Submission template

Public consultation: Regulation of health practitioners who perform and who advertise non-surgical cosmetic procedures

The Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards are reforming the regulation of registered health practitioners who work in the non-surgical cosmetic procedures sector in Australia to improve practice and standards, public safety, and provide opportunities for more informed consumer choice. Ahpra and the National Boards are consulting on three documents related to the regulation of registered health practitioners who provide and who advertise non-surgical cosmetic procedures:

1. Guidelines for nurses who perform non-surgical cosmetic procedures (nurses practice guidelines– applies to nurses only)
2. Guidelines for registered health practitioners who perform non-surgical cosmetic procedures (shared practice guidelines – excluding medical practitioners and nurses), and
3. Guidelines for registered health practitioners who advertise non-surgical cosmetic procedures (advertising guidelines – applies to all registered health practitioners).

The three proposed draft guidelines are intended to set out what National Boards expect of registered health practitioners working and advertising in this sector and provide clarity for consumers considering non-surgical cosmetic procedures about the standards expected of practitioners.

As the three proposed draft guidelines are all related to non-surgical cosmetic procedures, Ahpra and the National Boards are consulting on all three guidelines together. Feedback is welcome on any or all of the three draft guidelines.

We welcome feedback from organisations, registered health practitioners and the public.

There are some initial demographic questions and then questions on each of the guidelines we are consulting on. All questions are optional, and you are welcome to respond to any you find relevant, or that you have a view on.

The consultation questions are different in some sections as National Boards are intentionally consulting on the questions most relevant to the professions they regulate.

Your feedback will help us to understand your views and help National Boards set clear standards for registered health practitioners in the non-surgical cosmetic procedures sector, for the protection of the public.

Please email your submission to AhpraConsultation@ahpra.gov.au

Consultation is open for 10 weeks. The submission deadline is close of business **2 February 2024.**

How do we use the information you provide?

The survey is voluntary. All survey information collected will be treated confidentially and anonymously. Data collected will only be used for the purposes described above.

We may publish data from this survey in all internal documents and any published reports. When we do this, we ensure that any personal or identifiable information is removed.

We do not share your personal information associated with our surveys with any party outside of Ahpra except as required by law.

The information you provide will be handled in accordance with Ahpra's privacy policy.

If you have any questions, you can contact AhpraConsultation@ahpra.gov.au or telephone us on **1300 419 495.**

Publication of submissions

We publish submissions at our discretion. We generally publish submissions on our website to encourage discussion and inform the community and stakeholders about consultation responses. Please let us know if you do not want your submission published.

We will not publish on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

We can accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. A request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or if you want us to treat all or part of it as confidential.

Published submissions will include the names of the individuals and/or the organisations that made the submission unless confidentiality is expressly requested.

Initial questions:

To help us better understand your situation and the context of your feedback, please provide us with some details about you.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

x☐ Organisation

Name of organisation: **Australasia College of Cosmetic Medicine (ACAM) Pty Ltd**

Contact email: [redacted]

☐ Individual

Name: Click or tap here to enter text.

Name of organisation: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ A consumer / patient?

☐ Other – please describe: Click or tap here to enter text.

☐ Prefer not to say

Question C

Do you work in the cosmetic surgery/procedures sector?

☐ No

☐ Yes – I perform cosmetic surgery

☐ Yes – I perform cosmetic procedures (e.g. cosmetic injectable such as botulinum toxin and dermal fillers)

x☐ Yes – I work in the area but do not perform surgery or procedures (e.g. practice manager, non-clinical employee **Members and Fellows of ACAM perform these procedures, ACAM is a representative body for aesthetic medicine practitioners**

☐ Prefer not to say

Question D

Do you give permission for your submission to be published?

x☐ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name

☐ Yes, publish my submission **without** organisation name

☐ Yes, publish my submission **without** both my name and organisation name

☐ No – **do not** publish my submission

Guidelines for nurses who perform non-surgical cosmetic procedures

Consultation questions:

The Nursing and Midwifery Board of Australia (the NMBA) is developing draft nurses practice guidelines at Attachment A of the consultation paper to enable the terminology in the guidelines to be nuanced for nurses, and to delineate the separate roles and scope of enrolled nurses, registered nurses and nurse practitioners in the non-surgical cosmetic procedures sector.

Question 1:

Is the guidance in the draft nurses practice guidelines appropriate? Why/Why not?

Your answer:

The draft nurses practice guidelines are not appropriate in their current form, but do form a platform to refine the guidelines.

ACAM has a range of concerns, including the need to ensure professionalisation of the cosmetic/aesthetic medicine profession, some suggestions outlined in this document.

Question 2:

Does the guidance in the draft nurses practice guidelines sufficiently inform **nurses** about the NMBA's expectations of nurses (including enrolled nurses (EN), registered nurses (RN) and nurse practitioners (NP)) who perform non-surgical cosmetic procedures in Australia? If yes, how? If no, what needs to be changed?

