Medical Board Public consultation - Submission

Your details

Name: [redacted]

Organisation (if applicable): Australian Society of Plastic Surgeons

The Australian Society of Plastics Surgeons (ASPS) thanks the Medical Board of Australia for the opportunity to comment on the draft guidelines.

The ASPS is Australia's largest professional Specialist Plastic Surgery organisation, representing more than 500 members.

Are you making a submission as?

- An organisation YES

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.)

For medical practitioners, what type of medical registration do you have?

- Specialist registration only – Specialty (optional): Plastics YES
- All members of our society are Specialist Plastic Surgeons.

Do you give permission to publish your submission?

Yes.

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?

Endorsement of registration for cosmetic surgery for registered medical practitioners

To give feedback on a draft registration standard for an endorsement of registration for cosmetic surgery when the qualification on which the endorsement will be based has yet to be determined is very difficult. The qualification on which it is based is all-important. To effect patient safety the threshold must be a Fellowship in surgery, where the requisite number of training years and examinations have been completed.

ASPS believes an endorsement of registration has limitations in what it will achieve in terms of public safety, and may not be sufficient in itself.

First and foremost, any endorsement only regulates how doctors *identify*. It relies on members of the public *knowing* that they have to look for the endorsement on the AHPRA website, and on practitioners not to mislead people. It does not stop rogue doctors without endorsement from being allowed to continue performing cosmetic operations.

Secondly, the Board is stating that the registration standard "would apply to all registered medical practitioners who wish to provide cosmetic surgery" ("Statement of

assessment" - COAG Principles for Best Practice Regulation, Part B) which implies a surgical qualification may not be required to perform cosmetic surgery.

Because cosmetic surgery is real surgery, with real risks, a demonstrated knowledge of detailed anatomy, physiology, pathology and post-operative care is crucial to the safe care of patients. This means that a Fellowship from one of the Colleges accredited by the AMC for specialist surgical training (such as RACS) is the **only** safe baseline for any endorsement system. Whilst ASPS appreciates that the qualification for the registration standard has yet to be determined, the implication that it might not be a Fellowship in surgery is worrying and is essentially establishing a "second class" of surgical qualification. The standard for being permitted to perform surgery is already established by the AMC - namely through the various AMC approved college training programs. To infer that patients undergoing cosmetic surgery can be operated upon by those with lesser training and qualifications, and therefore be exposed to potentially more risk, is indefensible.The standards required to perform cosmetic surgery should not be different to those required for any other type of surgery. This is the only way to adequately protect the public, and is consistent with COAG Principles for Best Practice, Part A and Part C. As there are already several specialties with AMC-approved training qualifications it should also override any concerns about potential restriction of competition as outlined in Part B.

Thirdly, the mechanics of endorsement are difficult. Cosmetic surgery is not a homogenous, single entity. Cosmetic surgery of the facial skeleton could legitimately be performed by a Specialist Plastic Surgeon or by a Specialist ENT Surgeon, but not by a Specialist Obstetrician and Gynaecologist. Similarly, cosmetic genital labiaplasty should not be performed by a Specialist Ophthalmologist. If cosmetic surgery endorsement was confined to those with Specialist Surgical Fellowships, this could be somewhat solved by a phrase such as"Cosmetic surgery, aligned to their training through their Specialist College". The training afforded by RACS means that RACS surgeons are likely to stay within the confines of the training and mechanisms such as CPD, reflective practice, audits etc, which are an intrinsic part of belonging to the College will mitigate the risk of Specialist Surgeons going "off track".

If AHPRA felt that being within a Specialist Surgical College was not a sufficient safeguard for Specialist Surgeons to operate within their specialty field on its own, and preferred a separate mechanism on top of a Specialist qualification, then to be meaningful, there would have to be not one "cosmetic surgery endorsement" but several variations of it for different parts of the body. Specialist Gynaecologists could be endorsed for "female genital and lower abdomen cosmetic surgery", Specialist General Surgeons with a sub-specialty breast practice could be endorsed for "breast cosmetic surgery". Whilst this

would be possible, the mechanism would necessarily be bureaucracy-heavy and complex, and would appear to be inconsistent with the COAG Principles for Best Practice, Part D. There would need to be some sort of a panel to weigh up training for each area. To deliver such a mechanism seems an enormous task when the outcome is to deliver an *identifier* which the public may not use and which may be open to manipulation or misrepresentation.

