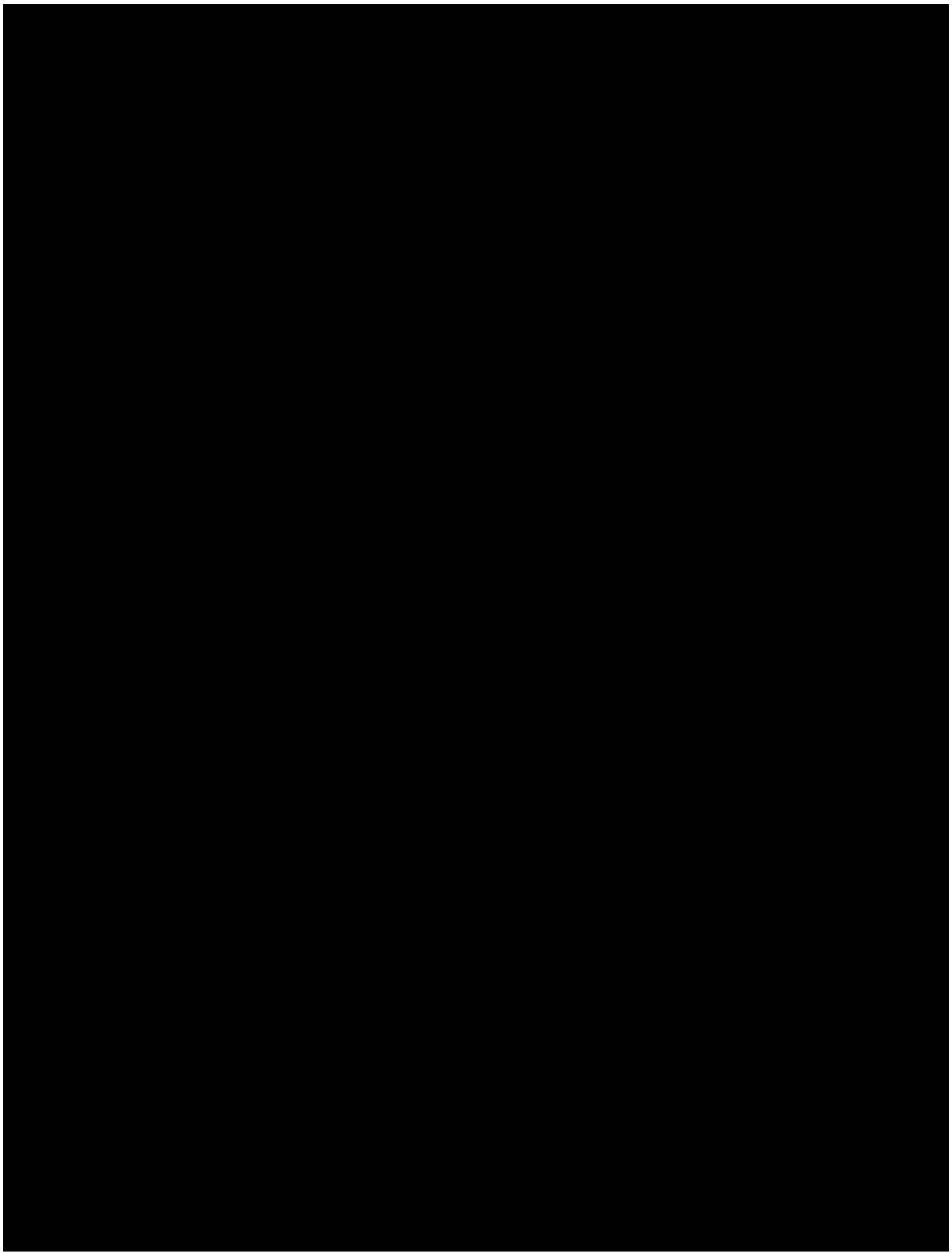
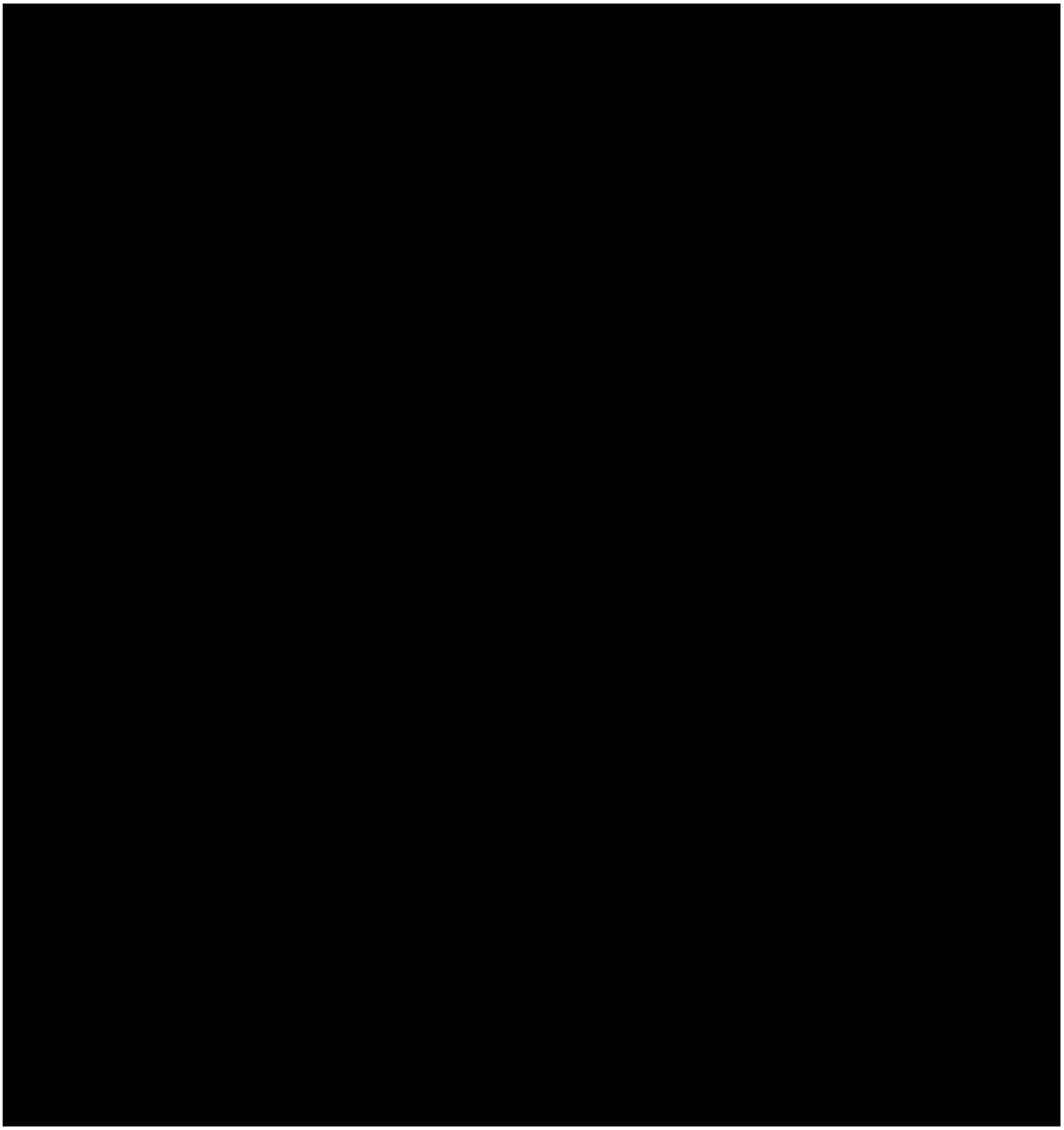
CMATT
Cosmetic Medical Alliance Think Tank