Your answer:

No

- Scope of practice requires refinement, commensurate with the recognised level of nurse training and come into line with other guidelines and policies as they relate to supervision (for example it is well established that an EN cannot conduct a number of tasks without the direct supervision of an RN) and obligation and responsibility for patient care.
- Similarly, guidelines relating to RN/NP education and practice standards should clearly outline 1) scope of practice; 2) indemnity requirements; 3) obligations and responsibility to the patient; 4) educational and CPD requirements as these contribute to patient care and safety and 5) supervisory requirements and methodology (specifically relating to obligation and responsibility for patient care).
- ACAM supports professional standards in cosmetic medicine with a higher level of education than a basic bachelor's degree and minimum of four years clinical experience before commencing work in the cosmetic/aesthetic medicine profession. A framework of qualification commensurate with the obligation and responsibility for patient welfare and safety should be considered under the Australian Qualifications Framework Council *Australian Qualifications Framework, Second Edition January 2013.* https://www.aqf.edu.au/framework/australian-qualifications-framework

Question 3:

Does the guidance in the draft nurses practice guidelines sufficiently inform the **public** about the

NMBA's expectations of nurses (including enrolled nurses (ENs), registered nurses (RNs) and nurse practitioners (NPs) who perform non-surgical cosmetic procedures in Australia?

Your answer:

- No.
- A searchable public register should be established so the public can review and check the qualifications, experienced and registration status of their practitioner. The register should outline their scope of practice.
- This would allow potential patients to reassure themselves that the individual is a registered practitioner who has undertakrn additional education and training to take part in the practice of cosmetic/aesthetic medicine. The register should also nominate the treating doctor responsible for the patient's treatment.
- ACAM does not endorse the concept of EN's in cosmetic medicine, regardless of supervision.

Question 4:

In **section 4.2**, the draft nurses practice guidelines propose that '*the registered nurse and/or the nurse practitioner must consider the clinical appropriateness of the cosmetic procedure for a person who is under the age of 18 years. The NMBA considers that botulinum toxin and dermal fillers should not be prescribed for persons under the age of 18 for cosmetic purposes.*'

Is this information clear? If not, why not?

Your answer:

- Yes, this information is clear and follows similar established guidelines.
- ACAM has long held the view that cosmetic/aesthetic medicine is not appropriate for individuals under the age of 18, even if accompanied or consented to a procedure by a parent, guardian or carer.
- Only in unique situations, with the involvement of appropriate medical and clinical screening should this be a consideration (i.e. an example would be dermal filler after oral reconstruction surgery whereby the remaining surgical deficit is impacting the psycho-social well being of the child and the decision is supported by their treating medical team, parents, guardian or carers).

Question 5:

Is there anything further you believe should be included in section **4?**

Your answer:

- A minimum defined penalty should be included in the guidelines for those individuals who do not adhere to the guidelines, once clearly determined.
- This would provide board support for those whom cultural expectations or other reasons, may feel pressured into fulfilling patient demands.

Question 6:

In **section 8.1**, the draft nurses practice guidelines propose *'the RN/NP is responsible for ensuring that any other person/s participating in the person's care or treatment have appropriate education, training and competence, and is adequately supervised as required'.*

Is this a reasonable requirement? If yes, why? If not, why not?

Your answer:

This is reasonable but should be further defined by whom you mean 'participating'. For example, beauty therapists are often part of a care team, and dermal therapists are another designation, both of whom often dispense treatments and advice that is beyond their training and responsibility levels. Consideration should be given to the working environment and protocols of the working environment, as some of these designations often 'consult' and 'provide advice' without the direct supervision or knowledge of a medically registered practitioner. In addition these professions reside outside the responsibility of the collective boards which constitute of AHPRA, but can operate devices and conduct some procedures that are the same as medical procedures or a close mimic of medical procedures.

A way to ensure that appropriate education, training and competence is maintained could be:

- Ensure all cosmetic/aesthetic medicine is conducted in a medical setting (i.e. in a medical practice with the tools and equipment [resuscitation requirement etc. is on hand and is medically supervised] and with appropriate locked and monitored storage (e.g. electronically monitored vaccination fridges) on site. See NSW Poisons and Therapeutic Goods Regulation 2008 https://www.health.nsw.gov.au/patients/cosmetic/Pages/amendments.aspx for ideal training, supervision, medicine storage and premises requirements.

- Examples of non-acceptable settings (taking into account the medical setting that accounts for privacy, hygiene and correct medical note storage) include: 'co-located clinics' within hairdressing salons, beauty therapy services, nail services salons, and other similar establishments, such as tattoo parlours.

- Any medical clinic site (a site offering medical services such as cosmetic/aesthetic medicine services) should have an appropriate Development Application (DA) in place for medical procedure/rooms. As a medical practice the clinic offering the services should meet the same clinical standards that a doctor's rooms, completing medical procedures, are required to meet.