Fourthly, there is already a comprehensive training course in cosmetic / aesthetic surgery within the SET training program of the RACS/ASPS Board of Plastic and Reconstructive Surgery. This is an AMC-approved specialist training program. For RACS Fellows in Plastic Surgery it seems unreasonable to have to go through further assessment and applications for recognition in cosmetic surgery.

<u>A short course in cosmetic surgery being used as a basis for endorsement</u>

Superficially a "short course" in cosmetic surgery with a quota of a variety of cases and a number of supervised hours seems a reasonable proposition. A two year course has been proposed previously. However, this notion disregards several important things:

Firstly, a RACS Plastic and Reconstructive Surgery Training in Cosmetic Surgery takes five years, with each year entailing more and more complexity. The development of generic technical operating skills and relevant knowledge to become a fully-qualified surgeon cannot be compressed into two years. This reinforces the notion that a two year course would create a "double standard" in surgical training.

Secondly, the training of Specialist Plastic Surgeons (or other surgical specialists) does not commence at the start of the SET training program in Plastic Surgery. Because there are fixed pre-requisites and a highly competitive entry to the program, it is only those doctors who have excelled in the ward care of surgical patients, in the Emergency Department and in ICU placements as well as at pre-clinical examinations in the surgical sciences who commence the program. All Specialist Plastic Surgeons therefore have proven competency in these areas between graduation from medical school and entry into SET training. Entrants into a short course in cosmetic surgery will have no such credentials. Safely performing surgery requires more than just being able to follow a limited number of surgical 'recipes'. It requires a thorough understanding of anatomy and physiology, choosing appropriate patients upon whom to operate, deciding upon the correct surgical procedure in any given circumstance, being capable of handling intraoperative challenges, and being able to manage unwell and deteriorating patients. Surgeons need to know how to handle the whole egg, not just the yolk.

Thirdly, the ten competencies of RACS are vital for the holistic development of ethically sound surgeons. An ethical approach to patient selection, informed consent and communication, as well as cultural safety are just as important as how many of a particular procedure has been performed. The importance of this cannot be understated.

The longer term consequence of a "short course" being deemed appropriate as the basis of an endorsement in cosmetic surgery, rather than a formal Fellowship of a Specialist Surgical College is that a far greater number of people in the community would be put at risk. Rather than undertaking thorough and arduous specialist training, many doctors may choose to pursue such a course as a path to an extremely lucrative career. Rather than safeguarding the public, this is likely to see an even greater expansion of the cosmetic surgery industry, with an influx of lesser trained 'surgeons' with a limited skill-set and the inevitable attendant complications and patient harm. The medical workforce in Australia would likely become further distorted with fewer medical graduates entering rural and regional general practice. An even greater number of GPs would be spending time seeing patients where cosmetic surgery has gone wrong. It would place a significant burden on the Australian healthcare system as a whole.

2. Are the requirements for endorsement clear?

No they are not clear at the moment. It is not really possible to have clarity, without knowing what the baseline qualification proposed is going to be.

In regards to definitions:

<u>Definitions</u>

Although the definitions of terms on page 4 are well-crafted there is a problem with one of the terms that are being defined.

"**Major cosmetic medical and surgical procedures**" is ambiguous, because grammatically it is uncertain whether the term "major" just applies to medical or whether it applies to both medical and surgical procedures. This is important, because if it is stated that there are "major" surgical procedures then it is a natural assumption that there are also "minor" cosmetic surgical procedures. This is not the case and does not really seem what is intended. Because it is a lengthy term, it is inevitable that it will get

contracted in this unintended way. There is an example of this on page 6 where the phrase "major cosmetic surgery" appears in the second paragraph under the box.

There are currently two classes of cosmetic procedure. It may be helpful to have three classes.

1) **Cosmetic surgery**
2) **Major non-surgical cosmetic procedures**
3) **Minor non-surgical cosmetic procedures**

The term "medical" has been purposefully omitted from the names above, as "medical" implies that pathology is present or that there is therapeutic intent, which in cosmetic procedures, there is not.

Whilst it is the opinion of ASPS that liposuction is intrinsically a surgical procedure, there are arguments (articulated in the Victorian Liposuction Review) that small volume local anaesthetic tumescent liposuction could be considered in an intermediate category. (Autologous fat transfer has significantly higher risks and can only be considered as a surgical procedure). Laser re-surfacing could be considered in the same category. If low volume LA tumescent liposuction were to be considered "major non-surgical cosmetic procedure" this class would have to have an endorsement with appropriate standards separate to the endorsement standards for cosmetic surgery.