SUBMISSION BY COSMETIC MEDICAL ALLIANCE THINK TANK ("CMATT") TO THE MEDICAL BOARD OF AUSTRALIA'S PUBLIC CONSULTATION PAPER and REGULATION IMPACT STATEMENT ("the Paper")





RESPONSE TO QUESTIONS

It is noted that throughout the Paper the questions are all based broadly on "*cosmetic medical and surgical procedures*" as defined in the first paragraph of definitions on page 7 of the Paper. There is generally no distinction drawn between major high-risk procedures and minor low-risk procedures, other than in Question 17.1.

Clearly to generalise and treat both high-risk and low-risk procedures together is simplistic and leads to conclusions, that are not warranted for both classes of procedures. This is especially so when the vast majority of evidence identified by the Board relates to problems arising from cosmetic surgery, not minor procedures.

Any recommendation by the Board that applies to both cosmetic surgery and minor procedures based upon general responses to the questions and the proffered evidence could be fairly criticized on this basis.

QUESTION 1 – Do you agree with the nature and the problem identified in this consultation paper, for consumers who seek cosmetic medical and surgical procedures provided by registered medical practitioners?

CMATT does not agree that the Paper has provided any substantive evidence supporting the conclusion that there are "problems" for consumers who seek cosmetic and surgical procedures provided by qualified practitioners.

Furthermore, by not drawing a clear distinction between high and low-risk *"cosmetic procedures*" and failing to treat the two as completely separate areas of practice, the Paper only serves to confuse the issue and generalise its observations, making it difficult to make definitive comment on the issues as canvassed in the Paper. As the Paper notes, data on the number of procedures performed is not available and not all complaints and adverse events are reported.

The Paper refers to "*surgical procedures", "major cosmetic surgical procedures"* , "*good surgical outcome"*, "*cosmetic medical and surgical procedures"* without any reference to *minor cosmetic procedures* within this question. Yet conclusions are ultimately drawn so as to effect *minor cosmetic procedures*

Moreover, the data that does exist emanating from statutory complaints bodies, suggests that there are currently problems with high-risk procedures involving cutting beneath the skin and general anaesthesia. This data also indicates there is no current major problem with low-risk or minor procedures such as cosmetic injectables.

As such, there is no viable empirical evidence at this stage which can be justifiably relied upon to base sound medical compliance policy.

Accordingly, many assertions regarding problems in the area of cosmetic medical and surgical services are based on limited evidence and anecdotal reporting.

However, it is intellectually clear there is the potential for problems to exist and expand in the future as a result of an expansion of demand for cosmetic surgery. Areas of concern that CMATT have identified include:

- Variable qualifications, experience, training and credentials of registered medical practitioners performing the services. As the Paper states, basic medical registration qualifies a practitioner to perform any cosmetic procedure irrespective of its risk and complexity, exposing a clear regulatory deficiency or loop hole. It is noted the Paper states that is unfeasible to close this loop-hole but provides no substantive reason to justify this conclusion.

- A competitive market based trading environment leading to potential and actual conflict of interests.

- Potentially vulnerable consumers who are presenting at times for major surgical procedures on the basis of social and self-esteem issues, decisions which are not underpinned by a socially accepted medical disease process. Although it must be noted that in some cases, especially in middle age there is a fine line between disease or the ageing process and purely aesthetic motivation.

- The lack of a gatekeeper in the form of the general practitioner.

QUESTION 2. Is there other evidence to suggest that there is a problem with consumers making rushed decisions to have cosmetic medical and surgical procedures provided by registered medical practitioners without adequate information?

Again there is no concrete data to substantiate the allegation that consumers are making rushed decisions into having major cosmetic surgical procedures. The evidence in this regard must be considered anecdotal.

However, again intellectually is possible to conceive that such a situation may exist or come to exist for the reasons previously identified in Question One.

QUESTION 3. Is there other evidence that consumers cannot access reliable information or are relying on inaccurate information when making decisions about these procedures?

