Australian Society *of* Plastic Surgeons

13 April 2022

ASPS SUBMISSION TO THE AHPRA INDEPENDENT REVIEW OF COSMETIC SURGERY

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?

No, the guidelines do not adequately address the issues relevant to the current and future practice of cosmetic surgery and contribute to safe practice. In these guidelines there is no reference to what the appropriate scope, qualifications, training or experience should be for someone performing cosmetic surgery.

The date of issue of these guidelines was 1 October 2016 and it is noted on the document that the Board will review the guidelines every three years. In October this year, it would have been six years since review. For example there has been significant change in medical practice due to the pandemic (ie telehealth) and the proliferation of non-traditional means of advertising services and recruiting patients.

2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?

Overall, in many statements within the guidelines the word 'should' is used. For some statements 'must' would be more appropriate, otherwise the guidelines are not helpful in managing the behaviour of rogue 'cosmetic surgeons'.

For example, 10.2 'Advertising content and patient information material <u>should not</u> glamorise procedures, minimise the complexity of a procedure, overstate results or imply patients can achieve outcomes that are unrealistic'. This is inconsistent with the National Law which states advertising must not 'create an unreasonable expectation of beneficial treatment'.

Or, 12.3, 'The medical practitioner <u>should not</u> provide or offer to provide financial inducements (e.g. a commission) to agents for recruitment of patients', which is clearly unethical. These guidelines should build upon *Good medical practice*, though in many instances, the statements just re-iterate that code of conduct.

Patient assessment

2.2 With the proliferation of telehealth, first consultations may be performed by video conference. A pre-surgical consultation should be in-person with the medical practitioner who will be performing the procedure.

2.5 The guidelines state that there *should* be a cooling off period of at least seven days between the patient giving informed consent and procedures 'other than minor procedures that do not involve cutting of the skin'. A mandatory cooling off period should be considered and a period of longer than seven days for major procedures for all patients.

Consent
4.3 It is appropriate for the initial information on a procedure to be given via telehealth where patients are rural or otherwise restricted from travel but as stated above, there should be a face to face consultation to discuss the procedure and obtain written consent.

Patient management
5.2 If the medical practitioner who performed the procedure is not personally available to provide post-procedure care, formal alternative arrangements must include another medical practitioner who will be available and made known to the patient.

5.3 When a patient requires sedation, refer to Australian and New Zealand College of Anaesthetists (ANZCA) guidelines – PS09 Guideline on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures.

5.5 Written instructions given to a patient on discharge from day hospitals should include alternative contact details of another qualified medical practitioner in the case the medical practitioner who performed the case is not available. Advice on the nearest hospital and instructions of when it is appropriate to present to the emergency department, as opposed to continuing to use contact details provided.

Training and experience
Completion of the 5 year RACS Surgical Education and Training program, with associated experience

Or

Completion of the RACS SIMG Specialist Pathway where a surgeon has originally trained overseas.

Advertising and marketing
10.1 and 10.2 state what is already the case, i.e. guidelines for which compliance is required of all medical practitioners (10.1) and then what is already in the guidelines (10.2).

There are many aspects of advertising that appear to be more of a concern in relation to cosmetic surgery services, which could be specifically referred to in these guidelines. For example:

- frequency of advertising of social media (including direct posts to patients who are followers, the use private Facebook groups to avoid scrutiny of regulators)
- advertising which targets vulnerable young people
- the use of sexualised images in advertising
- the objectification of women in particular by labelling bodies as being 'created by' a particular cosmetic surgeon
- third party sites that use testimonials AND advertise cosmetic surgeons.

The role of third party sites (eg [redacted]) are a particular issue as they are seen as being independent and objective but in fact surgeons are paying significant amounts to essentially advertise/ promote their practices. A disclosure should be made that many of the providers on these sites are paying subscriptions.

Financial arrangements
AHPRA should prohibit financial inducements financial inducements (e.g. surgery free of charge) to social media influencers, who then advertise the surgeon but do not declare the financial arrangement.

3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

The guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures appear to just include suggestions of appropriate behaviour and are only used to compare a medical practitioner's unprofessional conduct to a standard, after a complaint has been made and public harm may have occurred.

