MIGA
The Medical Insurance Group

National Free Call
1800 777 156

24 hour emergency advisory service (08) 8238 4444

Facsimile (08) 8238 4445

www.miga.com.au
miga@miga.com.au

Postal
PO Box 1223 Unley DC
South Australia 5061

Our Ref: CSM:LH
Your Ref:

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The Executive Officer, Medical
AHPRA
GPO Box 9958
MELBOURNE VIC 3001

Via E-Mail: medicalboardconsultation@ahpra.gov.au

Dear Sir

Re: Consultation – Cosmetic Medical & Surgical Procedures

Draft Supplementary Guidelines on Cosmetic Medical and Surgical Procedures for Good Medical Practice: A Code of Conduct for Doctors in Australia

Thank you for the opportunity to provide feedback on this document.

Medical Insurance Group Australia is a National provider of medical indemnity insurance to medical practitioners and other clients around Australia. It has a breadth of experience in assisting medical practitioners with legal and ethical issues arising from medical practice. This includes assistance with investigations by the Medical Board of Australia and we endorse the introduction of guidelines to assist medical practitioners in their practice of medicine.

We have considered the draft supplementary guidelines together with the final report entitled 'Cosmetic Medical and Surgical Procedures – A National Framework'.

By and large we endorse the Board's position that further guidance be provided to health practitioners practising in the field of cosmetic medical and surgical procedures (as defined) to assist them with safe medical practice.

MIGA's Risk Management for Cosmetic Health Practitioners

You may be aware that MIGA has a comprehensive risk management program to assist our insured clients with various aspects of health care. We are committed to providing services that assist doctors and businesses manage their risks in medical practice.

Medical Defence Association of South Australia Ltd
ABN 41 007 547 588

Medical Insurance Australia Pty Ltd
ABN 99 092 709 629 – AFSL 255 906

Brisbane
(07) 3025 3259

Melbourne
(03) 9832 0847

Sydney
(02) 9959 2275

Head Office
Level 9, 431-435 King William St
Adelaide, South Australia
(08) 8238 4444

MIGA, in collaboration with the Australian College of Cosmetic Surgery (ACCS) developed the Risk Management Insurance Package (RMIP – Cosmetic) which is an industry leading initiative focused on containing incidents of cosmetic claims. It offers an opportunity for doctors in cosmetic practice to access an insurance arrangement which is directly linked to key risk management initiatives with the aim of improving the claim experience.

The package is offered on the basis that key risk management initiatives will be implemented within each doctor's practice.

Participation requires cosmetic medical practitioners to:

1. Enrol in MIGA's interactive risk management program;
2. Implement a range of formalised risk management material in their practice regarding:

    a. Patient selection
    b. Managing patient's expectations
    c. Consent
    d. Documentation and records
    e. Guide to implementing the risk management materials.

We note that the matters we have targeted in the Package are the matters expanded upon in the Guidelines.

Draft Supplementary Guidelines (the Guidelines)

As a preliminary point, it is apparent that cosmetic medical practice creates a higher risk for medical practitioners because of its purely elective nature where patients are required to fund the costs associated with the treatment out of their own pocket in most cases. Furthermore, as correctly pointed out in the National Framework Report, cosmetic procedures are mostly performed out of patient desire rather than medical justification.

With these preliminary comments in mind we make the following general comments on the guidelines.

Definition of Cosmetic Medical and Surgical Procedures

More thought needs to be given to the definition to avoid situations which create doubt about *"cosmetic procedures"*. There needs to be clarity as to the difference between "medical" and "surgical" procedures. The definition as currently drafted may create uncertainty.

If there is agreement that cosmetic procedures must be outside the parameters of Medicare and private health insurance, there will be greater clarity. However, this will ignore a group of procedures which are commonly considered to be cosmetic.

In relation to adults

> *The first consultation should be with the operating doctor, not with an agent/patient advisor.*

We disagree that the first consultation should be with the operating doctor. Most cosmetic medical practices employ or engage experienced nursing staff suitably trained to assess a patient's expectations and can often be an appropriate filter for the medical practitioner who will ultimately only consult patients that are suitable candidates for cosmetic procedures.