Once again without data, evidence based conclusions cannot be made as to whether consumers are relying on accurate information when making important life changing decisions with regard to major cosmetic surgery.

Also, as above, one could conceive that pockets of information asymmetry and health literacy issues may exist or come to exist in the future.

CMATT considers it is unfair and probably inaccurate to consider this as a universal information asymmetry and quality problem with regards to consumers accessing cosmetic services. Whilst there are variably qualified registered medical practitioners practising in this field, there are many Board registered relevant surgical specialists involved who would undoubtedly be treating consumers accessing their cosmetic services in a professional, ethical and appropriate manner as regards provision of information about procedures.

QUESTION 4. Is there evidence that inappropriate use of qualifications and titles by medical practitioners may be misleading for consumers?

CMATT considers that certain medical practitioners may be construed to be using qualifications and titles inappropriately.

A recent piece on the ABC radio National dealing with issues around this current inquiry clearly demonstrated that the consumer at the centre of the story didn't understand that her breast augmentation procedure was being performed by a registered medical practitioner who referred to themselves as a cosmetic surgeon, but was in fact a general practitioner with no formal surgical training. The consumer stated that had she known this she would not have proceeded with the procedure.

Further, the Cosmetic Physicians Society of Australia (CPSA) use the term *"physician*" which is a generally accepted synonym for a registered medical practitioner with a specialist qualification in internal medicine. This gives consumers the impression that members of CPSA hold a level of training, experience and qualification that they may not possess. Members of the CPSA are general practitioners as far as we are aware. This includes both vocationally registered general practitioners and non-vocationally registered medical practitioners. Membership of the CPSA is by payment alone.

A similar situation exists with the recently constituted Australasian College of Aesthetic Medicine. Such an official name gives the impression to the consumer of higher training, something that is not to our knowledge, always the case.

QUESTION 5. Is there evidence that offers of finance for these procedures may act as an inducement for consumers to commit to a procedure before they have had adequate time to consider the risks?

Again there is no firm evidence that finance products are an inducement to commit to a cosmetic surgical procedure prior to obtaining informed consent. This is a perception. However, it is conceivable that this could occur on occasions but there is no evidence it is common or even of real concern.

All cosmetic procedures have to be financed, as is noted in the Paper, as these procedures fall outside the boundaries of Medicare and private insurance third-party funding.

Obviously this funding must come from savings, income or credit. Accepting a credit card is a form of finance at a very high interest rate in general terms, which can be more unfavourable than specific finance products.

Banning financing cosmetic surgery would give the impression of a more regulated medical environment, however it may also exclude access to the services for some consumers that really need the procedure.

To consider consumers on the whole to be induced into major surgery by finance products is arguably an inaccurate assessment of consumer intelligence. However, it is agreed the Medical Board should urge cosmetic consumers to exercise caution around such products, in a similar way that the community urges responsible gambling and drinking.

QUESTION 6. Is there other evidence of disproportionate numbers of complaints or adverse events for consumers who have had these procedures?

The Paper presents clear evidence of complaints and adverse events from high-risk cosmetic procedures involving cutting of the skin and a general anaesthetic. This data is derived from statutory complaints and medico legal proceedings. Due to the fact that accurate data regarding the number of procedures performed is lacking, it is difficult to derive an incidence rate, so such information is of limited use.

Further, there could be a bias involved in this complaints data, with a very different population demographic undergoing various cosmetic procedures for very different reasons. At best the data cited as supporting a claim there is a disproportionate numbers of complaints is of low to medium quality due to the obvious epidemiological short comings.

QUESTION 7. Is there other evidence to identify the magnitude and significance of the problem associated with cosmetic medical and surgical procedures provided by registered medical practitioners?

There is no evidence to support the statement "*magnitude and significance of the problem associated with cosmetic medical and surgical procedures".* This statement is provocative and unsupported by empirical data, something which is noted in the Paper.

The evidence before the Board is anecdotal and accordingly of low quality. To rigorously assess if there is a potential problem, evidence needs to be collected and analysed in a scientific manner. Any recommendation or regulation based arising from the Board's report will be based largely upon hearsay and innuendo and accordingly open to criticism.

QUESTION 8. Is there other evidence that the current regulation of medical practitioners who provide cosmetic medical and surgical procedures is not adequately protecting the public and not providing clear guidance on the Board's expectations of practitioners?

The evidence would indicate that the current regulation of medical practitioners providing cosmetic medical and surgical procedures is inadequate on two levels

1. **The skills, qualifications and experience of registered medical practitioners performing services**

As noted in the Paper, medical practitioners are deemed suitable to perform high-risk procedures involving the cutting of the skin and general anaesthetic by virtue of basic medical registration without a uniform and verifiable credentialing process.

Registered medical practitioners are being allowed to self-educate and to self-determine with no assessment by their peers of their competency to perform high-risk, high complexity and often life changing invasive surgery. Data from the complaints bodies presented in the Paper, indicates that the problems in the cosmetic surgery area relate to poor outcomes.

Plastic Surgeon Professor Haersch from Concord Hospital in Sydney on the radio National program made the point that extensive experience and training with human tissue is critical to good surgical outcomes in high-risk cosmetic surgical procedures. Professor Walton, the former director of the HCCC also made the point that competency is critical in this arena.

CMATT considers that the current medical regulation regarding credentialing for high-risk cosmetic surgery is inadequate and the lack of skill and adequate training has given rise to adverse outcomes, as indicated by data described in the Paper from complaints organisations.

Thus present regulation is currently not protecting the public adequately. As Dr Flynn noted on the radio National program, this loophole may need to be tightened in the future as there appears to be a ground swell of community sentiment in this regard. Again, it is noted the Paper states that is unfeasible to close this loop-hole due to State Health Minister cooperation requirements, but provides no substantive reason to justify this conclusion and its lack of feasibility. CMATT views this as a significant deficiency in the logic presented by the Paper regarding reform of regulation for cosmetic medical and surgical services.