- Co-located clinics, if they are so motivated, get around the medical room standard requirement by gaining an "injecting or body piercing" licence from their local council. Injectable treatments are medical grade treatments requiring the scripting of a an S4 medication; ACAM insists they are conducted in medically certified (i.e. appropriate DA) rooms with appropriate clinical conditions and support devices such as defibrillation devices and medication storage and monitoring, and appropriately trained and certified staff on site. See NSW Poisons and Therapeutic Goods Regulation 2008 https://www.health.nsw.gov.au/patients/cosmetic/Pages/amendments.aspx for ideal training, supervision, medicine storage and premises requirements.

- The level of responsibility toward patients between the different levels of practitioners requires definition and the level of responsibility towards the patient should be the same for the same procedures, i.e. the person conducting the procedure is equally responsible for any sub-optimal outcomes and this should be reflected all/their indemnity policy(s).

- The level of responsibility should be reflected in the nature of the procedures which can be offered by an individual (as a reflection of their designation, registration, training, education, qualifications and indemnity), to help patients identify these factors a licensing protocol could be established with an online registration portal. If the individual cannot demonstrate training of a procedure with a supervisor who is familiar and similarly trained, they should not be offering/conducting the procedure to patients. It should be noted, watching a procedure being performed at a conference

should be not be considered as adequate training to conduct the procedure.

- There have been cases where the non-medically registered practitioners 'standard of knowledge' has not protected the patient/client in the event of a sub-optimal outcome, and knowledge level of individuals (i.e. not medically trained to a recognisable standard) been used as a defence to limit liability. See Doug V Handley, Nick A Rieger and David J Rodda Rectal perforation from colonic irrigation administered by alternative practitioners. *Med J Aust* 2004; 181 (10): . || doi: 10.5694/j.1326-5377.2004.tb06454.x. Published online: 15 November 2004

- With regards to medical indemnity insurance, the RN/NP is effectively conducting the same procedures, with the same medications and devices, supervising and providing advice as a proxy medical practitioner, with the same global risk factors, individual indemnity insurance should be commensurate to that of a medically registered practitioner and be individually based regardless if the RN/NP is operating independently or within a corporate environment (i.e. Chain or Volume clinic scenario.

- Each Injector, as with medical practitioners, should be personally responsible for the treatments they conduct/undertake; this would increase interest in standards of training, guidelines and continuing professional development (CPD).

- It is not in the public, patient or profession's interest to use corporate or business public indemnity insurance and associated non-disclosure agreements in the event of a sub-optimal outcome. This should apply for any staff or practitioner the RN/NP may be supervising directly or indirectly, or by proxy;

- The TGA registration for most injectables have limited areas or types of treatment, this is often ignored, despite individuals being "appropriately" trained. This statement should be expanded to include "and use the medical devices and medicines as per their TGA registration and the registration level/status of the practitioner." "Off-license" use is the providence and privilege of the medically registered practitioner once they have appropriately consented a patient and should remain so.

- ACAM does not endorse the use of EN's in cosmetic medicine, an EN qualification does not have the required level of academic education or experience to work as a delegated injector regardless of the supervision level (RN/NP, medically registered practitioner or dentist). In addition they do not have the required training or minimal ability to psychological assess patients. See https://blog.tapoly.com/who-can-give-botox-fillers/) .

- Similarly ACAM does not endorse the use the beauty therapy class (i.e. often called "aestheticians" as in the United Kingdom) do not have the required academic education or experience to work as a delegated or independent injector of scheduled cosmetic medications. In addition they do not have the required training or minimal ability to psychological assess patients. See https://blog.tapoly.com/who-can-give-botox-fillers/) .

- ACAM would suggest the implementation of a laser and light device licensing scheme that is recognised Australia wide and within the Australian Qualifications Framework Council *Australian Qualifications Framework, Second Edition January 2013.* https://www.aqf.edu.au/framework/australian-qualifications-framework.

- An example of this scheme is https://www.health.qld.gov.au/system-governance/licences/radiation-licensing/apply. A review of suitable laser and light device courses should be conducted to ensure they meet a minimum safety officer standard, and additional certified training should be conducted for each different device (i.e. different devices and uses, vascular *vs* ablative *vs* non ablative).

- In some states there is no requirement for education, training, indemnity or housing of devices which may be under the supervision or operated by a RN/NP or by non-medically trained operator.

- ARPANZA has demonstrated an ongoing interest and should be consulted on this matter https://www.arpansa.gov.au/news/new-guidance-safety-cosmetic-laser-and-ipl as the required standards, education and level of treatments offered in which particular setting along with their recommendations as to level of supervision. By creating a national standard it would allow national recognition of skills sets and training achievement and facilitate employment opportunities for individuals if they move between states and territories.

- Supervisors should be immediately accessible to any delegated injector they may work with; unsuitable scenarios are those medical practitioners who may be working in emergency departments as well as 'supervising' a delegated injector, this is not appropriate for many reasons and is an example of unacceptable supervisory behaviour.

- The use of Telehealth means that a supervisor may not in the same state as the delegated injector, and not able to render assistance in the event of a sub-optimal outcome, this also relates to the number of delegated injectors supervised by one person at any point in time.

