Submission No 15

COSMETIC HEALTH SERVICE COMPLAINTS IN NEW SOUTH WALES

Organisation: Australasian Society of Aesthetic Plastic Surgeons

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Mr Adam Crouch
Chair
Committee on the Health Care Complaints Commission
Parliament of New South Wales
6 Macquarie Street
Sydney NSW 2000

Australasian Society of Aesthetic Plastic Surgeons

Friday 6th April, 2018

Dear Mr Crouch,

At the outset I would like to indicate that it is very encouraging that the Health Care Complaints Commission is examining the handling of complaints about cosmetic health service providers in New South Wales. We would hope that this becomes a more unified national approach in due course and are grateful that we have an opportunity to contribute to the process.

I write to you as the President of the Australasian Society of Aesthetic Plastic Surgeons (ASAPS). ASAPS is made up of almost 300 members who are all Specialist Plastic Surgeons from Australia and New Zealand with a special focus on the aesthetic/cosmetic elements of their practice both medical and surgical.

In this instance of course the handling of complaints about cosmetic health service providers relates to our Australian members. Our members have all completed Australian Medical Council (AMC) Accredited Postgraduate Surgical Training to become Fellows of the Royal Australasian College of Surgeons (FRACS) and have Specialist Registration in Plastic Surgery with the Australian Health Practitioner Regulation Authority (AHPRA).

Our overriding focus is on patient safety and successful patient outcomes. We are dedicated to upholding the highest standards of patient care and technical performance. Our Society runs a number of annual national educational meetings including the largest national meeting solely focused on cosmetic surgery and cosmetic medicine.

We are closely aligned to our sister organisations, the Australian Society of Plastic Surgeons (ASPS) and the New Zealand Association of Plastic Surgeons (NZAPS). Almost all of our members are also members of their respective national plastic surgery society. ASPS has also made a submission on this matter which is endorsed by ASAPS.

In a society such as Australia where we have such a high standard of living it often comes as a surprise to people when they learn how relaxed our laws are with respect to the regulation of this industry. With the exponential expansion of the cosmetic health sector over the past decade we have seen the rise of providers who have moved into the market preying on the vulnerabilities of people seeking these procedures. Some may offer no-frills services at what seem to become affordable prices however this may be at the expense of serious cutbacks that can compromise patient safety and patient outcomes. There is an opening for unscrupulous providers to offer low-cost treatments which are barely affordable by their target market and are then performed in suboptimal circumstances guaranteeing that the rate of complication is going to be higher. This is leaving too many of these patients in very difficult positions where the procedure they couldn't afford in the first place has now become a far more complex reconstructive procedure with additional costs.

ASAPS surgeons are confronted on a regular basis by patients who have suboptimal outcomes or complications. Patients are often incredulous that the person who they saw calling himself a surgeon did not in fact have AMC accredited Specialist Surgical Training but was still able to call themselves a surgeon. There is a similar degree of confusion about who is qualified to perform cosmetic medical

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procedures and what type of facility these can be provided in. The common injectable medical treatments such as the use of neurotoxins and dermal fillers are regulated medicines and as such the use of these should be overseen by a doctor. This is being sidestepped by nurse practitioners performing procedures without medical oversight often at hair salons or beauty clinics. An even more blatant and unlawful way around current regulations is the use of unregistered practitioners with unauthorised medications. This is especially prevalent in the non-English speaking communities and we have seen this come to light in New South Wales of recent time.

Many of the patients that our members encounter are embarrassed and feel responsible in a large part for their own dilemma because they felt they should have known or chosen better. On top of this the decision to undertake a cosmetic procedure is very personal and there are many who will judge individuals simply on the basis that they have sought this type of treatment. Most patients will not step up and complain because of these complex self-recriminations.

We see one of the greatest risks to patients is that they are unable to identify a reliable and trustworthy source of information. There is a lot of information available but too much is self-serving and designed to attract patients and not educate them.

ASAPS recommendations:

1. This process should culminate in a unified response from the Federal and State/Territory Governments. As doctors we are regulated by national bodies, the RACS, AMC and AHPRA and healthcare is now mobile. We recently saw in Penrith, NSW in October 2017 when a “Cosmetic Surgeon” was shut down, among his first steps was to advertise his relocation to Queensland’s Gold Coast which thankfully was stopped when his medical registration was removed by the national body. A national approach is going to be key to success.

2. A government run advisory service that could be seen as an unbiased, reliable and trustworthy source of information about practitioners, regulations and minimum standards for training and facilities.