2. There does not appear to be any effective control on advertising.

Simply Google "Botox" and you will see how many cosmetic medical practice websites are using the trade names of S4 medication. It is rare to find a website that does not include patient testimonials. Risks and complications are rarely mentioned and inducements to cosmetic medical services are commonplace e.g. discounts for referring a friend for cosmetic medical services.

By not enforcing medical advertising rules, an unfair and anti-competitive marketplace for cosmetic services has been allowed to prosper. Compliant medical practitioners fail to feature in an Internet search.

Further, non-compliant advertising has contributed to consumers having unrealistic expectations regarding outcomes. High-risk cosmetic medical and surgical procedures are presented in such a way that consumers could conclude that outcomes are universally excellent. For example the web sites and social media pages of breast augmentation clinics, in many instances create misleading views as to realistic outcomes.

This misrepresentation is in our view similar to the computer manipulation by programs such as Photoshop of photography in popular glossy magazines which may well also generate unrealistic expectations of what constitutes normal appearance particularly amongst young people. This may generate demand for cosmetic surgery but unfortunately cannot be regulated it would seem.

QUESTION 9. Does the Board's current code of conduct and the existing codes and guidelines of the professional bodies provide adequate guidance to medical practitioners providing cosmetic medical and surgical procedures?

It is confusing that the Medical Board considers its current code of practice as satisfactory for disease based medical services but inadequate for cosmetic medical and surgical services. CMATT takes the view that a high standard of medical practice should be universal across all regulated services irrespective of whether a reconstructive or aesthetic motivation underpins presentation.

Professional bodies are not well placed to give guidance due to their professional self -interest which is the fundamental raison d'être of these groups.

QUESTION 10. How effective are existing professional codes and guidelines in addressing the problem identified by the Board?

It has to be noted the question assumes a problem which is not justified by the available evidence.

Properly and rigorously enforced it is CMATT's submission that the present professional codes and guidelines should adequately address most issues. However, given the heterogonous nature of registered medical practitioners providing cosmetic medical and surgical services, some strengthening of the guidelines may be warranted to provide greater clarity as exemplified by option 4 (See later).

QUESTION 11. Do you agree with the costs and benefits associated with retaining the status quo as identified by the Board?

Yes

QUESTION 12. Are there other costs and benefits associated with retaining the status quo that the Board has not identified?

No

QUESTION 13. Would consumer education material be effective in addressing the problem?
If so, how could it be designed to ensure it is effective and kept up to date and relevant?

CMATT disagrees that there exists tangible evidence of a problem. However, again we reiterate that a problem may come to exist in the future.

It is submitted that a comprehensive centralised consumer education material repository could be useful. However, it is questionable as to whether it is feasible or within the Board's charter to provide education services.

One of the guiding principles for the Board is to protect the welfare of the public. As such the Board may be able to justify operating an independent site to inform consumers of their rights as regards cosmetic medical and surgery services. This could include:

- Fostering a greater understanding of what constitutes informed consent.
- Highlighting the need for consumers to satisfy themselves they have taken adequate time to digest information presented by registered medical practitioner.
- Stressing the need for consumers to fully understand the risks and benefits of proposed procedures, as well as expectations they should have of their cosmetic medical practitioners and their quality of practice.

- Addressing what is seen as significant source of information asymmetry in the provision of cosmetic medical and surgical services, that being an explanation to the consumer as to the meaning of different qualifications and titles and the implications these have for training, experience, skills and credentials.

Such information will empower consumers to make their own informed decisions as to whether they believe their registered cosmetic medical practitioner is sufficiently qualified to undertake their particular procedure. This point was made abundantly clear by the young lady featured in the radio national piece who did not know the difference between cosmetic surgeon and plastic surgeon.

QUESTION 14. Who do you think is best placed to design consumer education material about cosmetic medical and surgical procedures provided by medical practitioners?

For consumer education material about cosmetic medical and surgical procedures to be meaningful and impartial it must be designed by registered medical practitioners who hold independent respected academic posts, are experienced in education and have no commercial conflict of interest.

QUESTION 15. Who should pay for the development of consumer education material?

Consumer education material would have to be funded by the Medical Board through registration fees and government funding allocation, although, a centralised site providing general information and a consumer charter of rights and expectations of care as discussed above should not be particularly costly.

QUESTION 16. Are there any other costs and benefits associated with providing consumer education material that the Board has not identified?

No

QUESTION 17. The Board seeks feedback on elements for potential inclusion in guidelines:

QUESTION 17.1 - Should there be a mandatory cooling off period for adults considering a cosmetic medical or surgical procedure (other than for minor procedures)? **If so, is seven days reasonable?**

There is no persuasive evidence that a mandatory cooling off period for adults is required or would be effective, and in particular:

- There is no objective evidence the correct cooling off period should be seven days as opposed to a lesser or greater period. In some cases this may not be enough time and in some cases more time is needed. Consumers have a right to make their own decisions. However it will always be the responsibility of the doctor to ensure that informed consent has been obtained prior to treatment. In the event of a complaint or legal action, the doctor will have to defend their actions, irrespective of a cooling off period prescription.

- Basing a significant regulatory impost on anecdotal evidence is extremely dangerous, especially when a failure to comply can carry possible penalties and/or deregistration. A more measured, balanced, proportionate and reasonable response in this circumstance in accordance with the guiding principles of the Paper is recommended.

- Specifying a cooling off period does not ensure informed consent. Informed consent implies a thorough understanding of the proposed procedure, its risks and benefits and other options. From a legal point of view, no prescribed time limit defines this process absolutely.