- An associated issue for delegated injectors and remote supervision: consideration should be given to the number of nurses a single doctor is supervising at any one time, for example if there are ten delegated nurses supervised by a single doctor, who work 8 hours a day, five days a week, budgeting one patient per hour, the supervising doctor would be required to review 400 patients in a 5/7 week; if the appointments are 30 mins, this number could potentially be 800 patients a single doctor is responsible for, calling into question adequate review of the patient(s) and supervision of delegated injectors.

Question 7:

In **section 16.1**, the draft nurses practice guidelines propose '*that RNs first practise for a minimum of one-year full-time equivalent post initial registration, to consolidate the foundational skills and knowledge as an RN in a general or specialist area of nursing practice (not in the area of non-surgical cosmetic procedures). RNs who perform non-surgical cosmetic procedures are required to undertake detailed assessment and planning of care, have complex anatomical and physiology knowledge as well as decision-making relating to pharmacodynamics and pharmacokinetics*'.

Is the guidance proposed a reasonable requirement? If not, why not?

Your answer:

- RN's do not undergo an 'intern' year or other such review of their practical and working skill base after the award of their degree and before they gain general registration, this should be addressed.

- As such, ACAM suggests that the RN first practice in the cosmetic/aesthetic medicine profession should be allowable four years after gaining their general registration; this is weighted against the risk of causing lifelong and permanent harm to patients.

- Delegated injectors should be required to demonstrate the necessary Post-Graduate training in the areas of cosmetic/aesthetic medicine with an independent [of industry] providers and companies which recruit delegated injectors [there is a financial and recruitment incentive to pass all standards, poor or otherwise], reputable training organisation such as a university and other independent training organisation, and that all should be trained and have knowledge of regulation, legislation, scripting and dispensing guidelines, applicable laws as well as practical skills and knowledge such as high level anatomy, infection prevention and control and laser and light physics knowledge.

- Delegated injectors must demonstrate current and ongoing CPD as per the medical practitioner guidelines and have commensurate professional indemnity insurance for the procedures they are conducting and not rely on the PI of a corporate entity or a supervising medical practitioner.

- This reflects the sentiments in the updated Telehealth guidelines Medical Board of Australia 2023 Guidelines: *Telehealth consultations with patients.* https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Telehealth-consultations-with-patients.aspx# with regards to remote scripting and Medical Board of Australia 2023 *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures.* https://www.medicalboard.gov.au/codes-guidelines-policies/cosmetic-medical-and-surgical-procedures-guidelines.aspx%C2%A0 with regards to CPD and ongoing training/currency of practice.

- This concept is consistent with some Medical Defence Organisations who now require medical practitioners to complete a focussed cosmetic medicine Fellowship for indemnity coverage.

- ACAM proposed this as RN, NP, and delegated injectors are often undertaking equivalent tasks to medical practitioners, and should be required to undergo the equivalent measures with regards to demonstrated education, CPD and their practice currency, and importantly from a patient perspective should have equivalent indemnity insurance (i.e. many work as independent contractors, with limited or remote supervision sometimes with doctors who do not know the injectors education, experience or skill base.

- In the interest of patient's safety and reassured they are being treated by a registered practitioner under the auspices of AHPRA, individuals should be held accountable for their education, CPD, indemnity and the procedures the conduct without the ability to shield behind corporate or business insurance policies.

- Appropriate indemnity, a certificate of currency, and CPD completion in the vein of those required by medically registered practitioners should be required for registration purposes as many delegated injectors are offering the same procedures but not with the same education, responsibility or obligation to the patient.

- It would be fruitful if a minimum standards of post-graduate qualifications (post completion of an accredited nursing degree) be completed to work as an RN in cosmetic medicine; NP training this similar qualification should focus on the individuals, medications, patient management, management of sub-optimal outcomes and the legalities of patient care, obligation and responsibility to patients.

- Educational focus should be on raising the basic qualifications of cosmetic nursing in all subjects (not just limited injectables treatments, which is not the holistic view of cosmetic medicine) and they may encounter as a delegated injector.

- Further all RN/NP as per the Medical Board of Australia 2023 *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures.* https://www.medicalboard.gov.au/codes-guidelines-policies/cosmetic-medical-and-surgical-procedures-guidelines.aspx%C2%A0 should be required to demonstrate currency and CPD annually.

- Prescriber responsibilities alone do not provide the best safety net for patients who experience sub-optimal outcomes. Nurses who are able to prescribe injectable medications are unable to order such things as emergency ultrasounds in the event of an arterial or other occlusion. In addition the disparity between indemnity insurance of that experienced by a doctor *vs* nurse for the same task can impact on the patient's ability to seek recompense in the event of a sub-optimal outcome. An RN/NP completing the same tasks, with the same medications, and devices should carry indemnity insurance commensurate to that of a medically registered practitioner. In the event that an individual works for a corporation, they should still carry personal professional indemnity insurance to this level for the benefit of the patient.