Proactive auditing of compliance with such codes and guidelines is required for the Board to achieve its role in truly protecting the public. This is needed for cosmetic surgery, due to the commercialisation of this subspeciality area (as referred to in the background of the consultation paper, p.7).

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifing their risk assessment process, and why?

It is noted that when assessing a notification about a medical practitioner, Ahpra and the Board used 'risk-based assessment' and considers: the specific concerns raised and whether the practitioner is practising below a reasonable standard; the type of practice engaged in; practice setting, including vulnerability of patient group; and the practitioner themselves. This is the case for managing notifications for all medical practitioners.

There is no further detail about methodology for risk-assessment or the investigation protocol for cosmetic surgery. Is cosmetic surgery as a 'type of practice' (commercialisation) and due to 'practice setting' considered higher risk (higher proportion of surgical procedures performed in private clinics, vulnerable patients)? Are complaints about cosmetic surgery more robustly assessed or investigated?

How does Ahpra know the 'type of practice engaged in' by a registered practitioner? Is this requested during the registration process? Or assumed based on their qualification?

The 'Background' section of the consultation paper (p.7), states that:

- Ahpra does not know how many medical practitioners use the title 'cosmetic surgeon' as there are a range of medical practitioners providing cosmetic surgery including across several specialities and registration types.
- The size of the cosmetic surgery sector is difficult to quantify because procedures are not covered by Medicare or private health insurance.

It would seem prudent to be able to categorise medical practitioners according to the 'type of practice engaged in' (cosmetic surgery), across different specialities and registration types. In a risk-based approach, this category and any other areas of medicine which have been commercialised (e.g., fertility treatments) should be deemed higher risk and considered differently.

5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Complaints and concerns are managed by different entities. While efforts are made to ensure complaints are dealt with by the appropriate organisation, how are complaints categorised in different organisations?

Is the enormity of complaints and notifications about 'cosmetic surgery' fully known?

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?

The current approach to regulating advertising in cosmetic surgery is not sufficient and has not been for some time. Advertising by 'cosmetic surgeons' has often been associated with 'soft' pornography, with the use of sexualised images and targeting vulnerable patients with the promise of changing their lives.

Medical practitioners have been concerned about the lack of professionalism exhibited by their colleagues, with no apparent intervention by the regulator unless a complaint is made. Some practitioners employ marketing experts to cleverly adhere to current advertising guidelines, and exploit the broad statements in the guidelines, which apply to every medical specialty.

Ahpra's current enforcement strategy considers the advertising of an individual practitioner. The advertising practices of multiple practitioners in a specialty or profession and its impact on cultural norms, and the reputation of medical practitioners in general, also requires consideration.

7. What should be improved and why and how?

A proactive approach to monitoring compliance is needed, rather than waiting for complaints. One possible avenue is a mechanism whereby practitioners provide urls and social media accounts used for advertising with their annual registration. A random audit could then be conducted.

Responsiveness to complaints. It appears it could take at least 120 days after a complaint is registered for a practitioner to amend their advertising. A timelier response to compliance and enforcement is required.

Increased penalties for practitioners who have commercially oriented advertising. Current financial penalties, when compared to the money made by practitioners with advertising that is non-compliant, are not a deterrent. The revenue from increased fines, in turn, could be utilised to routinely audit practitioner adherence to the guidelines, rather than only responding to submitted complaints.

8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?

If practitioners could be categorised across various registration and specialty types, practitioners who practice 'cosmetic surgery' could be more proactively audited for compliance. As could practitioners who had been found to be non-compliant previously.