- How can the Board justify prescribing a cooling off period for cosmetic medical or surgical procedures when a cooling off period is not required for high-risk medical interventions. This shows a lack of consistency, which is the foundation for the protection of the public which is underpinned by the national law. It is already incumbent on the medical practitioner to satisfy themselves that informed consent has been obtained. This includes giving the patient enough time to consider the information presented and make an informed choice. To establish two distinct and separate Codes, with different rules sends mixed messages to the public and creates a very dangerous precedent for general medical practitioners.

- Compliance with a prescriptive explicit guideline does not in and of itself ensure that informed consent has been obtained. Informed consent is the outcome of many and varied pre-operative processes, and it is against this standard that any conduct or performance investigations by the Board should be judged.

- CMATT is of the view that such a prescription may prejudice medico legal remedy on the part of patients suffering poor outcomes from high-risk cosmetic medical and surgical procedures, where the basis of their complaint is “failure to warn”. If the doctor being sued can show compliance with a cooling off period and other prescriptive processes, this may act as a defence and compromise natural justice for the patient.

A more measured and less burdensome response may not impose a mandatory cooling off period, but rather review the outcome of less prescriptive guidelines and obtain actual evidence and data upon which to base regulation, if indeed a problem is identified.

QUESTION 17.2 - Should there be a mandatory cooling off period for patients under the age of 18 who are considering a cosmetic medical or surgical procedure? If so, is three months reasonable?

Again there is no evidence to support the three month period as the right amount of time in order to ensure informed consent. It is agreed that high risk cosmetic surgery provided to patients less than 18 years of age may require special consideration, although the question still has to asked, as to what is a reasonable period.

Again it is important to recognize that informed consent should not a prescribed process, but rather the desired outcome of appropriate preoperative assessment and management. Proceedings against rogue registered medical practitioners performing high-risk cosmetic surgical services should the based on the existence of an actual meaningful informed consent rather than adherence to a prescriptive process as an evidentiary guide. In reality the use of a prescriptive process is the soft option for the regulator.

The assertion that in the absence of prescription, the Medical Board would not have an evidentiary basis for disciplinary action, is not accepted. The guidelines specific informed consent as judged by their peers, which must include appropriate time to consider a decision to proceed with surgery. If there was not a period of time for patients to consider and assess information, the registered medical practitioner will have to justify on what basis they consider informed consent was obtained.

One could foresee the circumstance where guidelines are followed yet informed consent is judged not to have been obtained, just as the signing of a consent form does not automatically constitute informed consent.

With these above comments in mind, it is CMATT's position that a patient's general practitioner should be involved as part of enhanced guidelines and code of practice for patients less than 18 years old accessing high-risk cosmetic surgery. The patient's general practitioner is well placed to provide insights into the appropriateness of such surgery and to advise as to whether they believe their patient has sufficient insight, information and appropriate emotional and psychological health to give informed consent.

In a disciplinary action by the Medical Board, the practitioner will have to justify why a general practitioner was not involved.

Thus a prescriptive cooling off period will not necessarily achieve the desired protection for this potentially vulnerable demographic.

Again a hasten slowly approach is a more proportionate response with data being collected going forwards and regulation further tightened if required by the evidence. Regulation must be based on empirical evidence and not anecdote. Such an evidence based approach is consistent with the guiding principles of our health care system.

QUESTION 17.3, 17.4 and 17.5 –

17.3 - Should medical practitioners be expected to assess patients for indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure?

17.4 - Should medical practitioners be expected to refer these patients to an independent psychologist or psychiatrist for evaluation?

17.5 - Is it reasonable to expect that registered medical practitioners refer all patients under the age of 18 to an independent psychologist or psychiatrist for evaluation before a cosmetic medical or surgical procedure is performed, regardless of whether legislation exists (as it does in Queensland via the Public Health Act 2005)?

These questions will be dealt with in the same response as they are closely aligned.

As indicated in the response to Question One, the registered medical practitioner community providing high-risk cosmetic medical and surgery services is quite heterogeneous from the perspective of training, skills, experience and qualifications. For this reason it is unrealistic to expect that all practitioners in this area possess the relevant skills and clinical insight to enable effective psychological assessment.

Accordingly, it is unrealistic to then expect them to appropriately refer patients for independent psychological and psychiatric evaluation. As noted in the Paper, there are significant risks to good medical care in the provision of high-risk cosmetic surgery resulting from practitioner conflict-of-interest.

Following this logic, there is a disincentive for such practitioners to diagnose psychological issues, as this may result in the consumer not proceeding with the procedure. As such if the Medical Board considers there needs to be a minimum level of psychological health for practitioners to proceed with cosmetic surgery, then this cannot be assessed by the surgeon proposing to perform the procedure.

Therefor the involvement of the patient's usual general practitioner becomes important to ensure a high standard of care. The independent general practitioner will obviously have his or her patient's well-being both physical, emotional and psychological foremost.

Further, such general practitioners are privy to the entire medical history of the patient. Given that cosmetic surgical procedures, can be significant and invasive surgery involving general anaesthesia, it seems natural that a general practitioner with all the patient's medical information at hand should be consulted. If the general practitioner feels that a psychological or psychiatric referral is appropriate, they would arrange for this independent of the cosmetic surgeon. This is what would constitute good medical care and be protective for the public.

Referring all patients for psychological assessment prior to high-risk cosmetic surgery is highly prescriptive and overly burdensome at the very least both to the medical practitioners and consumers. Such prescription may be interpreted by the community as the Medical Board viewing those accessing cosmetic medical and surgical procedures as being psychologically unstable.

Furthermore, this would add an additional high regulatory cost due to added patient burden on already stretched mental health services, possibly impeding psychiatric care for those who truly require, stressing already scare resources.

It should be the responsibility of the registered medical practitioner providing the high-risk cosmetic surgical services to be able to justify to both disciplinary and judicial proceedings that informed consent has been obtained. Enhancing the code of conduct should give very explicit guidance on what constitutes informed consent, focusing particularly on informed consent for patients less than 18 years of age, who constitute a special category of informed consent.

