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20 April 2015

Dr Joanna Flynn AM
Chair, Medical Board of Australia
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MELBOURNE VIC 3000

By email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn

MBA Public Cosultation & RIS – Cosmetic medical and surgical procedures provided by medical practitioners

Thank you for your email of 17 March, giving the College an opportunity to comment on the public consultation paper regarding cosmetic medical and surgical procedures provided by medical practitioners.

Attached please find a submission from the College.

If you require any further information or clarification, please do not hesitate to contact us.

Yours sincerely

Stephen Shumack, OAM, FACD, FAICD
President

'Registered medical practitioners who provide cosmetic medical and surgical procedures' – consultation and stakeholder (ACD) response

Overview

The Medical Board of Australia (MBA) has requested feedback on the best way to protect consumers seeking cosmetic medical and surgical procedures provided by medical practitioners. The MBA initiative to further this agenda is based on (1) better patient education and informed consent and (2) adhering to a proposed set of guidelines. Of the 4 listed options, the MBA has a stated preference for option 3 as this is likely to have the most desired impact without excessive costs (time, money, resources) to stakeholder.

While the ACD broadly agrees with the general principles of the discussion paper and supports attempts to improve patient experience and outcome relating to cosmetic procedures, we have several concerns and reservations: (1) definition of a 'cosmetic services', (2) the lack of procedural stratification, (3) potential reach of this initiative, and (4) other areas requiring clarification.

(1) Definition of 'cosmetic services'

Background

The Australian Health Ministers' Advisory Council (Cosmetic medical and surgical procedures – a national framework, Final Report, Australian Health Ministers' Advisory Council, Australian Health Ministers' Conference, 2011) proposed the following definitions:

Reconstructive surgery – "being surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease, is not intended to be captured, nor are procedures involved in gender reassignment."

Cosmetic surgery – "Operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem."

The MBS is also currently reviewing and devising an updated definition of 'cosmetic'. The definition will apply across all MBS services and will make clear that the MBS does not provide rebates for non-therapeutic cosmetic services. The process is ongoing but the ACD and most invited stakeholders support the definition proposed by the AMA as listed below:

'Cosmetic service' means an operation, procedure or treatment undertaken for the dominant purpose of improving appearance or improving psychological wellbeing where: (a) there is no disease, deformity, injury or disorder; or (b) the deformity is the result of a normal physiological process of pregnancy or ageing.'

Issues from the ACD perspective

The ACD is concerned that because the skin is inherently a visible organ, much of our core work in dermatology will be inappropriately rendered 'cosmetic' if any associated improvement in appearance is not underpinned by the qualifications of "disease, deformity, injury or disorder". This is an important clarification with which all other stakeholders involved in the MBS review are in agreement.

The ACD therefore strongly reiterates the need for a fair and acceptable definition of 'cosmetic' services by the MBA, which should at a minimum incorporate all procedures and services listed as rebatable by the MBS.

Hence, according to AHMAC and AMA definitions, legitimate medical concerns such as portwine stain and other vascular lesions, pigmented birthmarks, acne and other scars, appendageal tumours and physical deformities such severe eye lid sagging, bat-ears, gynecomastia, macromastia etc will still be appropriately considered 'non-cosmetic' within current accepted definitions, on account of underlying "disease, deformity, injury or disorder".

(2) Procedural stratification

The cosmetic procedures need to be stratified according to degrees of invasiveness ie minor vs major procedures. Many minimally invasive procedures with excellent safety profile need not fall under the blanket recommendations proposed by the Option 3 guidelines as this would add cost, complexity and impose barriers to efficient service delivery. MBA will need to consider stratifying devices into levels of safety and operational complexity to reflect current realities. The type of energy device and its manufacturing quality (eg TGA approved vs 'black-market') has a bearing on procedural outcomes and risks – beyond practitioner/ practice competency and adherence to the proposed guidelines. The ACD will be able to assist with this if required. Examples of these issues will be highlighted in the next section ("Other areas requiring clarification"), of which the responses are framed within the context of minimally invasive procedures, which constitute the majority of cosmetic events.