We agree that there should be a comprehensive consultation with the operating doctor at some stage prior to performance of any procedure, with a cooling off period.

If one takes the requirements as set out in point 2 of the supplementary guidelines regarding the assessment of the patient; that is not necessarily a task that is exclusively within the capacity of a medical practitioner to perform. A suitably qualified nurse would be able to adequately, or perhaps more adequately, assess a patient's perceptions and expectations than the medical practitioner. The operating doctor should revisit these matters as part of their comprehensive assessment.

Furthermore, while the medical practitioner should also explain the technical aspects of the procedure and specific risks and potential complications of the procedure with the patient it is often beneficial for someone with whom the patient can relate with to be able to explain, in general terms, the proposed procedure and common risks and complications. The patient may feel more comfortable to ask questions of the nursing staff at first instance rather than the operating doctor no matter how reassuring the operating doctor is.

The nursing staff will often identify patients that may not have realistic expectations or may have other issues that can be brought to the attention of the operating doctor before the doctor consults the patient.

Other than the issue set out above we agree that the operating doctor should consult with the patient prior to the procedure.

In item 4 in our view the words "reasonable time" should be substituted by a specified time frame e.g. one week.

In item 3, is it suggested that this review with feedback from the reviewing practitioner should be completed prior to performance of any procedure? If so then the Guideline should make this clear.

1. In relation to a person under 18 years of age

   - Any guidelines regarding cosmetic, medical and surgical procedures regarding minors should be consistent with legislation. For example in Queensland the *Health Legislation (Restriction on Use of Cosmetic Surgery for Children and other Measure) Amendment Act 2008 [QLD]* regulates the performance of cosmetic treatment on children.

     Section 5 of that Act makes it an offence for any person to perform or offer to perform, a cosmetic procedure on a child unless the person believes, on grounds that are reasonable in the circumstances, that the performance of the procedure is in the best interests of the child. The definition of cosmetic procedure is very broad and would incorporate the definition of cosmetic or medical and surgical procedures as defined in the supplementary guidelines.

- It may also be appropriate to define the term 'medical justification'. A procedure may be medically justified if it will promote the psychological wellbeing of a patient.

  For example, it may be argued that a person with prominent ears that desires a cosmetic procedure to have their ears pinned back and has been the subject of ridicule by his or her peers because of that 'deformity' may benefit psychologically from a cosmetic procedure and it may well therefore be "medically justified".

- In paragraph 1 there is a reference to a period of 3 months. We suggest it might be better to say "period of no less than 3 months".

Post Operative Care

- In relation to the supplementary guidelines about post operative care we agree that cosmetic medical practitioners should have protocols and pathways in place to cover all aspects of post operative care, including the full range of complications and arrangements with specific hospitals and staff to be involved in care should the patient unexpectedly require it. Does the arrangement with specific hospitals include public hospitals where a patient may be directed by the practitioner to attend for further treatment?

- In regards to point 2 of the post operative care guidelines we recommend that further guidance be provided regarding the level of monitoring of patients receiving injectable opiates and use of narcotic medical generally. Would this require a face to face consultation with the medical practitioner in all cases? In our view there needs to be greater clarity in the Guidelines about what and the level of monitoring the Board envisages.

Informed consent

Subject to the comments made at the beginning of this submission about initial consultation, we agree that in advance of performance of the procedure (but not necessarily at the initial consultation), written information should be provided. We agree with the comments made about precisely what information should be provided. This information should also be provided orally and we suggest this should be written into the Guidelines.

In relation to paragraph 1 g) there may be a point in time where a deposit is not refundable. This paragraph should be redrafted to allow this.

In relation to paragraph (i) the word displayed should be defined or expanded upon. Would a flyer dealing with the complaint handling process be sufficient?

Overall we believe that the proposed supplementary guidelines will further promote good risk management and patient care.

We trust that these few comments and suggested amendments are helpful. Please let us know if this response requires any clarification or if we can assist further.

Yours sincerely

Cheryl McDonald
Claims Department Manager
[redacted]

Anthony Mennillo
Senior Claims Solicitor
[redacted]