- Technically, care planning should be the providence of the treating or supervising doctor or NP who are acting as a proxy for a medically registered practitioner and has ultimate responsibility for and obligation to the patient. This may require firm definition including reference to scope of medical practice of RN/NP, EN, beauty or dermal therapists or dentist, or other skills sets that may constitute part of a '*treatment team*'.

- ACAM does not condone EN, beauty or dermal therapists as delegated injectors in cosmetic medicine.

Question 8:

Is there any further detail that needs to be included in the draft nurses practice guidelines to ensure public safety? If yes, please provide details.

Your answer:

- Nurse practice guidelines should stipulate that the nurse should be four years post graduation before they can consider a career in the cosmetic/aesthetic medicine profession, particularly as there is no 'intern' or equivalent year, that reviews and tests practice skill base and behaviour in the professional environment.

- Delegated injectors should be required to demonstrate the necessary post-graduate training in the areas of cosmetic/aesthetic medicine with an independent [not of industry] providers and companies which recruit delegated injectors [there is a financial and recruitment incentive to pass all standards, poor or otherwise]; reputable training organisation such as a university and other independent training organisations, should provide training and have knowledge of regulation, legislation, scripting and dispensing guidelines, applicable laws as well as practical skills and knowledge such as high level focussed anatomy, infection prevention and control, and laser and light physics knowledge.

- ACAM does not condone the use of EN's in any capacity in cosmetic/aesthetic medicine (i.e. delegated injectors).

- The TGA registration and use for each device and scheduled medicine should be maintained by RN/NP, dentist and any delegated injectors, with respect to their scope of practice and the use which the TGA has on the medicine's or device's registration.

- It should be noted there are scenario's (i.e. dermal filler occlusions, infections) where the ability to prescribe a mediation such as a cosmetic injectable does not translate to holistic and safe care for patients, a NP is unable to: order imaging such as ultrasounds without a commercial charge and therefore may be reluctant to do so in the event of a dermal filer occlusion; If inexperienced (i.e. not enough post general registration experience) they are may not recognise infections (fungal, bacterial, viral) and allergic reactions or be able to initiate appropriate management or describe the symptoms to someone who can; and in the event of infections, swabs and cultures will be commercial provided, the cost no doubt passed on to the patient.

- In the event of infection etc. or other incidences that requires medical treatment NP do not have the prescribing breath to take into account all medications that may be suitable to begin medical treatment in a timely manner, potentially worsening the outcome for patients. These scenarios require some direction in guidelines the interest of patient safety, holistic care and particularly in the event of sub-optimal outcomes (e.g. arterial occlusion) and infection risk.

- RN's and NP's would benefit from joining or undergoing the culture of the new MBA CPD Homes

project, to ensure standards of education and currency of skill base are maintained. The CPD Home concept allows for organisation's to audit and provide remediation or up-skilling if required, and also allow the public and indemnity providers some confidence in the RN/NP skill base.

Guidelines for registered health practitioners who perform non-surgical cosmetic procedures.

Consultation questions:

The proposed draft shared practice guidelines (at Attachment B of the consultation paper) will apply to all registered health practitioners, except for medical practitioners (who are already subject to the Medical Board of Australia's (the MBA) *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures*) and nurses (who will be required to comply with the draft *Guidelines for nurses who perform non-surgical cosmetic procedures*, if approved).

Question 9:

Is the guidance in the draft shared practice guidelines appropriate? Why/why not?

Your answer:

No

- A statement is required defining the scope of practice of RN, NP, dentists and other delegated injectors, particularly in relation to the TGA registration of use of scheduled medications and devices and scope of practice.
- Cosmetic medicine is not limited to injectable medications, cosmetic medicine should be a holistic approach to the patient with the ability to review and diagnose other disease or pathology that may impact on an individual's appearance causing them concern they seek treatment to remediate their concern (e.g. scleroderma, melanoma skin cancer, roseacea, sun-damaged skin, per-keratinocyte skin changes, mental health disorders). For the safety of the patient these guidelines should provide practice boundaries and articulate clearly the obligations and responsibility towards the patient.

Question 10:

Does the guidance in the draft shared practice guidelines sufficiently inform **registered health practitioners** about National Boards' expectations when performing non-surgical cosmetic procedures in Australia? Yes/No. If no, what needs to be changed?

Your answer:

No

- A statement is required defining the scope of practice of RN, NP, other delegated injectors and Dentists, particularly in relation to the TGA registration of use of scheduled medications and devices.
- In addition there are ongoing concerns with laser and light devices, practitioner education and training, use and application of devices and scope of practice (i.e. dental and NP completing medicated skin treatments they are not trained and perhaps indemnified to complete). ARPANZA has demonstrated an ongoing interest and should be consulted on this matter https://www.arpansa.gov.au/news/new-guidance-safety-cosmetic-laser-and-ipl as the required standards, education and level of treatments offered in which particular setting along with their recommendations as to level of supervision. This is should be a national standard to allow recognition of skills sets and employment opportunities between states and territories.