(3) Potential reach of guidelines

We have some concern that the policy may be 'preaching to the converted' in that doctors performing cosmetic services belonging to specialist Colleges may already have similar guidelines in place. Doctors that do not belong to any affiliated body may well fall outside of the net. Ultimately, the patients that we are trying to protect may still be exposed to these risks because the proposed guidelines do not apply to non-medical cosmetic service providers such as nurses, dentists, beauticians, dermal therapists and salon/ spa owners. Without a much-needed integrated approach, this well-meaning but narrow (medical practitioner only) initiative may have the unintended consequence of driving vulnerable patient/ consumers to the uncharted and unregulated service providers listed above. Taking a wider view, we consider this narrow reach/ scope a major limitation of this initiative. Again, many of the ensuing comments the ACD are framed within the context of minimally invasive procedures, which we believe constitute the majority of cosmetic events.

(4) Other areas requiring clarification (in numerical page order)

Page 5 (footnote)

"[1] You are welcome to supply a PDF file of your feedback in addition to the word (or equivalent) file, however we request that you supply a text or word file. As part of an effort to meet international website accessibility guidelines, AHPRA and National Boards are striving to publish documents in accessible formats (such as word), in addition to PDFs. More information about this is available at www.ahpra.gov.au/About-AHPRA/Accessibility.aspx"

Please clarify that the formal submitted document on the website is in PDF or equivalent NON-EDITABLE format. Perhaps the download version can be PDF or in an editable version such as Word or equivalent.

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"Professional association membership provides an indication of the numbers of medical practitioners who provide cosmetic medical and surgical procedures, although membership is

optional and members can belong to multiple associations (providing they meet the membership criteria). Currently, the Australian Society of Plastic Surgeons has 319 members and 96 trainees and the Australasian Society of Aesthetic Plastic Surgery has 203 members and 10 trainees. Membership of the Australian Society of Plastic Surgeons and the Australasian Society of Aesthetic Plastic Surgery is restricted to medical practitioners who hold a specialist qualification from the Royal Australasian College of Surgeons (RACS). The Australasian College of Cosmetic Surgery has approximately 150 members and the Cosmetic Physicians Society of Australasia has approximately 200 members.7"

The Australasian College of Dermatologists College of Dermatologists teaches Cosmetic Dermatology as part of it's training to all trainees and has approximately 600 Dermatologists and trainees and there is a separate body whose aim is to further train College members and trainees of College with close tires to College and the Skin and Cancer Foundation that is a specific Cosmetic body with 145 members.

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"Cosmetic medical and surgical procedures are surgical operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.2"

This would have to be more spelt out if there was to be legislation as it would prohibit many procedures we currently do to dermatology patients as well as cosmetic ones eg many acne scarring procedures cryotherapy for seborrhoeic keratoses, or lentigines and many more. Please refer to earlier comments in 'Definition of 'cosmetic services' section.

"Other procedures are minor (non-surgical) procedures, that do not involve cutting beneath the skin, but may involve piercing the skin; for example, non-surgical cosmetic varicose vein treatment, laser skin treatments, use of CO2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.4"

"Non-surgical cosmetic varicose vein treatment": Varicose vein is a chronic progressive disease with significant health complications. There are MBS rebatable non-surgical procedures such as ultrasound guided sclerotherapy and endovenous laser/ RF ablation in place. Suggest substituting 'non-surgical cosmetic vein treatment' with 'cosmetic leg vein treatment'.

"Within the wider community, 'cosmetic' procedures are alternately viewed and promoted as medical procedures, beauty treatments and consumer products. This can lead to a vast and potentially confusing array of services and practices that can be invasive and non-invasive, lower-risk and higher-risk, and be accessed from a range of providers, including registered health practitioners."

The MBA will need to remember that it does not control the bulk of this industry such as beauty therapists, dermal therapists and business (salon/ spa) owners are not under MBA jurisdiction. Imposing drastic regulation will likely drive patients to less qualified people not under their control

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"If lasers or IPLs are used for cosmetic purposes, regulation is determined at the state or territory level and comes under a jurisdiction's radiation protection or radiation safety legislation. Only some states and territories regulate these devices."

