SUBMISSION TO THE AHPRA/MEDICAL BOARD ON NEW COSMETIC SURGERY GUIDELINES

Background

I am a medical practitioner who has practised in the area of cosmetic and aesthetic medicine since 1989. Prior to that time I worked as a general practitioner. I have been in fulltime aesthetic and cosmetic medical practice for more than 15 years. During all of this period I have been self-employed.

Over the period 1989 to 2015, there has been a massive explosion in the treatments, procedures and machines available for treatments. There has also been a growing acceptance of cosmetic treatments by most sections of society. Aesthetic treatments are no longer viewed as the exclusive domain of the 'rich and famous'. I believe there has been a concomitant decrease in the perception by both practitioners and patients/clients of the potential adverse or down side of such treatments.

Treatments

I perform many treatments, including laser for many different vascular and pigmented lesions, ablative laser treatments, compression and microsclerotherapy, chemical peels, muscle relaxing injections and dermal fillers. I also do general skin checks and minor excision work.

All my treatments, plans and procedures are based on a medical model of assessment and treatment in consultation with the patient. I do not call them clients but rather patients as that is how I view them. I also employ registered nurses under my direct supervision both for laser treatments and aesthetic injections. These nurses are closely supervised and treatment plans are approved by me.

All of these treatments are performed at the one location which is my clinic. The clinic has appropriate facilities for sharps and soiled material disposal. There is also resuscitation equipment in case of the extremely rare event of a medical event.

Training

My own training in this area of medicine was somewhat ad hoc, as the entire area was very new to medicine. At that time, essentially I sourced a practitioner who was known to be competent in a particular technique or in the use of a specific machine and would spend time with them at their clinic. Early on, this often meant travelling interstate or overseas. Knowledge was also gained at conferences and from colleagues.

Since then specific training courses and qualifications have been developed. However as the consultation documents from AHPRA indicate, these are not compulsory or even recommended by any regulatory authority except under the Board's code of conduct *Good medical practice.* As with most things in life the 'good' practitioners abide by these guidelines and the 'not so good' practitioners do not and there are no penalties for them.

Training opportunities have also bloomed in more recent history, especially with many of the industry offering training courses. The companies associated with dermal fillers and muscle relaxants have been especially active. Of course this is not completely altruistic on their behalf, but perhaps more with an eye to the bottom line. Nevertheless, they do provide a learning pathway for the new practitioner.

Over the last 10-15 years I have been involved with many of these companies in providing training to newcomers and advanced users. I did this in the belief that well trained practitioners would enhance the outcomes for patients and the general reputation of this sector. More recently I have become disillusioned with some of the practitioners and supervisors and their standards of ethics and practice. The focus seems to be away from good and safe outcomes to results driven by greed and empire building.

Professional groups

Since I commenced in the cosmetic medical area, several societies and colleges have developed. The Cosmetic Physicians Society of Australasia was started in about 1995 and is now transforming to the Cosmetic Physicians College of Australasia. I was a member until recently and have reapplied to join the new college. The Australasian College of Cosmetic Surgery opened membership to cosmetic medical practitioners in 2002. I was 'grandfathered' into this College as a fellow after passing an exam in 2002. More recently the Australasian College of Aesthetic Medicine has been formed and I am a fellow of this college. There has also been an Australasian College of Phlebology formed in 1993 and I am a fellow of this college.

Concerns

I have been listening to the general talk around me at various meetings, training sessions and conferences over recent years and I have to say I am appalled at some of the comments I hear, especially about the biochemistry and characteristics of various products.

The other area that concerns me is anatomy especially of the face. Some of the comments I hear demonstrate a complete lack of knowledge about the anatomy. Obviously this is not from every practitioner but there seems to be a prevailing attitude that aesthetic injecting is a bit of fun and makes everybody feel good. There appears to be very little understanding of potential side effects and adverse outcomes.

My very strong opinion is that no practitioner should undertake any procedure where they cannot treat every possible problem themselves, or are in a clinic with another practitioner on the actual premises who can treat these problems.