QUESTION 17.6 - Should there be further restrictions for patients under the age of 18 who seek cosmetic medical and surgical procedures?

No

QUESTION 17.7 - Should a medical practitioner be expected to have a face-to-face consultation (in person, not by video conference or similar) with a patient before prescribing schedule 4 prescription only cosmetic injectables? If not, why?

As noted in the Paper, there is no evidence of any significant problem with minor cosmetic medical services including cosmetic injectables. Further there is no evidence that banning video Telehealth would have any protective effect for the public. It is counterproductive to bring in a guideline to protect a service provision for which there is no clearly identified problem

Telehealth is a well-accepted modality to provide clinical care to compliment traditional face-to-face medical service delivery. In fact it is encouraged by the Commonwealth government. There are 22 MBS item numbers for Telehealth consultations which have been in existence since 2011.

These MBS item descriptors provide clear guidance on appropriate Telehealth service provision and give no indication that cosmetic injectables consultation and prescription would not be appropriate for this modality.

"A video consultation will involve a single specialist or consultant physician attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse, aboriginal and Torres Strait Islander health practitioner or aboriginal Health worker at the patient end."

"The specialist or consultant physician must be satisfied that it is clinically appropriate to provide a video consultation to patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist or physician. Telehealth specialist services can be provided to patient when there is no patient end support service provided. "

As in Medicare funded Telehealth, it should be the responsibility of the prescribing registered medical practitioner to satisfy themselves that video consultation is clinically appropriate, as it is for disease based Telehealth consultations. Not all patients are suitable for Telehealth. However, it is suitable for many patients and complements face to face consultations.

If this modality of health care provision is appropriate for severe medical conditions requiring S4 prescription, how is it inappropriate for cosmetic injectables where patients are often quite healthy and much younger than Medicare funded clients?

There is robust evidence that video Telehealth is appropriate for dermatology and psychiatry, the same skill set as required for cosmetic injectables. There could be a significant flow on effect on the general health system if this regulation is introduced into the code of conduct and guidelines. Such a regulation could jeopardise the progress of the introduction Telehealth into the health care system and could set a precedent that would be readily adopted in medico legal proceedings. This in turn would then act as a significant deterrent for doctors to provide much-needed Telehealth consultations to those rural and isolated Australians who do not enjoy the level of health care provision so abundant in urban areas.

All of this would at the expense of the Queensland and NSW Governments extensive investment and development of Telehealth[vii].

Further, a lack of consistency across medical disciplines (which CMATT believes is critical for public protection by the Board as part of national law) may impact on other medical services in our health care system. For example, telephone support given by specialists to hospitals and emergency departments. If it is inappropriate to prescribe cosmetic S4 injectables via video Telehealth how can it be appropriate to give phone S4 prescription orders at 3 AM to a junior emergency department medical officer in need of advice for emergency patient care.

Specialists who provide Telehealth consultations for isolated patients with a medical disease, may also use video teleconsultation to offer a cosmetic injectables service. Such specialist practitioners, who are of course the only truly credentialed practitioners providing cosmetic services, also provide reconstructive and emergency services to hospitals particularly in regional areas.

In these circumstances Telehealth is used to supplement and make more efficient the consulting practice for the specialists. Like specialists providing medical Telehealth, cosmetic injectables consultations via video teleconsultation are used on occasions and are not the only form of service provision used.

For example, a regional plastic surgeon can provide a compliant, effective, safe consultation to a cosmetic injectables patient without having to leave the operating theatre. To do so would cause great inconvenience to surgical service provision at the hospital, for absolutely no increased benefit for the cosmetic injectables patient.

These patients can be fully assessed as to whether they are suitable from a medical, psychological, pregnancy and allergic point of view. Lines wrinkles and skin texture can all be effectively assessed. Facial volume assessment is easily visualised via video link up. A rational and safe management plan can be devised and a prescription with clear instructions provided. This is manifestly compliant and consistent with the expectations of good medical practice.

Further, inhibiting Telehealth is a clear retrograde step as regards innovation in cosmetic service provision for zero gain in terms of patient welfare and outcomes.

Banning Telehealth will inhibit competition, because it will make it very difficult for specialists to be involved in cosmetic injectables practice without compromising their disease based reconstructive practice. This would of course compromise services to the health care system at large. Given the lack of skills qualifications and credentials that pervade cosmetic medical services, it is not in the best interest of the community to exclude specialists from this discipline.

It is the cosmetic general practitioners who provide cosmetic injectables services that are advocating this overly burdensome guideline. They are seeking to exclude the aforementioned specialists from the market. If successful this will significantly lessen competition and provide an opportunity for an increase in charges. It will certainly restrict services to outlying areas, not serviced by such cosmetic general practitioners.

It is difficult to see the connection between this guideline and the regulation of high-risk cosmetic surgery procedures. Cosmetic injectables is a minor procedure by definition and the Paper has not identified any problems in this regard.

Alignment with the United Kingdom is hardly relevant as we live in a vastly different geography, where Telehealth is used to overcome the tyranny of distance. It is an essential tool for the effective practice of registered specialist medical practitioner who provides cosmetic injectables services, particularly in regional areas where cosmetic practice is often combined with disease based reconstructive practice.

Furthermore, any regulation has to be considered in the light of the technology that is available today and the investment that the state and federal governments have made in such technology to achieve this very end.

The Board should be very careful not to jeopardise the progress of Telehealth which represents a very useful innovation to complement health care delivery in our large country as the introduction of NBN sees the move from the analogue age to the digital age. In proposing a restriction on Telehealth, the Board must be seen as being out of step with the expectations and progress of society and Government at large. CMATT is of the view that the Board would have to answer to the public via the media, politically and in court proceedings should such an inconsistent regulation be enacted.

QUESTION 18. Are there other elements not included in the draft guidelines at Attachment B that could be included?