We would like to see this being a national initiative but only if blanket regulation can be applied to ALL users ie both medical and non-medical practitioners. It would also have to take into consideration the advances in device technology enabling safe operation by non-medical

practitioners eg. hair removing lasers and some fractionated machines. The MBA could be updated probably from the ACD in consultations with other stakeholders as to how to characterize these devices and there are other devices such as cryolipolysis devices, directed ultrasound and radiofrequency devices that are popular and are not IPL or lasers

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"The Australian Health Ministers' Advisory Council's (AHMAC) Inter-jurisdictional Cosmetic Surgery Working Group was tasked with undertaking the review. In its report, *Cosmetic Medical and Surgical Procedures – A National Framework,* the group expressed concerns about the inconsistent nature of regulation in an area of practice with 'rapidly changing technology' and 'burgeoning activity'. The group noted that these medical and surgical procedures 'are not a commodity to be treated lightly – they are medical interventions which carry risks and a complication and failure rate'.16"

All medical procedures carry risks, complications and failure rates. However, there are many minimally invasive procedures that have much lower incidence of doing harm and should not fall under excess control measures.

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The report contained a number of key recommendations directed to the Medical Board about medical practitioners who perform cosmetic medical and surgical procedures

The MBA now covers nurses as well, and nurse practitioners ought to be part of this enquiry/ initiative. They perform many procedures with a degree of uncertainty about their status.

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The GMC has also issued specific guidance for medical practitioners who prescribe cosmetic injectables such as 'Botox'. Medical practitioners are now required to have a face-to-face consultation with a patient before prescribing a cosmetic injectable. Remote prescribing, for example, by phone or video link, is not permitted.25

We would support face-to-face initial consultation but given the wide expanse of Australia, established teleconferencing modalities should be considered a viable alternative to face-to-face consultations, particularly for less invasive procedures or 'minor' procedures (see 'procedural stratification' heading). Routine patient reviews and routine consultations for recurring events fall into this category eg for Botox this would be 3-4 monthly intervals, and if remotely located, may be an unnecessary impost on patients and practitioners. Certainly Botox as a relatively benign procedure, and selected recurrent laser treatments (as part of a prescribed course of treatments) need not require face-to-face medical practitioner consultations. The ACD will be able to assist the Board with this stratification of procedural complexities and associated need for face-to-face and/or alternative (tele-) consultations.

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Health care is characterised by encounters in which the consumer knows less about services and procedures than the provider. This information asymmetry can create a power imbalance which places the consumer at a disadvantage.

When the effect of information asymmetry on the medical market was initially explored, health care was thought of as a non-commercial activity35 and patients' need for medical care was unpredictable.36 Health care has since changed, and some procedures are undertaken by choice, not because of medical need. Cosmetic medical and surgical procedures are entirely elective and are usually initiated and requested by the consumer, which can amplify the information asymmetry.

This may be an outdated statement – the Internet, web sites and social media have possibly reversed this status with most patients very well informed before they even see the doctor or health practitioner.

Consumers usually request cosmetic medical and surgical procedures directly from the medical practitioner providing the procedure, without a referral from a general practitioner. This means that a step that usually helps consumers develop their understanding of their options and the possible risks and benefits is missing. In the NSW report, the committee noted that the absence of general practitioner referral in the cosmetic procedures market exacerbates the information asymmetry between the medical practitioner and the patient.37

Unfortunately most patients will know a lot more than their GPs in this area generally and do we really want every cosmetic patient to burden Medicare and heath system for this?

Surgical procedures are not like other products and services which are repeatedly consumed and where the consumer learns from repeated consumption. Major cosmetic surgical procedures are much less likely to be a regular, repeated purchase and therefore the consumer cannot make these decisions based on experience.39

Once again, we need to stratify the procedures into degrees of invasiveness. Most cosmetic procedures are minor, recurrent treatments and not individual events – I think this is being confused with major procedures eg breast augmentation, face-lifts, that are usually one-offs. However the bulk of cosmetic encounters are minimally invasive and recurrent, and often, over many years.

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Given the information asymmetry, the sometimes unrealistic expectations of consumers, and the commercial relationship between the medical practitioner and the patient, it may be difficult for the medical practitioner to objectively determine the appropriateness of a cosmetic medical or surgical procedure and whether it is in the best interests of the patient. Therefore, there can be an increased risk of exploitation of patients.

Majority of adverse outcomes are not from patient exploitation by the medical practitioner but the result of discordant views on the procedure and its outcome between the 2 parties (medical practitioner and patient).

In Australia, there is limited information for consumers which is comprehensive, independent and reliable and can help consumers understand what to expect when they see a medical practitioner who provides cosmetic medical and surgical procedures.