Question 11:

Is the guidance in the draft shared practice guidelines useful for the **public** to understand National Boards' expectations of registered health practitioners who perform non-surgical cosmetic procedures in Australia? Yes/No. If no, what would be more helpful?

Your answer:

Yes: Some points.

No: In that scope of practice, obligation and responsibility towards the patient further clarification for patients, along with the other legislative regions such as the TGA registration for use of devices and scheduled medication, as well as ARPUNZA requirements concerning the use of lasers and other light devices in cosmetic medicine.

Question 12:

Is there anything you believe should be added to or removed from the definition of 'non-surgical cosmetic procedures' as it currently appears in the draft shared practice guidelines?

What changes do you propose and why?

Your answer:

Suggested changes:

- The current definition of cosmetic medicine should be changed as the mention of mole removal in the Australian vernacular usually refers to melanoma/skin cancer. This can be quite confusing for the general public.
- The definition should encompass other sections of the profession, which it does not, instead the definition focuses on injectable medications and laser technology. This does not encompass skin remediation by other forms and does not reflect the knowledge required to understand and recommend and educate people in areas of skin care, topical medications, topical skin treatments and the conditions they are suitable for.

Question 13:

The draft shared practice guidelines propose a set of consistent requirements for practitioners practising in this sector.

Do you think it's appropriate for consistent requirements to apply to all practitioners practising in this sector regardless of their profession? Or do you think there are variations, additions or exclusions required for a particular profession or professions?

What changes do you propose and why?

Your answer:

- ACAM supports increased safety measures for all patients comes from a foundation of accredited and independent education, application and educational currency, appropriate reflection of education, college membership with peer review and review of practice currency and fluency.
- All practitioners should be required to have the same minimum standard of education, training and personal professional indemnity if they are conducting/offering the same procedures. All

practitioners should have the same level of indemnity cover as delegated injectors do not always follow procedures, or direct instructions in the interest of the patient(s). Finally the individual who creates a sub-optimal outcome should be held equally responsible and should ensure they have appropriate personal professional indemnity to compensate the patient if this is the outcome.

- Medical scope of practice requires clarification for RN, NP and dentists; ACAM does not support EN's practicing any form of cosmetic/aesthetic medicine. As teeth are not resident in human foreheads, the dental use of injectables in this region requires defined scope of practice provisions.

- There are many varied skill sets that work within the cosmetic medicine profession; however a patient will often confuse the delegated injectors responsibility and obligation with that of a medically registered doctor's responsibility and obligation. This comes about as both are conducting the same procedures and many delegated injectors seemingly working/operating under or unsupervised. One way this could be remediated, with the patient in mind, is being provided in these circumstances with written information who is technically responsibility for their treatment. In addition, all delegated injectors, RN and NP and dentists should carry the equivalent indemnity insurance as a medically registered professional, and share equal responsibility for any suboptimal outcomes, if they are in the role of delegated injector.

- In this vein if a patient has an sub-optimal outcome their claim should be against the individual practitioner and not be covered by corporate or business public indemnity insurance and patients should not be required to sign a non-disclosure agreement. It is difficult to determine data and practice issues if patients are not able to openly report incidents. This system also does not allow indemnity companies to identify those practitioners, who for whatever reason, may not suitable for this type of medical work.

- ACAM continues to voice its concern of doctors providing scripting services without demonstrable cosmetic/aesthetic medicine training, and suggests that any Telemedicine be conducted by doctors who are appropriately cosmetically trained and insured correctly themselves with a transparent declaration of total billings be declared by all involved. Doctors who perform this function should be annually audited as to the CPD education along with those individuals they are supervising.

- The supervising doctor should be required to have a defined and demonstrable long term working relationship with any delegated injector, the supervising doctor and be able to demonstrate they have attended training with those that they supervise and have the capacity to ascertain and understand the skill base they are supervising. ACAM's understanding is that a NP can only prescribe for themselves, this status should be maintained.

Question 14:

While it is acknowledged that many people who seek non-surgical cosmetic procedures do not have an underlying psychological condition such as body dysmorphic disorder (BDD), the Medical Board of Australia's practice guidelines and the Nursing and Midwifery Board of Australia's proposed guidelines require medical practitioners and nurses who perform the cosmetic procedure or prescribe the cosmetic injectable, to assess their patients for underlying psychological conditions, such as BDD.

Is this a reasonable requirement of other registered health practitioners performing cosmetic procedures as well? If yes, why? If not, why not?

Your answer:

- Yes

- This is a reasonable requirement of all practitioners who work within the cosmetic profession.

In general, as there is not an accredited pathway, psychology is not taught in the current available education pathways, excepting for ACAM Fellowship pathway. Psychological training is not undertaken by those who make up delegated injectors pool, dentists, EN and RN's and therefore a mechanism is required to ensure screening for BDD helps maintain a safe practice environment for these individuals.