For example, one of the most devastating potential problems that can occur is occlusion of a major blood vessel in the treatment area, either by direct injection or pressure from injected product. This is an emergency as the risk of skin necrosis in the affected area is high. The risk of such a disastrous result can be minimised by an immediate injection of hyaluronidase into the area with the idea of dissolving the product. This needs to be done as soon as possible. I believe that many clinics do not stock supplies of hyaluronidase as it is too expensive and 'the staff don't know how to use it'. I would contend that this is a completely untenable situation and very poor practice. The cost of the hyaluronidase is high but much less than any potential legal action, not to mention the ongoing problems for the patient.

There are other occasions when a prescription for antibiotics may be needed. Rarely some sensitivity or allergic reactions can occur that respond to a short burst of oral corticosteroids for which a prescription is needed. Such treatments will be delayed if the prescribing doctor is not on the premises.

Overall, the cosmetic medical industry has moved too far away from providing treatment based on a proper medical model of history, examination, assessment and appropriate treatment. It has become viewed more as fun and easy with few if any consequences. Realistic benefits and serious side effects are not always discussed with the patients. I am concerned that some patients may suffer serious adverse effects due to less well trained practitioners without adequate backup treating them. I am certainly not condemning all nurse practitioners. There are many excellent well qualified and safe nurse injectors and on the other hand some medical practitioners who are neither.

Option 3- Strengthen current guidelines for medical practitioners providing cosmetic medical and surgical procedures through new, practice- specific guidelines that clearly articulate the Board's expectations of medical practitioners

I support option 3 over the other proposals from the medical board. I genuinely feel that this industry has spiralled out of control and that only firm, legislated procedures and expectations will help to rein it in. This is not said from a perspective of 'protecting my patch' but from a concern about potential serious outcomes and side effects for patients. The current guidelines of *Good medical practice* are being ignored by some unscrupulous and greedy practitioners. Hence, I feel that very specific guidelines must be spelled out and that the regulations and requirements must be very specific. Some of this sector has already demonstrated a willingness to stretch and circumvent the present regulations with impunity.

The other area that should be addressed is that of consumer education. As stated in the consultation papers this is patchy at best. I certainly feel that a uniform approach to patient education would benefit all. This education should stress the importance of finding out about the practitioner who has been selected. Patients need to ask their practitioner about their qualifications and ability to perform that procedure. They also need to understand it is alright to obtain information and costings and then have a cooling off period to process this information.

One of the issues is matching patient expectations to achievable, reasonable outcomes. The current mismatch in these two can lead to unhappy patients and the observed increase in medical litigation. In my clinic the plan is to under promise and over deliver whenever possible.

Follow-up by the practitioner who actually performed the procedure is vitally important. There needs to be explicit guidelines particularly for practitioners who fly-in and fly-out. This type of approach can lead to serious deficiencies in post-treatment care.

Consideration of penalties may be required for practitioners who are involved in so-called “Botox” parties and similar events that are performed in an atmosphere not conducive to informed consent and appropriate standards of medical practice

Oversight of Regulations

It is very important that any new requirements for the cosmetic medical and surgical practitioners are seen to be and are backed by a framework that includes consequences. One of the issues has been a perceived lack of follow up by both AHPRA and the TGA after issues are reported. This is almost certainly due to a lack of funding and staff but there is no point in tightening these regulations as proposed if no follow up on reports is possible.

It would also help if there could be a clearly defined protocol or pathway for those reporting concerns to APHRA. Currently such concerns when reported seem to disappear into a black hole. This can be frustrating and may lead to reports not being made.

CONSULTATION QUESTIONS

17.1 A mandatory cooling off period for adults of 7 days is appropriate except for minor procedures.

17.2 A three month cooling off period for patients younger than 18 is also appropriate.

17.3 Medical practitioners should perform a consultation themselves for long enough to assess the patient's mental state. Obviously such practitioners are not psychiatrists but if any red flags are raised during the consultation then further assessment would be needed.