Agreed. The MBA should encourage Colleges to display such information as most information patients have to rely on is from overseas websites and companies. The ACD have a public forum on the College website with procedural patient information aimed at the layperson written and peer-reviewed by dermatologists (A-Z patient information).

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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.58

Please refer to the procedural stratification section. Something like Botox, or a hair removal test patch, or a laser treatment or a minor treatment in a visiting patient from overseas should obviously not be under the same umbrella as a major procedure such as breast augmentation or abdominal liposuction.

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It should be noted that complaints data are collected differently in different jurisdictions. For example, in Western Australia, the Health and Disability Services Complaints Office cannot accept complaints about surgery or procedures undertaken purely for cosmetic purposes.60 The Victorian Health Services Commissioner and the recently established Office of the Health Ombudsman in Queensland (which replaces the HQCC) both receive complaints about health services provided by both registered and unregistered providers.
It makes a lot of sense for a 'Complaints unit' to receive complaints about services provided by both registered and unregistered practitioners. This is clearly a requirement for subsequent action against rogue providers – both businessmen and companies and medical practitioners. Again this might fall outside of the MBA jurisdiction.

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Option 1
Retain the status quo of providing general guidance about the Board's expectations of medical practitioners providing these procedures via the Board's approved code of conduct
Under this option no action is proposed and effectively the status quo is retained.
Unless we can drive similar changes across the whole industry including nurses, beauty therapists, dermal clinicians and business people none of the 4 options will likely lead to a marked improvement in outcomes and risk management. We are simply not reaching the practitioners that need this framework / support guidelines the most. As a result, option 1 may prove to be ultimately the most sensible option when we factor in effort and likely outcome. The qualification here is in the consideration of minimally invasive procedures. For more invasive procedures, the MBA recommendation of Option 3 is probably justified. Please refer to the 'procedural stratification' and 'potential reach of guidelines' sections.

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Other sections of the guidelines would provide guidance to medical practitioners on training, experience, qualifications and titles, as well as guidance on advertising and financial arrangements with patients.
This would have to be elaborated on a little more as there are concerns the guidelines would be excessive for most procedures but possibly has some good points.

Pages 33-38. Option 3 – Strengthen current guidance for medical practitioners providing cosmetic medical and surgical procedures through new, practice-specific guidelines that clearly articulate the Board's expectations of medical practitioners

Potential benefits for consumers, medical practitioners and the community
Under this option, the guidelines would include a defined cooling off period after the patient's initial consultation, to help ensure that consumers do not feel pressured to make a rushed, potentially inadequately informed decision to have major surgery.
The MBA should consider delineating what procedures fall under this requirement as mentioned earlier. Please refer to the 'procedural stratification' section.

Guidelines approved by the Board would place the onus on the medical practitioner who provides cosmetic medical and surgical procedures to follow the guidance and ensure their practice is consistent with the expectations of the Board.
These may be met much better by those who are already meeting a quality of care and not be looked at quite as closely by those who need to do so. Again it is the chain clinics and the business models they invoke, the personnel they choose to employ, that will escape this approach unless the MBA has some way of bringing these into the fold.

Defining good practice for the management of a patient and post procedure care following a cosmetic procedure would make the medical practitioner's responsibilities explicit and clear, and would ensure that the patient knows what to do if complications arise. This is especially relevant for cosmetic procedures as they are often performed outside a hospital setting. In the cases cited that were subject to coronial investigations, failures of post-procedure follow up by the medical practitioners resulted in death of the patients.

We should be careful that regulation isnot taken from the specific to the general. First liposuction, whilst a procedure with significant adverse reactions, these are rare and it has been found worldwide to be a safe procedure especially when performed with a change of older techniques. On the other hand, we must be careful not to over regulate procedures that do not require this – ie minimally invasive procedures – especially when these procedures are also performed by competitive unregulated non medical practitioners.*

* *Tierney EP, Kouba DJ, Hanke CW. Safety of tumescent and laser-assisted liposuction: review of the literature.J Drugs Dermatol. 2011 Dec;10(12):1363-9.*

National consistency is a key public protection mechanism under the National Law. The benefits to consumers, practitioners, governments, employers, and others of having a nationally consistent approach to providing formal guidance that applies to all medical practitioners undertaking these procedures, mirrors the benefits identified in the RIS for the decision by governments to implement a national registration and accreditation scheme, including:

- no matter where a consumer lives, and no matter where the medical practitioner practices, the same guidance and the same expectations apply; which not only provides clarity and certainty for medical practitioners and consumers but should also preserve and potentially improve consumers' confidence that, if accessing cosmetic medical and surgical procedures from registered medical practitioners, there are clear expectations about good medical practice, and there are protections under the National Law if a practitioner does not fulfil these expectations;

The MBA ought to consider, if appropriate, looking at the State legislature regarding lasers etc as it is not national, and possibly outdated.