As described above, provision for involvement of the patients usual general practitioner for high-risk cosmetic surgical procedures, especially when proposed for those less than 18 years of age.

QUESTION 19. Do you agree with the costs and benefits associated with guidelines with explicit guidance (option 3) as identified by the Board?

See answer to question 20 below.

QUESTION 20. Are there other costs and benefits associated with guidelines with explicit guidance (option 3) that the Board has not identified?

CMATT does agree with the costs and benefits associated with option three. The scenarios presented are over simplified. For a true cost analysis and economic impact to be assessed, there must be a modelling process using a recognized statistical method such as linear regression analysis to take confounding factors into account.

For example, the Paper does not take into account the fact that mental health professionals may charge greatly inflated fees to assess potential cosmetic surgical patients (perhaps proportional to the fees the patient may be charged for the actual procedure) and the fact that they could be held liable for not detecting subtle conditions that may manifest psychologically or psychiatrically after an unsuccessful outcome from the cosmetic surgery.

Further, there is no assessment of the economic impact to the mental health care system as a consequence of the greatly increased burden resulting from preoperative cosmetic patient assessments. It is clear that this is not possible to accurately assess these amount because of the lack of meaningful data. It clearly is impossible to assess the economic impact of these highly prescriptive guidelines without knowing how many procedures are being conducted. Accordingly, any prescription needs to be delayed until such data is available.

This is the reason CMATT suggests that the prudent course is to hasten slowly by tightening existing guidelines and code of conduct documents without being highly prescriptive when there is no evidence to base this prescriptive regulation on. Data should be collected rigorously going forwards and there is evidence should inform future regulatory modifications at the Medical Board level.

QUESTION 21. Would the benefits of guidelines with explicit guidance (option 3) outweigh the costs, or vice versa?

CMATT submits that the costs would outweigh the benefits of the overly prescriptive option three, mainly because these costs have not, and at present cannot, be accurately assessed.

CONSULTATION QUESTIONS

QUESTION 22. Do you agree with the costs and benefits associated with guidelines which are less explicit (option 4) as identified by the Board?

See answer in question 24 below.

QUESTION 23. Are there other costs and benefits associated with guidelines which are less explicit (option 4) that the Board has not identified?

See answer in question 24 below.

QUESTION 24. Would the benefits of guidelines which are less explicit (option 4) outweigh the costs, or vice versa?

CMATT submits that option 4 is the most reasonable, measured and balanced approach to tightening guidelines and coded conduct provisions for high-risk cosmetic medical and surgical procedures. It recognises that there is scant evidence to support the more explicit prescription of option three, and that without accurate data the outcome or effect of heightened regulation may not be as predicted.

Option 4 recognises that whilst data is lacking, it is conceivable that a problem may well exist or come to exist in the future as a result of the growth and normalisation of cosmetic medical and surgical services. As alluded to in Question one, there are a number of reasons for this not the least of which is the variable training and skills of registered medical practitioners providing highly complex surgical interventions.

If option 4 were to be implemented, the code could be tightened by including a guideline to involve the patient's usual general medical practitioner for the provision of high-risk cosmetic surgery and in particular when patients are less than 18 years of age. This approach is consistent with best practice medical care globally, and provide independent patient centric General medical information, history and psychological background with appropriate referral as indicated by evidence. This would remove the burden from cosmetic medical practitioners, from consumers who have no psychological contra indication to high cosmetic surgery and prevent an increased burden on mental health care services which are already stretched to the limit.

By prescribing in detail what the Board considers appropriate for true informed consent, including an overly prescriptive cooling off period the Board may not in the end achieve the goal of true informed consent and fail to discharge its duty of care to the public

The Board is obliged to provide an evidence based approach to the regulation of medical services and this can be achieved by collecting independent meaningful data and commissioning rigorous evidence based research. If the data suggests that option 4 is not having the desired effect, then regulation can be strengthened with greater prescriptive features guidelines and code of conduct.

QUESTION 25. The Board seeks feedback on the cost estimates and assumptions underlying the consumer scenarios.

CMATT considers that the cost estimates and assumptions underlying the consumer scenarios as presented in attachment C of the Paper are inaccurate in relation to option 3, because:

- mental health professionals are likely to charge cosmetic patients above standard fees due to the high fees charged by surgical colleagues, they will have a captured market and a high-risk exposure

- The cost of increased demand on the mental health care system from cosmetic pre-operative evaluations. This will mean decreased access to services for patients with psychiatric or psychological diseases and disorders. There will be a flow on effect to economic productivity for such patients and society as a whole.

QUESTION 26. Are there other options that the Board has not identified?

No

QUESTION 27. Which option do you think best addresses the problem of consumers making rushed decisions to have cosmetic procedures without adequate information?

There has no evidence produced by the Board to suggest that there is a problem of consumers making a rushed decision to have a cosmetic procedure.

In the absence of objective proof of a problem, then intervention cannot be justified. However, by adopting Option 4 the Board can adopt a moderate and balanced approach, which van be tightened if subsequent data collection indicates that option 4 is not successful.

CONCLUSION and COMMENTS

It is CMATT's opinion that the Paper demonstrates a flawed understanding of the current environment surrounding the provision of cosmetic medical and surgical services by registered medical practitioners. The Paper ask questions which assume a problem that the Board admits it is based largely on scant anecdotal data and evidence. The Paper proposes a preferred option (Option 3) based on what it admits is inadequate data and even calls for further evidence of a problem. CMATT is of the view that this is putting the "cart before the horse", by proposing a solution before it is established a problem exists and the exact nature of such a problem.

This leaves the review process open to criticism that political self-interest groups may be distorting this reform agenda and thus compromising the principles of transparency and fairness which are enshrined in principles of best practice regulation and underpinned by national law.

Furthermore the questions generally treat minor cosmetic procedures and cosmetic surgical procedures as being one and the same. Most responses will be directed at certain acknowledged problems with cosmetic surgical procedures and the Board has to be very careful not to use such responses as a justification for regulating minor cosmetic procedures in the absence of hard empirical date and relevant responses. This is neither fair nor transparent.