17.4 If the practitioner is significantly concerned then an independent psychological evaluation should be obtained. Performing any procedure on a patient with body dysmorphic disorder for example is a complete disaster for the patient and the practitioner as well.

17.5 Referral of all patients under 18 for a psychological assessment may be too difficult. However it is prudent with young patients to take time and include their parent or guardian in the process. A mandatory 3 month cooling off period may mean that the family rethinks the need for the procedure.

17.6 In my opinion there are very few situations that require a cosmetic medical or surgical procedure in someone under 18. This is except for congenital abnormalities and injuries from trauma.

17.7 My very strong belief is that all consultations about cosmetic medical and surgical procedures must be performed in a face to face setting. This includes consultations about the prescription of S4 injectables by supervising doctors. In my opinion consultations via

Skype or any similar system are not appropriate. It is impossible to accurately and effectively assess a face, neck or décolletage via Skype. A good consultation involves sitting adjacent to the patient with a mirror and pointing to the particular area under discussion and demonstrating the predicted outcome of a particular treatment or procedure. This is absolutely impossible to do from a remote location via Skype. In my view no patient should receive a treatment with any S4 injectable without a thorough initial consultation by the prescribing doctor.

The stumbling block is for remote and rural patients for whom Skype has previously been used. I still believe that a yearly face to face consultation is necessary for these patients. I appreciate this may be an imposition for these patients but they have to travel for other medical treatments and these treatments will just have to be the same.

Cosmetic medical treatments do not have a foolproof 'recipe' that can be used for every patient. Each patient must be assessed on their merits. The other factor is that the needs for any particular patient will change over time as they age and so constant reassessment is needed.

18 I am not aware of any other elements.

19 I agree with the costs and benefits as identified by the Board.

20 I have no information about other costs.

21 I believe the benefits outweigh the costs. Almost all of these procedures and operation are elective. If there is a small cost increase for the patient then that should just be factored in to the overall cost. If any patient cannot afford these increased costs then they probably cannot afford the actual treatment.

Lasers and light sources

I understand that the regulation of these devices is under the jurisdiction of ARPANSA. I presented a submission to ARPANSA in approximately 2003 on behalf of the then Cosmetic Physicians Society of Australasia regarding the regulation of Class 4 lasers and particularly Intense Pulsed Light (intense pulsed light) devices. The IPL machines do not appear to be regulated at all. They have been sold and marketed very well and extensively especially to the beauty therapy sector. I regularly see patients with adverse outcomes from IPL treatments. Many practitioners in this sector have minimal training and very little understanding of how these devices work and most particularly the damage they may cause. Little attention is paid to eye protection and safety by many IPL users and there may be significant consequences later on.

Another area that seems to be uncontrolled is the second hand sale and disposal of Class 4 medical lasers. Such lasers regularly appear at Beauty therapy clinics without any known provenance.

My understanding is that the current president of the Cosmetic Physicians of Australasia, Dr Gabi Caswell is currently in discussion with ARPANSA on this issue.

Summary

In summary I support the proposed option 3. This is from the perspective of a medical practitioner who performs cosmetic medical procedures but not cosmetic surgical procedures.

The climate within cosmetic medical practices has changed over recent years and the patient is not always the prime focus. I believe this is wrong and that this type of medicine needs to refocus on the patient. We need to provide these patients with an exceptional level

of assessment and appropriate treatments on a background of education and informed consent (including financial). Patients expect and should receive their treatments from appropriately qualified practitioners in a safe environment with first class post treatment care. Any less than this will further damage the reputation of cosmetic medicine and surgery and prolong the rates of litigation.

For treatments involving S4 injectables it should be mandatory for face to face consultations to be performed by the prescribing doctors if the treatments are to be performed by nurse practitioners.

If the consulting committee of AHPRA would like any further information about this submission I am more than willing to help.

As an “elder statesperson” of the sector I have a long term perspective on this sector and am happy to help improve it as much as possible.

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