Potential impact on consumers

The potential impact on consumers from implementing guidelines is expected to be positive from an onus being placed on medical practitioners to better inform consumers about the nature and risks associated with these procedures and from consumers having ready access to adequate and unbiased information by being able to access guidelines so they can form their own views.100 The impact is also expected to be positive from having greater confidence that there is consistency across Australia in the elements (including for informed consent) that medical practitioners are expected to follow and that these are clear and based on good medical practice so that avoidable poor outcomes are minimised.

The very practitioners these guidelines are designed to impact are also possibly the least likely to abide by them. Need to reach businesses owning clinics with non-Board compliant practitioners.

There would be costs associated with the guidelines under this option, if patients were referred to an independent psychologist or psychiatrist for evaluation if there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure. The aim of this step would be to help ensure that the consumer has thoroughly considered the procedure, their motivation for having the procedure and whether their desired outcome is realistic. It also serves a protective function as the medical practitioner has the opportunity to decline to operate if the procedure is not in the patient's best interests.

This is a major cost and who should pay for this (the patient or the clinic) and what level of procedure would require this? Facial laser hair removal would not require a psychiatric consultation nor Botox for frown lines. Should Medicare really be paying for an opinion about cosmetic procedures, should health insurance companies? On the other hand there is an argument for selected (and arguably even all major surgical procedures) to have patients undergo pre-procedural psychological/ psychiatric assessments.

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 problem is accurately identified but the current focus is on more invasive or major procedures with serious potential adverse outcomes. It is less a problem for the many less invasive or more minor procedures including modern energy based devices (lasers, IPLs and RF/Ultrasound), chemical peeling, needling and botox. However, there is definitely room for improvement.

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?
   Not as a general rule. Most patients have researched their procedure before seeing a doctor. The information out in the Internet should be improved but that would require the MBA and TGA to get together with the medical community to improve this. Current guidelines may be getting in the way of correct information to consumers rather than helping the education process.

3. Is there other evidence that consumers cannot access reliable information or are relying on inaccurate information when making decisions about these procedures?
   Q3 As per Q2

4. Is there evidence that inappropriate use of qualifications and titles by medical practitioners may be misleading for consumers?
   Yes. 'Cosmetic Surgeons' belong to a broad church with some very well credentialed practitioners doing good work. However, practitioners should only be permitted to give degrees associated with an AMC recognized College or University degree rather than a range of credentials and qualifications that are misleading to the public. The use of the term cosmetic surgeon is therefore unhelpful and confusing to the public in terms of actual qualifications.

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?
   If such inducements exist, we would not be in favour of it.

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

Unable to comment on inducement related complaints but a rushed consent induced by the convenience of organized finance without adequately considering associated risk is likely to lead to patient dissatisfaction and regret.

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 MBA should look closely at multi-clinic business growth in Australia. In this environment, the consent process and adequacy of oversight/ follow-ups are in question. However this may fall beyond the MBA jurisdiction, as business people own many of these clinic chains.

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?
   Perhaps not evidence but a modernization is required to come to terms with a rapidly changing landscape. This document needs to accommodate the vastly different risk profiles of different procedures. Please refer to the procedural stratification section.

Option one

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?
   No.

10. How effective are existing professional codes and guidelines in addressing the problem identified by the Board?
    Not overly effective.

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

12. Are there other costs and benefits associated with retaining the status quo that the Board has not identified?
    No.

Option two

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?
    Yes – information needs to be developed by the profession and trade and vetted and approved by the Board. It needs to be disseminated and be a condition on the consent form that the patient has read and understood this.

