried out by other health care providers.

Furthermore, a referral via a GP will involve unnecessary financial implications on the public health system. For instance, each pre-cosmetic surgery consultation will involve a cost to Medicare, which in RANZCOG's opinion is an inappropriate expense on the taxpayers.

Finally, RANZCOG flags that such referrals will blurr the line between GP referrals to surgeons for medical reasons – e.g. a suspicious skin lesion – and referral for cosmetic purposes. For instance, a necessary procedure to remove a lesion may involve a degree of reconstructive surgery. Thus, a patient seeking cosmetic surgery can manipulate this to allow a Medicare funded surgical consultation to remove any skin lesion, whereby the cosmetic surgery they seek can be covered by Medicare as a necessary reconstructive surgery. Therefore, in RANZCOG's view, the proposed GP referrals will have the potential to mix up legitimate medical referrals with pure aesthetic cosmetic surgery – possibly with a Medicare subsidy.

To this end, RANZCOG proposes that the better approach would be for the patients seeking aesthetic cosmetic surgery to directly approach their choice of service provider. Given that the situation could be manipulated and exploited both by patients as well as cosmetic surgery providers, RANZCOG is

of the view that the onus of responsibility should be upon cosmetic surgical providers, not general practitioners.

Thus, RANZCOG favours the approach where the cosmetic surgical provider has the onus of responsibility to ensure the patient receives the necessary assessment and consent, whereby an initial assessment and recommendation for surgery is made by the cosmetic surgery provider. Subsequently, prior to surgery, the patient could then attend a GP or Specialist of their choosing (not associated with the cosmetic surgery provider) to discuss the proposed surgery. As such, the patient could proceed with the proposed surgery, only after being consulted and counselled by an appropriate health care provider.

In summary, it is anticipated that this proposed approach will result in the following:

- Patients who are deterred by an initial consultation with the surgeon will rarely attend a GP regarding the matter (and hence not cost the community via a Medicare subsidy). It is anticipated that many patients attending for consideration of major cosmetic surgery will not proceed.
- Patients must hear an independent assessment prior to proceeding. If they do not get a favourable response from a GP and chooses to attend others, they will at least have reinforcement of the risks and dangers attendant with their proposed surgery. The standard of care for the GP is then simply to assess whether the proposed surgery is reasonable in all the circumstances, taking the patient's physical and psychological state into account.
- The details of assessment – such as BDD screening can/ should be performed before the GP sees the patient.
- The GP can better satisfy their duty of care, if the proposed surgery is already clear. For instance, the GP may suggest that some aspect of the surgery is reasonable but others are not.
- The onus is then placed upon the cosmetic surgery provider to recommend reasonable surgery and is more accountable by referring back to another practitioner.

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

Yes, RANZCOG supports the requirement for major cosmetic surgery to be undertaken in an accredited facility.

9. Is anything missing?

Please see the comments above.

Feedback on draft Advertising Guidelines

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?
Yes, RANZCOG confirms that the guidance in the draft Advertising Guidelines is appropriate.

11. Are the draft Advertising Guidelines and the Board's expectations of medical practitioners clear?
Yes, RANZCOG affirms that the draft Advertising Guidelines and the Board's expectations of medical practitioners are clear.

12. Is anything missing?
RANZCOG is in support of the Guidelines and confirm that they are appropriate. However, it is proposed that standards to be introduced for measuring the impact/ outcomes of the Guidelines. For instance, the language or images used in the advertising may be measured by the standard of the 'average, reasonable' person.

Additional comments

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

RANZCOG does not have further comments.