ASPS has a neutral stance in terms of whether a third level of endorsement for minor non-surgical cosmetic procedures (fillers, botox etc.) would be desirable.

3. Is anything missing?

The requirement for Specialist Surgical Training is missing. It is the only meaningful baseline for safe cosmetic surgery.

There should be a requirement for Fellowship of one of the AMC accredited Specialist Surgical Programs / Colleges before endorsement is considered.

Cosmetic surgery has all the same risks as other forms of surgery, and therefore should require the same training standards.

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, the changes are appropriate with the following modifications / concerns.

ASPS suggests amendments to the definitions (major cosmetic medical and surgical procedures, etc…) as outlined above in the section on endorsement, namely:

"**Major cosmetic medical and surgical procedures**" is ambiguous, because grammatically it is uncertain whether the term "major" just applies to medical or whether it applies to both medical and surgical procedures. This is important, because if it is stated that there are "major" surgical procedures then it is a natural assumption that there are also "minor" cosmetic surgical procedures. This is not the case and does not really seem what is intended. Because it is a lengthy term, it is inevitable that it will get contracted in this unintended way. There is an example of this on page 6 where the phrase "major cosmetic surgery" appears in the second paragraph under the box.

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Major Procedures (Page 4)

For section 1.1 (page 4 of draft guidelines) The paragraph on conflict of interest could be expanded. ASPS would suggest wording such as:

"In particular medical practitioners must not compromise their adherence to the "Duties of a Doctor" in the pursuit of financial gain. Setting up systems within a practice where not only the doctor neglects their duty, but also actively coerces ancillary staff into purposeful neglect of care or misleading of the patients in favour of commercial benefit is misconduct of the highest order.

The design of written or verbal protocols or other "culture setting" activities where the purpose is to subvert care in favour of financial gain is likewise misconduct of the highest order."

Although some of the elements of this are in the financial section, nowhere in the existing draft is there anything that speaks to the whole of system culture. This is important. It should in the view of ASPS be a principle present across the whole of the policy of the Board, not just in cosmetic surgery. Setting up business models and protocols where financial concerns are held above concerns for patient care erodes the general public's faith in the medical profession as a whole, which is a very serious matter.

Section 2. Page 4

ASPS welcomes the clarity around the assessment of patient suitability. We do see issues to address around referral. We believe that requiring a referral would generally raise the standard of screening and impartiality of the information transfer for patients. There will likely be some confusion around Medicare rebates for these referrals which will not generate a benefit as they do not fit the Medicare definition of a medical service and it is unlikely that a General Practitioner who rarely deals with cosmetic issues will understand the nuances of cosmetic billing for the referral. It may be that referral is provided in the context of an existing consultation and this may have no impact on the Medicare rebates for that consultation but if the sole reason for the consultation is to obtain a cosmetic referral, then the consultation would not be covered by Medicare and there would be importance around the clarity of these charges by medical practitioners.

Another issue which arises is the current variability in quality of referrals from General Practitioners and other medical practitioners. Whilst they are commonly very comprehensive (almost to a fault as they are a printout of the electronic medical record), they are sometimes remarkably brief and irrelevant. For a referral to be meaningful, the medical practitioner would need to give the patient's medical history, current medications and allergies, as well as some indication of their general suitability for the procedure in question from a social or medical or psychological point of view. ASPS would welcome such high quality referrals. This works well when the practitioner knows the patient but can be less effective when the patient is unknown to the referrer.

It is important that the referral for a particular area is indefinite unlike current Medicare rules mandate (expiry after three months from another specialist and after 12 months from a General Practitioner unless noted as indefinite). This referral would be about safe access and not a determinant of Medicare rebate and so has a different rationale.

It is important to clarify whether a new referral would be required for a different area of the body. It is quite common for practitioners to refer for the "wrong procedure", or write what the patient requests which may be an inappropriate choice of procedure. There are some practitioners who refuse referral on moral grounds (unnecessary surgery) and some patients who will not disclose the reason they want the referral (ticket of entry). They sometimes ask to be referred along for a mole as they won't talk to their regular practitioner about their breasts or thighs or labia or gynaecomastia out of embarrassment or fear of being judged.

We welcome the other requirements in section two and particularly the independence of the referrer.

Section 3 Page 4.