14. Who do you think is best placed to design consumer education material about cosmetic medical and surgical procedures provided by medical practitioners?
    As per Q13

15. Who should pay for the development of consumer education material?
It should be funded by the Board for the time they take to vet information and the profession for the time and effort to produce the materials. Dissemination should be by downloadable pdf available to the public and profession

16. Are there any other costs and benefits associated with providing consumer education material that the Board has not identified?
Costs to the practice staff for assuring dissemination to patients and costs of altering existing consent forms

Option three

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?
Yes for major procedures only ie those requiring elective GA associated procedures or elective extensive surgical procedures. Seven days is reasonable.

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?
Yes in principle. However need to define this according to procedural stratification and meaningful and appropriate classification of what is 'cosmetic'. Would disfiguring birthmarks (those not covered by medicare) or a simple wart have to wait 3m before treatment for example even with parental consent?

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?
This sounds reasonable but many patients initially come across as normal before therapy. Perhaps a validated screening test may have merit and can be performed by the medical practitioner. Some advocate that for major operations, a professional counselor should screen all the patients, but the practicalities and associated cost may make this recommendation unfeasible.

17.4 Should medical practitioners be expected to refer these patients to an independent psychologist or psychiatrist for evaluation?
It depends on the individual situation. It often works better if the GP is notified about the patient's psychological issues and the referral originating from that end.

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*)?
Again depends on the type procedure (cosmetic definition and the procedural stratification). Major procedures reasonable but not so for minor procedures.

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

The ACD supports a cooling off period – major 3m, minor 1 week and with parental consent if attainable.

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?
The requirement for face-to-face is desirable but need not be mandatory especially for minimally invasive procedures such as Botox, which carries very little long term risk to the patient.

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?
Broadly agree but still uncertain whether the Board has factored in the cost of compliance fully eg the cost of policing this.

20. Are there other costs and benefits associated with guidelines with explicit guidance (option 3) that the Board has not identified?
No
21. Would the benefits of guidelines with explicit guidance (option 3) outweigh the costs, or vice versa?
The effectiveness of the guidelines may not reach the 'right' audience as discussed earlier in the 'potential reach of guidelines' section. It would seem difficult to police the very people the board may wish to bring into line.

Option four

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

23. Are there other costs and benefits associated with guidelines which are less explicit (option 4) that the Board has not identified?
It is hard to know without more detail but it seems minimal.

24. Would the benefits of guidelines which are less explicit (option 4) outweigh the costs, or vice versa?
Very few benefits except for mandating consultation – also very few costs.

Consumer scenarios

25. The Board seeks feedback on the cost estimates and assumptions underlying the consumer scenarios (Attachment C).
Reasonable cost estimates and assumptions.

Other options

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

One would think taking the best out of options 2 and 3 would be wisest. The Board must look at non medical clinics

Preferred option

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

- Option one – Retain the status quo of providing general guidance about the Board's expectations of medical practitioners providing these procedures via the Board's approved code of conduct
- Option two – Provide consumer education material about the provision of cosmetic medical and surgical procedures by medical practitioners
- Option three – Strengthen current guidance for medical practitioners providing cosmetic medical and surgical procedures through new, practice-specific guidelines that clearly articulate the Board's expectations of medical practitioners
- Option four – Strengthen current guidance for medical practitioners providing cosmetic medical and surgical procedures through new, practice-specific guidelines as per option 3 but which provide less explicit guidance to medical practitioners

A blend of Options 2 and 3 might work best.

Option 2 promotes what is missing for consumers – unbiased correct information. At present there are TGA guidelines that get in the way of real information about injectable agents, there is little mention of adverse reactions on web sites and dire warnings that are largely inaccurate elsewhere. There are some good sources of information but they are either overseas or not readily findable to the patient. The ACD will be able to assist with the production of this.

Option 3 in its current format is not a good fit for the diversity of cosmetic services. It is pitched at more invasive and major surgical procedures and does not appropriately cater for less invasive and minor procedures as we have outlined with earlier comments and examples.

Option 4 is better than nothing but is suboptimal.

Other – please specify

This project is mostly pitched at major cosmetic procedures so needs to be tweaked for minimally invasive and minor procedures, which arguably constitutes the bulk of cosmetic procedures. The Board should also consider a national approach to energy based devices and procedures and updating these, and having some way to involve non-medical health providers. The exclusion of other non-medical players in the cosmetic arena is a significant detraction to an otherwise commendable initiative in increasing safety and satisfaction in the patients seeking cosmetic procedures.