Specific guidelines for the advertising of cosmetic medical and surgical procedures could be developed. Such guidelines could be more prescriptive in areas that are more relevant to cosmetic surgery than other areas of practice such as:

- The description of clinical experience by practitioners: that may include surgical rotations during PGY1-3; or rotations completed during a training program, which the practitioner was subsequently dismissed from; that patients may misperceive as surgical training.
- The use of images which sexualise and objectify patients
- The use of clinical 'before and after photos' only, that demonstrate the result of the procedure and do not advertise the patient's broader appearance (for which cosmetic surgery had no impact upon) or lifestyle
- Inclusion of patient stories as a marketing tool, which may not be classed as 'testimonials' but describe why patients decided to have cosmetic surgery procedures and the positive impact on their life. Like clinical details, such detail is patient specific and not necessarily generalisable to other patients.
- Advertising financial arrangements, such as offering loans, use of 'buy now, pay later' options
- Advertising multiple procedures as packages

- Prohibiting the targeted advertising of cosmetic procedures to persons under the age of 18 (which comes into effect in the United Kingdom in May 2022).
- A sub section specifically for advertising on social media (see below).

9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?

Recent research provides evidence that social media may adversely impact young women's health care choices in relation to cosmetic surgery.

Social media platforms have acknowledged the concern and restricted viewing of diet related and cosmetic surgery posts to people under the age of 18. Ahpra needs to consider attention to this in advertising guidelines.

Frequent posts by medical doctors, whom the public place a greater amount of trust in, are potentially more powerful in unconsciously condoning or persuading young women to undergo invasive procedures.

Social media is not just another form of advertising. In addition to the content of advertising (posts), specific cosmetic surgery advertising guidelines could address the functionality of these platforms which can be used to aggressively market to vulnerable persons, for example, the frequency of posts, use of direct messaging, use of private groups, links in advertising to patients' social media accounts (especially in the case of social media influencers).

10. Please provide any further relevant comment in relation to the regulation of advertising.

Publishing complaints made about the advertising of regulated services, and how they are handled, would be helpful to show that AHPRA is investigating complaints and practitioners are changing their practice to become compliant. At present the perception is that the advertising guidelines (and National Law) are not being enforced. The therapeutic goods advertising compliance annual report is an example of how reporting on advertising breaches could be done effectively.

Update the Ahpra website, for example, the most recent case listed on the webpage 'Advertising cases heard by courts and tribunals' is from over 8 years ago. The Ahpra 'Advertising hub - Information for the public' could include a section on what to look out for in cosmetic surgery advertising.

Ahpra could be more proactive in providing education for practitioners, specifically in advertising cosmetic surgery services.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?

Endorsement in relation to the practice of specific operations in cosmetic surgery would perpetuate the idea that cosmetic surgery is an unsophisticated area of surgery that does not need the rigorous training and examination process that exists in every other area of surgery. It fails to recognize the core skills in anatomy, pathology, physiology, wound management, complication management and psychological assessment that underpin a specialist training in surgery. Rather than protect the public, it is likely to increase public confidence in endorsed practitioners who are not qualified as specialists.

Cosmetic surgery is still 'real' surgery and needs to be performed by those with recognised surgical qualifications. Endorsement will just further confuse the picture and likely be contradictory to the outcome of the Health Council RIS.

There are precedents for endorsements in Australia and the most notable is the GP Anaesthetic qualification. That endorsement illustrates the issues that make an endorsement in Cosmetic surgery untenable.

- GP anaesthetists provide a life saving service in rural and regional Australia. There is an established unmet need. There is no equivalent unmet need for cosmetic surgery.
- The Joint Consultative Committee on Anaesthesia has brought together 3 AMC accredited training bodies to cooperate in the delivery of training to benefit regional Australia. There is no appetite from specialist surgeons to train non surgeons to do complex operations that have significant risks and high stakes for patients. The "need" for cosmetic surgery has been amplified extraordinarily by social media advertising and many procedures that are undertaken for commercial gain are either not indicated or not in the patient's best interests.

If this type of endorsement system were introduced against advice, it would be important that any trainee who was being supervised, was not restricted by the requirement to have an endorsement or a fellowship.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?

There is a significant risk that the public will equate an endorsement with specialist training. This would be misleading. We would replace one flawed system (Titling) with another (endorsement)

13. What programs of study (existing or new) would provide appropriate qualifications?

ASPS regards RACS as the only legitimate provider of surgical training in Australia.

The only programs of study considered appropriate are the 5 year RACS Surgical Education and Training Program and the 2 year RACS SIMG Specialist Pathway Program.

The resultant qualification for both programs of study is the FRACS.