ASPS recognizes that the cooling off period, and the requirement for an initial face to face consultation, will create particular difficulties for patients from regional and rural areas. We would suggest there being some exception given in the circumstance where a patient needs to travel more than a certain distance (say 1000km?) ASPS agree that these rules will protect patients from unscrupulous practitioners but it may disadvantage some remote and rural patients of ethical practitioners, especially with respect to the inability to schedule . We strongly agree that the final decision to have surgery should be made at a face to face consultation.

Section 4 Page 5.

Agree.

Section 5 Page 5.

ASPS largely agrees with section 5 but would request refinement and point out an exception that should be documented in 5.3.

It is indefensible to provide major cosmetic procedures (and most minor procedures) without "before and after" photos for medicolegal purposes.

The wording should read:

"Consent must be obtained for photographs and videos taken in consultation or during a procedure……"

The exception is that there are photos and videos that are taken without a prior plan during a medical procedure to document some aspect of anatomy or pathology and these form an essential part of the medical record. There are also photos taken to be part of the surgical record. We suggest adding in

"Nothing in this guide should prevent the appropriate medical documentation of a procedure" (Photos are taken to show lesion position, fat removed, skin resected and symmetry problems etc intra op and these are part of the record for medico-legal reasons)

Section 5.5 would be better phrased as

"…..and reconfirmed on the day of surgery if the consent was obtained more than 3 months prior to the surgery……."

Reconfirmation on the day should be able to be verbal and largely limited to answering patient questions. A reiteration of complications on the day when they have all been carefully covered is unsettling for patients and does not result in them remembering the conversation (retrograde amnesia) or cancelling surgery.

Section 6 Page 7

Section 6.6

A practitioner providing major cosmetic operations must have admitting rights to an appropriate hospital or should not be doing the procedure in question. Providing appropriate medical care is not just for when surgery goes well, but also for when there are complications that require additional treatment. This would be a significant protection for patients in that the practitioner would have at least been reviewed by a MAC and found suitable to perform the procedure in question, and will also provide for continuity of care.

Section 7 Page 8

Agree

Section 8 Page 8

Agree

Section 9 Page 8

ASPS do not agree with endorsing any practitioner who does not have an AMC recognized Surgical qualification.

There needs to be allowance in this section for supervised training of trainees who are enrolled in an AMC recognized training programme in Surgery.

Section 10, 11, 12, 13.

Agree

Minor Procedures (Page 10)

Section 3

This needs clarity around the length of time that a prescription can be valid for. Will the responsible prescribing practitioner have to see them every time they have an injection with a delegated health professional, or have to see them intermittently?

(eg: once a year after writing the prescription with repeats?)

Video prescribing has been very problematic in this area and ASPS would say that this is such an important area requiring additional protection that video prescribing is inappropriate. It is essential to good assessment that a face to face consultation should be mandatory at least for an initial consultation. There is an industry of practitioners with large numbers of registered and enrolled nurses working under their "supervision" who never see the patient for assessment or for complications. We know the assessment to be cursory and the provision of aftercare to be non-existent. This is a major issue.

Because of this status quo, we suggest that in

Section 7.1

the prescribing practitioner must be available within one hour of the treatment location as some of the complications which occur can cause tissue loss if not appropriately and urgently managed and blindness can be a rare complication of filler injections. We recognize this places an impost on regional patients and perhaps this restriction should only be on urban treatments?

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

As per our comment above, it may be appropriate to have three classes of cosmetic procedure:

1) **Cosmetic surgery**
2) **Major non-surgical cosmetic procedures**
3) **Minor non-surgical cosmetic procedures**

If this were the case, the sections would have to be adjusted.

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

The draft is clear but some changes should be considered.

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

ASPS support the requirement of a referral in general. Please refer to our additional comments above.

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

The term "major cosmetic surgery" is misleading (as per our comment above). All cosmetic surgery is surgery and has significant risks.

ASPS strongly supports the requirement for all cosmetic surgery to be undertaken in an accredited facility.

9. Is anything missing?

There are some features missing that are addressed in our comments above.

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, these guidelines provide more detailed direction on cosmetic surgery advertising content, which is vital to protect the public and maintain medical professionalism. Below are some suggestions for improvement.

What is considered advertising?, p.3, paragraph 3.

Does this paragraph need to be included? Advising practitioners that providing information within a consultation is not considered advertising signals to unscrupulous practitioners to ensure that their advertising complies and then methods or materials that would not be compliant could be used at this time instead.

