Australia & New Zealand Rhinologic Society

28TH May 2015

The Executive Officer, Medical
Medical Board of Australia
AHPRA
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Dear Executive Officer,

**SUBMISSION TO PUBLIC CONSULTATION: REGISTERED MEDICAL PRACTITIONERS WHO PROVIDE COSMETIC MEDICAL AND SURGICAL PROCEDURES**

The Australian and New Zealand Rhinologic Society (ANZRS) represents a group of specialists of mainly otolaryngologic and plastic surgical training that care for patients with disorders of the nose and sinuses. A main service provided by our members is rhinoplastic surgery. Although rhinoplasty is often performed as a purely cosmetic procedure, in our subspecialty it is also commonly performed for functional improvement in nasal breathing. The goal of many rhinoplasties performed by our members is therefore both function and cosmesis. The ANZRS represents a large group of surgeons who perform rhinoplastic surgery and we are therefore an important stakeholder in this consultative and regulatory process.

***Responses to Consultation Questions***

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

The Australian and New Zealand Rhinologic Society believe that perspectives put forward in the consultative document represent reasonable concerns but there are some discrepancies between the reality of clinical practice and the third party perspectives that are put forward in the paper.

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?**

Although there may be individuals who have expressed concern regarding this, we believe that this problem is grossly overstated. Potentially more than any other surgical service sought by patients from our members, patients frequently seek their own information via the internet and personal recommendation, obtain frequent second opinions and therefore thoroughly research and perform due diligence on their prospective surgeon and recommended procedure. Unfortunately, procedures required for more serious health concerns (such as cancer) are less likely to be scrutinized by patients and more likely to suffer from this problem. The general practitioner may actually have a

small number of patients who have undergone rhinoplasty and may therefore not be an ideal position to provide accurate information about the outcomes or reputation of providers of cosmetic services beyond what is available to patients through other means (web forums, personal recommendation etc).

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

There is enormous wealth of information on rhinoplasty and cosmetic procedures available from US, UK and Australia sources. Although some is of poor quality, some excellent evidence based documents have been provided by local (and international) societies, such ASPS (Australasian Society of Plastic Surgeons) and ASOHNS (Australian Society of Otolaryngology Head & Neck Surgeons). There are patient and internet forums that provide a very candid commentary of patient experience from both cosmetic procedures in general and from particular surgeons. This information is all separate from that provided by industry, surgeon websites, and sponsored sites.

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

We agree with this 100%. Whilst patients and the public are not naïve, the use of the term 'surgeon' should be limited to those with formal surgical training and the term "cosmetic surgeon" continues to be used by medical practitioners who are not Fellows of the royal Australasian College of Surgeons. Other descriptions are very variable. The term "Facial Plastic Surgeon", for instance, is an example of a sub-specialty shared by otolaryngology and plastic surgery. In the USA, this group consists of 50/50 split of training background between the two groups. Attempts to restrict titles and qualification beyond broad terms is more like to reflect internal politics between specialty groups rather than consumer ambiguity yet we would take the opinion that the term "surgeon" should be restricted to individuals with an FRACS. ASOHNS trains and examines surgeons in facial plastics and therefore provides quality control which can be reassuring to patients. Other cosmetic surgeons do not have the same training and quality control measures AT ENTRY into practice.

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?**

Credit and finance is easily available to consumers. While the offer of finance at the point-of-care location for patients may appear as an ethical dilemma, and is not encouraged by the ANZRS, it is commonly provided when purchasing other goods and services in Society. We agree there is a conflict of interest if a surgeon derives commission or other benefit for such financial services and we would support legislation to outlaw such practice. Our clinical experience is that patients are very price sensitive with regards to cosmetic procedures (and more so than more serious health interventions).