- Volume clinics are of particular concern to over treating by a) encouraged through payment systems that are volume related, i.e. based on *amount* of medications used; b) poorly psychologically skilled delegated injectors who are not trained in psychology and incentivised in their treatment recommendations; c) often younger personnel who have not had extensive experience in any clinical settings before they undertake delegated injector employment.

- The onus of diagnosis of BDD and other appearance related mental health variants, along with more common mental health issues (depression, obsessive compulsive disorders) should not be left to individuals who cannot offer further treatment or refer individuals. It is inappropriate to suggest that the diagnosis of mental health disorders is the remit of delegated injectors and it suggested for the safety of both the patient and the delegated injector, that an external viewpoint be consulted before diagnoses are made by inexperienced and inadequately trained delegated injector, often with limited clinical experience.

ACAM raises concerns for online forum and 'tick a box' diagnostic tools:

- All such tools require independent validation;
- A motivated patient will conquer these types of questionnaires, the subtleties of their diagnosis is best reviewed in a clinical setting with a practitioner skilled in this area of medicine;
- Having Body Dysmorphic Disorder (BDD) or other diagnosis does not preclude a patient from treatment and may in fact save the patient from seeking (i.e. travelling overseas) extreme treatments or self injecting after internet purchase of injectables. It does require however well thought out patient management and defined management plan(s) in place;
- Inaccurate completion on online forms, or other diagnostic tools may lead to miss-diagnosis, this could be catastrophic for some individuals;
- Who will receive the diagnostic information? Will the potential patient be consented for the evaluation, and will the understand the extent of the consent? Will any diagnoses be discussed with the patient in a clinical (i.e. non-cosmetic) setting?
- Who will be responsible for referral for a consultation (the delegated injector, supervising doctor, online psychologist, AI [will a referral be needed?], and will this consultation be covered by Medicare?
- Who will be responsible, in the event of a diagnosis, for patient follow-up for continuing assessment and care?
- How will this be audited/monitored or reviewed and by which authority?
- Who will be responsible for follow-up with the patient if a diagnosis is reached by remote testing, and will the patient's general practitioner or other medical carer be alerted? What will be the confidentiality arrangements of this situation? How will the patient's general practitioner or medical care provider be alerted and how will this be validated (i.e. this is actually the patient's general practitioner and they have followed-up with them). What is the procedure if the patient does not wish to attend or have their general practitioner alerted, is this a breach of their confidentiality?
- Will this diagnosis be added to the patient's My Health Record, and who will have access to this digital record?

Question 15:

Is there any further detail that needs to be included in the draft shared practice guidelines to ensure public safety? If yes, please provide details.

Your answer:

ACAM maintains a culture of transparency, and all guidelines should aim to:

- Identify and clarify the registration status of an individual;

- Appropriate and defined independent [of supplies or corporate companies who have in interest in recruitment of injecting staff] education and training which can be monitored and audited;
- A higher recognised level of education, demonstration of currency and appropriate indemnity for the procedures undertaken by the RN, NP or other delegated injector or dentist;
- RN's should be required to finish a minimum of four years in a clinical setting, gaining experience as a general nurse due to the education and clinical experience they will gain, before they can enter cosmetic/aesthetic medicine after the completion of appropriate independent education, training and commensurate indemnity for the procedures they will be completing;
- Defined scope of practice for RN's, NP's, EN's and Dentists, for example dentists, RN and unless specifically trained NP should not for example be offering skin cancer or skin remediation services, these patients are a great risk of misdiagnosis and skin cancer morbidly and mortality;
- Appropriate medical indemnity insurance for all practices i.e. of equal value to that which a medical practitioner is required to have, as every procedure is of equal risk to the patient, who should have access to redress if required, regardless of who the injector is;
- Appropriate and coordinated national law in relation to laser and light devices, the administration, storage and setting in with they are deployed;
- A critical review of where cosmetic medicine is conducted to ensure that any setting meets the standard of a location suitable for the provision of medical service, and has an appropriate DA in situ. ACAM would deem non suitable sites to include tattoo parlours, hairdressers and beauty salons that do not provide the necessary privacy and equipment (i.e. resuscitation equipment) that would be expected for other skin procedures (i.e. skin cancer medicine).
- An understanding that cosmetic medicine is *not just* 'injectables' requiring a broader skill base;
- An adherence to the TGA registration for use of all scheduled medications and devices, bearing in mind the prescribing privileges of registered general practitioners.

Guidelines for registered health practitioners who advertise non-surgical cosmetic procedures

Consultation questions:

The proposed draft advertising guidelines (at Attachment C of the consultation paper) will apply to all registered health practitioners who advertise non-surgical cosmetic procedures.

Question 16:

Is the guidance in the draft advertising guidelines appropriate? Why/why not?

Your answer:

Yes

Question 17:

Does the guidance in the draft advertising guidelines sufficiently inform **registered health practitioners** about National Boards' expectations when advertising non-surgical cosmetic procedures? Yes/No. If no, what needs to be changed?