2. Titles and claims about registration, competence and qualifications, p.4, 2.3.

"All medical practitioners advertising cosmetic surgery should include clear and unambiguous information about their **experience,** qualifications and type of medical registration."

Some practitioners refer to surgical rotations completed during PGY1-3, which are not formal periods of surgical training. Patients assume that the practitioner has completed some type of surgical training and this is deliberately misleading.

3. Social media influencers and ambassadors, p. 5, 3.1

"Responsible advertising of cosmetic surgery must not use ~~paid~~ social media 'influencers'…"

Delete the word paid. Sometimes social media influencers are offered other incentives for promotion, which may not be considered to be 'payment'.

4. Use of images and before or after photos, p. 5, 4.3

Although referred to in the current guidelines for advertising regulated services, it would be helpful to reiterate that 'before' and 'after' photos should be consistent in terms of lighting, camera angle, clothing etc. so the only difference in the images is as a result of the advertised procedure.

Points a. and b. are more common in cosmetic surgery advertising using single images, though here they are sub-points of 'before' and 'after' photos in this draft. It is suggested that these points are a separate point above. In addition, the phrase 'poses that imply sexual readiness' could be used. This would then include revealing clothing, lying on a bed etc.

6. Body image and promotion for wellbeing or psychological health, p.6

Change title – possibly 'Body image and promotion of cosmetic surgery for wellbeing and improved mental health'

6.1

In relation to: "Responsible practitioners <u>are aware</u> that interventions other than cosmetic surgery may be better to address the concerns of such patients." Could this be stronger? For example, practitioners should suggest alternate options to cosmetic surgery for such patients rather than just be aware of them.

6.3

Cosmetic surgery advertising should also not encourage patients to undergo multiple procedures at the same time for convenience (i.e., while under general anaesthetic, so patients can recover from procedures at the same time) or sell 'packages' which may lead patients to have additional procedures they do not necessarily need.

8. Targeting people potentially at risk, p.7

Responsible advertising considers the frequency of posts. Excessive posting (e.g. daily) also contributes to body image dissatisfaction among vulnerable groups by creating the perception that the norm is to have cosmetic surgery to improve physical appearance.

It could be added that it is inappropriate to proactively target advertising to young people who react to ('like' or respond to) other cosmetic products or services.

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

Some elements could be clearer.

Introduction, p.2, paragraph 5-6.

It could be clearer that practitioners are expected to comply with the other guidelines referred to as bullet points, in addition to these guidelines.

Who do these guidelines apply to?, p.2.

It appears the guidelines only apply to registered medical practitioners and not third party advertisers who are not registered medical practitioners, or businesses or corporate entities that advertise cosmetic surgery. Can this be expanded?

5. Risk, recovery and idealising cosmetic surgery, p.6, 5.7

It would be helpful to clarify the use of emojis. Advertising must not use emojis to trivialise surgery or more broadly? Emojis (sad faces) have been used to cover nipples on Instagram, to indicate that the breasts in the image need augmentation, or have been used to indicate that a patient looks 'hot' or 'on fire'. The use of emojis in these manner in also unacceptable. Asking followers to rate patients who have received cosmetic surgery or vote on which patient's breasts look the best is another example of unprofessional cosmetic surgery advertising, which is inappropriate.

12. Is anything missing?

It is surprising that there is not a section on the use of testimonials, as they are used in cosmetic surgery advertising far more than advertising for other medical procedures/treatment. The definition of a testimonial (i.e., clinical content, including an expression of the skills and/or experience of the practitioner) and reiterating that testimonials must not be used to promote cosmetic surgery services should be in these guidelines.

Third parties create websites for patient reviews and then link these reviews/patient stories to surgeons (advertising the practitioner, providing contact details, link to website or direct enquiry). Users can search by surgeon, procedure or read patient stories. It doesn't appear that these new guidelines cover this type of advertising.

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

ASPS welcomes the efforts of AHPRA and the Medical Board to improve cosmetic surgery regulation.

A stronger mechanism than endorsement would be to restrict those with no Specialist Surgical Fellowship from having a scope of practice that included cosmetic surgery. Although placing this isolated restriction of scope of practice would be a paradigm shift for the Board, ASPS feels that this is warranted, in view of the substantial harm to members of the public that has already occurred and the risk of greater harm in the future.

ASPS looks forward to working alongside AHPRA in educating its members about the new guidelines and advertising standards.