The Paper alludes to a consultation process with stakeholder groups as one means of collecting the information that formed the basis of the 4 options. Such stakeholder groups are not identified in the Paper and in the absence of such disclosure, it is easy to be cynical regarding the motives of some stakeholders, especially as the Paper makes express reference to the opinions and policies from the Australian Society of Plastic Surgeons, Australian College of Cosmetic Surgeons and the CPSA. All these bodies or groups are professional self interest groups and it would be helpful to know if independent stakeholders and consumer groups were consulted as well, to ensure that a balanced view was presented. Again, such an approach would be consistent with fairness, transparency and best practice regulation.

The Paper makes note of the competitive market for cosmetic medical services. The fact that there has been an attempt to link an actual or potential problem with high-risk cosmetic surgical services with the use of Telehealth for the prescription of low-risk cosmetic injectables, certainly gives the impression of attempts to restrict competition and innovation in an area, where there is no identified problem or risk.

Commercially, there is no better way to limit competition than to lobby for regulation, which then justifies anticompetitive behaviour without running the risk of ACCC intervention. However, CMATT is of the view that such regulation would not preclude an investigation by the ACCC. An adverse finding by the ACCC would arguably compromise the public's confidence in the Board.

There would be a clear lack of regulatory consistency (and very mixed professional messages) to promote Telehealth as acceptable for certain medical treatments and not for others. To seek to restrict consultations for S4 cosmetic injectables prescription to only in person face to face consultations (Video Telehealth is in fact by definition face to face) is in our view inconsistent with the Paper's position regarding the importance of national consistency as a key public protection mechanism under national law.

CMATT is of the opinion that there must be regulatory consistency across service delivery in all medical disciplines, all governmental health care administrative jurisdictions, as well geography. To regulate that Telehealth as appropriate for some complicated conditions and not appropriate for less complicated conditions such as cosmetic injectables, would have a significant adverse impact on public confidence in the integrity of their health care system.

To recommend any restriction of Telehealth is highly inconsistent with the fact that we are now in the digital age. All advanced jurisdictions are embracing this new age and this is consistent with the expectations of the community. CMATT is of the view that the Board should strive to be in-step with expectations of society.

The negative impacts of seeking to restrict Telehealth are only heighted when is no empirical data evidencing a problem that can justify the restriction. The only evidence would appear to be the opinion of professional groups who have a clear conflict of interest, leaving a perception that politics and commercial interest are interfering in the regulatory decision making process.

A transparent approach to regulatory reform would acknowledge the potential for bias in such a consultation process and undertake to confirm or deny claims by prospective data collection and robust analysis, while minimising unjustifiable regulatory interference.

Accordingly, in the interim, by providing a reasonable and balanced response the Board can discharge its duty of care to public safety without stifling innovation and competition and accordingly the only present acceptable course of action is Option 4.

Option 4 emphasises that the Board takes potential conflicts of interest and the quality of medical practice in the provision of high-risk cosmetic medical and surgical services very seriously, and gives the practitioners in this area a reasonable amount of time to react, modify their practice and comply with the principles of the current code of good medical practice assisted by the supplementary guidelines, given that this group is constituted by practitioners with variable training and vocational education backgrounds and hence professional values.

Yet, as the Paper confirms, these doctors perform high-risk, highly invasive surgeries in often non accredited clinic environments that can have adverse life changing repercussions. These practitioners will know they are under scrutiny in terms of their processes and outcomes.

If the professional behaviour of registered medical practitioners providing cosmetic medical and surgical services is still not acceptable, further regulatory tightening could then be enacted, using data and not anecdote to drive the process.

Supplementary guidelines to the code should focus on emphasising that registered medical practitioners must attain a meaningful and effective informed consent before proceeding with cosmetic service provision. This is consistent with legislation underpinning medico legal actions by patients against doctors where negligence is alleged.

This means the provision of unbiased information (including other non-medical options) and sufficient time in which to assess such information. It should be further emphasised that this requirement will open to intense scrutiny and in particular for patients of less than 18 years of age, who constitute a potentially vulnerable segment of the community, where extreme caution and diligence is mandatory.

Further, the strict enforcement of laws surrounding cosmetic medicine advertising is critical to ensure the public have realistic expectations for the outcomes of cosmetic surgery and to encourage compliance amongst all registered medical practitioners providing cosmetic medical and surgery services.

As such, all practitioners need to be at the ready to justify their professional decisions and actions or face disciplinary and or medico legal action for unprofessional behaviour and in particular if it is deemed that informed consent has not been obtained.

It is submitted that Option 4 is the only reasonable initial response if best practice is to be followed for regulatory reform as it presents the lowest cost to benefit ratio.

If after proper and informed independent research a problem is identified then root-cause analysis should be instigated to find its true aetiology. For example it may be found that the major root cause of poor outcomes from high-risk cosmetic medical and surgical services arises from inadequate skills, training, surgical location and aftercare, with cooling off period issues and psychological aberration only as minor contributors.

The use of Telehealth for cosmetic injectables consultation may be found to be an invaluable adjunct, promoting high quality of care and good medical practice. Without data the true picture is unclear and open to manipulation for commercial reasons. CMATT is of the opinion that there is a high likelihood that this may be the case.

In such a scenario, the reforms suggested in option 3, which have a higher cost to benefit ratio compared to option 4, would not be successful in further protecting the public. It would be a very disappointing policy initiative from the Board, if creating extra costs and regulatory interference failed to deliver better outcomes.

CMATT believes there is a ground swell of public opinion for appropriate credentialing of registered medical practitioners providing high-risk cosmetic surgery. This was clearly demonstrated by the content of the ABC radio national piece recently aired and supported by comments from Professor Walton and Dr Flynn.