Your answer:

Yes

Question 18:

Is the guidance in the draft advertising guidelines useful for the **public** to understand National Boards' expectations of registered health practitioners who advertise non-surgical cosmetic procedures in Australia? Yes/No. If no, what would be more helpful?

Your answer:

- It allows members of the general public to ascertain what type of practitioner the registered health practitioner is.

Question 19:

Is there any further detail that needs to be included in the draft advertising guidelines to ensure public safety? If yes, please provide details.

Your answer:

- ACAM suggests that in addition to advertising, displaying the registration number of the practitioner they should clearly state if they are a registered nurse, registered nurse practitioner, registered dentist or medically registered doctor. At this point in time patients may still need to go through the act of searching the registration data base, which may be an inconvenience over come (despite the 'coding' of the registration categories).

The definition of 'non-surgical cosmetic procedures' in the draft advertising guidelines includes

examples of what are considered non-surgical cosmetic procedures and includes procedures that are restricted to the practice of registered health practitioners as well as procedures that may be performed by people who are not registered health practitioners. This decision was made to promote consistency between the various guidelines which regulate both the practice and advertising of non-surgical cosmetic procedures and cosmetic surgery.

Question 20:

Is the definition of 'non-surgical cosmetic procedures' in the draft advertising guidelines appropriate when setting standards for the advertising of non-surgical cosmetic procedures by regulated health practitioners? Why/why not?

Your answer:

- Yes

Question 21:

Is there anything you believe should be added to or removed from the definition of 'non-surgical cosmetic procedures' as it currently appears in the draft advertising guidelines?

What changes do you propose?

Your answer:

- Yes
- The inclusion of Mole removal harks to skin cancer/melanoma, and it suggested that this phrase be changed to "*benign solid lesion (which may include non-malignant mole removal*)."

About IV infusion treatments:

Ahpra and the National Boards are aware of concerns about the advertising of IV infusion treatments and have issued previous statements in relation to this. IV infusions, like non-surgical cosmetic procedures, are invasive procedures with inherent health and safety risks for patients.

While IV infusion treatments are not strictly a non-surgical cosmetic procedure, many advertisers quote their patients as looking or feeling better after an infusion. Ahpra takes the view that there is little or no accepted evidence to support such generalised claims, and that claims about general improvements in health, wellness, anti-ageing or appearance are therefore misleading and in breach of the National Law. As with any regulated health service claims made about the benefits of IV infusions must be accurate and not misleading. This is because consumers are likely to rely on purported scientific claims and be significantly influenced by such claims, when making health care choices.

While these draft guidelines are focused on the advertising of non-surgical cosmetic procedures, we welcome feedback on whether separate guidelines should be developed in relation to the advertising of IV infusion treatments.

Question 22:

Do you support the development of separate guidelines in relation to the advertising of IV infusion treatments? Why/why not?

Your answer:

- Yes

- A separate guidelines should be developed as this treatment is quite different in nature to cosmetic medicine and carries with it different risks (i.e. greater infection risk, air embolism risk).

- Further these categories of treatments could be thought of as more 'wellness' or 'internal/physiological rejuvenation' rather than to do with appearance medicine.

Question 23:

If you support the development of separate guidelines in relation to the advertising of IV infusion treatments, what do you believe should be contained within these guidelines?

Your answer:

- Risk associated with treatment;
- The required setting for such treatment;
- The required triaging of individuals receiving treatments;
- Required level of training for individual administering treatments;
- The appropriate equipment and protocols in the event of an arrest or other untoward outcome
- Restrictions on the type of medications, the source and registration that is required before it can be used in this way. See Shehab N, Brown MN, Kallen AJ, Perz JF. U.S. Compounding Pharmacy-Related Outbreaks, 2001-2013: Public Health and Patient Safety Lessons Learned. *J Patient Saf.* 2018 Sep;14(3):164-173. doi: 10.1097/PTS.0000000000000188. PMID: 26001553; PMCID: PMC4668233;
- Only registered compounding chemists should be the source for these infusions, if they are to be utilised;
- An appropriate warning and consent system in place that there is no effective peer review information on the outcome of these categories of treatments;
- Appropriate infection prevention and control training, with mandated and audited CPD;
- Mandated level of personal professional indemnity insurance with minimum registration and training (i.e. RN);
- Appropriate DA applied for the rooms in which conducting of what can be considered a medical procedure (a lot of clinics gain an 'injecting licence' this is not a through enough setting for a medical type procedure). It is suggest that the NSW Poisons and Therapeutic Goods Regulation 2008 https://www.health.nsw.gov.au/patients/cosmetic/Pages/amendments.aspx for ideal training, supervision, medicine storage and premises requirements provide a template for minimum room standards and penalties for delegated injectors and supervisory roles.

Question 24:

Do you have any other feedback about the draft practice guidelines and draft advertising guidelines for non-surgical cosmetic procedures?

Your answer:

- Apart from the registration number it would aid the public and help them identify the type of practitioner they were consider if Nurse etc. was also included on the advertising.