14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

The issue of protection of the title of surgeon is critical to addressing the current issues in cosmetic surgery. Patients clearly have a perception that use of the title of surgeon implies the practitioner has undertaken specific surgical training, which in fact is not necessarily the case.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?

All complaints should go to Ahpra as a central body.

16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.
Do AHPRA do in depth checks with regulators of other countries? E.g. GMC in the UK?

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?
Yes, the current guidelines for mandatory notifications adequately explain reporting obligations. What is not always clear is the consequences of failing to report.
20. Are there things that prevent health practitioners from making notifications? If so, what?
Examples may include: • Power imbalance – practitioner with notifiable conduct is your employer • Confidentiality – notifications cannot be made anonymously. Also, you may be the only one with information that would lead to the notification and the practitioner with notifiable conduct would know who made the notification. • Relationships – concerns that relationships with other colleagues may suffer as a result of making the notification. • Hope that the practitioner's behaviour will change through an alternate intervention. • A practitioner may have a reasonable belief that others do so, and assume that another practitioner who directly observed the incident or behaviour should make the notification. • Concerned about the outcome for the practitioner with notifiable conduct, if the perception was wrong, or it happened to be an isolated incident.
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
Examples may include:

Peer review by practitioners that may not work for, or with, medical practitioners who perform medical or surgical procedures.

Confidential reporting – reporting by a third party (professional association) though the actual practitioner remains anonymous, rather than the practitioner reporting to Ahpra directly.

22. Please provide any further relevant comment about facilitating notifications

While disciplinary action may be taken against a practitioner who fails to make a mandatory notification when required, it is not common knowledge as to whether this actually happens, or how often. This may contribute to whether practitioners feel compelled to notify.

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?

Yes. Section 4 of the Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures includes detailed points of what information should be provided for informed consent.

24. If not, what improvements could be made?

25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

No. Should a patient wish to make a complaint about a practitioner, a quick Google search of 'complaint doctor' provides links to how to lodge a complaint with the Medical Board of Australia and Ahpra.

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?

No it does not provide sufficient information. It basically shows that the practitioner is registered to practice.

The majority of patients are not aware of which qualification (AMC recognized Fellowship in surgery) a practitioner should have to ensure they are safe to perform cosmetic surgical procedures. Patients assume that doctors who advertise cosmetic surgery have the requisite training and experience.

27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?

An education campaign about the required surgical training and experience should be included.

- The #besafefirst campaign is a start, though the fact sheet 'about what to think about before deciding on a cosmetic procedure or surgery and who to go to if you have a concern' focuses on only cosmetic injectables.
- Information about 'whether the person carrying out the procedure is registered, qualified, skilled and experienced' focuses on prescribers of injectables and provides no information about surgical education and training of practitioners who perform procedures. The consumer is just directed to the register, which does not provide any further information other than whether the practitioner is registered.
- On the #besafefirst webpage Ahpra actually states 'registration may not be enough to ensure the person carrying out the procedure is qualified, skilled or experienced to carry out the procedure' though gives no direction on how a consumer would be able to determine that.
- On the 'Fact sheet on injectables' page, a series of questions to ask the practitioner are suggested. If patients do ask the 'cosmetic surgeon' about the training they have had and where they trained, most patients don't know what the answer should be.
- How many patients ask a doctor in an initial consultation 'Have you had a bad outcome? What happened and why?'.
- The link to more resources at the end of the 'Fact sheet on injectables' page, directs the reader back to the #besafefirst page – there are not additional resources.
- Ban the use of non accredited post nominals on websites, advertising etc
- Require the practitioner's registered specialty or title to be the first thing listed after their name and post nominals.

28. Is the notification and complaints process understood by consumers?

The webpage 'Concerned about a health practitioner?' provides detailed information on raising a concern and who to submit a complaint to.

29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?

30. Please provide any further relevant comment about the provision of information to consumers.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.

We would trust that as part of the review process that a draft report will be circulated for additional feedback prior to the implementation of significant change.

ASPS believes there is a pressing community need for reform in this area and is heartened that AHPRA is taking this approach

Yours sincerely

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