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

Members of the ANZRS are acutely aware of the need for careful decision making and risk-benefit judgements that are required for cosmetic procedures. The lower risk to benefit ratio is already acknowledged by both surgeon and patient. The informed consent process is usually even more involved than that for conditions where the natural history of the disease makes the decision of moving forward easier to define.

However, scope has to be made for the varied expectations of outcome that will be provided by surgeons and the varied outcomes ('successful procedures) that are expected from patients. In some circumstances, success as defined by surgeon, patient, colleagues, family and third parties can all differ. This is the nature of cosmetic interventions.

With that proviso, our members are not experiencing high number of complaints from these procedures. Complaints continue to be made where poor clinical decision making for implementing

surgical services is associated with significant harm and not simply a 'less than perfect' or 'undesired' outcome.

There is increased risk for non-RACs surgeons in terms of increased litigation in this field and higher indemnity premiums.

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?**

The ANZRS is not aware of other data that supports the claims made by this consultation document.

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?**

Cosmetic surgeons seem to have many more breaches in terms of unethical advertising on web-sites etc.

***Option 1***

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?**

Yes. RACS has CPD requirements whereas cosmetic "surgeons" do not and cosmetic specific CPD might be appropriate for non-RACS cosmetic doctors

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

The current codes and guidelines cover these areas adequately

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

The ANZRS believe that the current status quo, for the most part, is adequate in ensuring patient safety with respect to FRACS-trained surgeons. We cannot comment on the need for this within non-FRACS practitioners.

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

Apart from avoiding the obvious cost of regulation – that might be ineffective and become a tool with biased political/lobby group pressures – no.

***Option 2***

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?**

This is challenging as any information would need to be kept entirely separate and independent with substantial cost. ASOHNS has constructed its own documents on rhinoplasty and the use of such brochures is to be recommended.
Potentially, it might be more appropriate to have consumers directed to large societies and governing bodies rather than individual surgeons, institutions or industry sites.

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

A combined effort from all RACS qualified and non-RACS cosmetic practitioners. It would need to be impartial with contribution as there are many 'non-RACS' qualified cosmetic physicians that provide excellent services and despite traditional RACS group reluctant to have them participate, their involvement is important and required.

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

The consumer.

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

n/a

***Option3***

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

**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?**

The ANZRS is supportive of "A key element of consent is ensuring that the consumer has 'time to reflect, before and after they make a decision, especially if the information is complex or (it) involves significant risks.'57 A two stage consent process, where the patient has a 'cooling off period' after their initial consultation with the medical practitioner, encourages a period of reflection during which the patient 'has the opportunity to consider the full implications' of the proposed procedure" and this essentially reflects common practice but a 'defined' cooling off period is neither data driven nor likely to be of value in consumer protection and safety.

**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?**

As above but no defined period

**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?**

No – as this becomes a judgement of many shades of grey. Mental health states (whether DSM defined or not) are not black and white conditions and the ability to define traits and predispositions makes this very hard to implement. Perhaps, where a psychiatrist is already involved then consultation with the psychiatrist might be appropriate, but it will still be the consumer/patient who has to declare this mental health background. It should remain the discretion of the medical practitioner.

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

No – for the reasons stated above. Additionally, some patients are not forthcoming with background history or information and to hold the medical practitioner to such a standard would be unreasonable.

**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*)?**

No - It should remain the discretion of the medical practitioner.

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

No - It should remain the discretion of the medical practitioner and the autonomy of the patient.

**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?**

No - It should remain the discretion of the medical practitioner. But appropriate records on treated patients and their health status is required.

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

No

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

No

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

Costs of enforcement?

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

The costs would outweigh any added protection to consumers/patients

***Option 4***

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

No – as per 17.1 – 17.1

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

N/A

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

Costs outweigh additional consumer protection

***Preferred Option from the Regulatory Impact Statement: Option 1 with some elements of Option 2***

Sincerely,

Prof Richard Harvey MBBS PhD FRACS
Secretary
Prof Simon Carney MD, FRACS
President