3. To improve patient safety the best way forward may in fact be to go to the source rather than only dealing with the management of complaints when they arise. The provision of information needs to be managed hand-in-hand with improved transparency in the industry, prescribed minimum standards of qualification, facility requirements and tighter regulation over claims of qualification, expertise and outcomes. To this end ASAPS believes that there are six key areas that could be tightened to improve patient safety that are explained more fully at the end of this document
    a. Elimination of the confusion created by the title ‘Cosmetic Surgeon’.
        I. Consistent use of nomenclature that correctly defines and reflects the AMC accredited standards of training and the AHPRA registrable qualifications and experience.
        II. Restrictions on medical marketing to increase transparency regarding the practitioner’s expertise and training.
    b. Standardising minimum qualification requirements for cosmetic procedures and appropriate scope of practice.
    c. Greater regulation of facilities, the requirements around the administration of anaesthesia and clarity regarding which procedures must be performed in licensed facilities offering Level 3 Surgical Services, or Level 3—Perioperative—Day Surgery Services. This should be further expanded in this setting to cover the minimum standards for facilities where minimally invasive/injectable treatments are carried out.

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d. Who are accredited trainers of surgeons?
e. Tightening of rules around Schedule 4 Drug prescribing.
f. Enforcement of existing and new regulations.

4. The ability to investigate and enforce penalties needs to be increased for the HCCC and the other health regulatory authorities. In many instances existing regulations exist within the registration standards for AHPRA and the law however the resources are stretched and therefore unable to perform as intended. Unfortunately we have seen there are always those willing to take advantage of these man-power shortages. For patients, there will be a greater understanding about what is appropriate and what minimum standards can be expected. It will be clearer for the regulators when and who is in breach. For the vast majority of cosmetic health care providers this type of regulation and control will be well received as it will be viewed as improving patient safety and controlling the burgeoning underground market preying on the vulnerable.

    a. S4 medications are not legally able to be prescribed and administered by registered nurses outside emergency provision of medical care in rural settings. Despite this it is commonplace for nurses to be injecting these medications without adequate oversight.
    b. It is clearly illegal for unregistered practitioners to inject unauthorised medications and yet it happens.

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Australasian Society of Aesthetic Plastic Surgeons
Key priority areas to improve patient safety in cosmetic surgery

Members of the Australasian Society of Aesthetic Plastic Surgeons (ASAPS) believe there are six key areas that need to be tightened to improve patient safety in cosmetic surgery:

1. Elimination of the confusion created by the title 'Cosmetic Surgeon'.
    1.a. Consistent use of nomenclature that correctly defines and reflects the Australian Medical Council's (AMC) accredited standards of training and the Australian Health Practitioner Regulation Authority's (AHPRA) registrable qualifications and experience.
    1.b. Restrictions on medical marketing to increase transparency regarding the practitioner's expertise and training.
2. Standardising minimum qualification requirements for cosmetic procedures and appropriate scope of practice.
3. Greater regulation of facilities, the requirements around the administration of anaesthesia and clarity regarding which procedures must be performed in licensed facilities offering Level 3 Surgical Services, or Level 3—Perioperative—Day Surgery Services. This should be further expanded in this setting to cover the minimum standards for facilities where minimally invasive/injectable treatments are carried out.
4. Who are accredited trainers of surgeons?
5. Tightening of rules around Schedule 4 Drug prescribing via Skype.
6. Enforcement of existing and new regulations.

Now more than ever, the public, regulatory agencies and the state and federal governments need to be concerned about the risk to public health and safety due to unscrupulous, unqualified practitioners operating out of unlicensed premises and who use deceptive marketing tools to mislead the patients on their surgical skills and ability to achieve desired outcomes.

1. Eliminating confusion created by the title 'Cosmetic Surgeon'

A growing number of medical practitioners without training in plastic and reconstructive surgery are performing surgery to improve the patient's appearance. Because it is an unregulated area, pursuing these patients can be on the basis of low cost and a reliance on volume and at the expense of patient safety and outcomes. Recent media reports document the considerable morbidity when detailing accounts that range from breaches in safety and hygiene protocols, disfiguring results to actual patient mortality.

The problem with the term '*Cosmetic Surgeon*' is that it doesn't mean anything. Cosmetic Surgery isn't a separately recognised specialty by the AMC, the AHPRA or Medicare Australia and the title is not protected. Consequently there is no benchmark for those who can use the term cosmetic surgeon, hence, it has become the working title for someone just out of medical school who wants to go into practicing cosmetic surgery.

a. Consistent use of nomenclature that correctly defines and reflects AMC accredited standards of training and AHPRA registrable qualifications and experience

Specialist Plastic Surgeon is a protected title only available to FRACS accredited surgeons. There are other professions entitled to legitimately use the term surgeon that do not overlap this discussion. Veterinary Surgeon, Podiatry Surgeon, Dental Surgeon and Oral Surgeon are examples and some are protected titles just as Specialist Plastic Surgeon is. What binds us all together is that this title requires the completion of AMC recognised accredited training and then appropriate AHPRA registration in line with these titles (or equivalent in the case of Veterinary Surgeons).

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While Dental Surgeons and Veterinary Surgeons may not require a postgraduate degree, their undergraduate degrees train them specifically for these roles.

A basic medical degree provides a framework of general knowledge that can then be honed into specific areas with additional appropriate postgraduate training coordinated by Colleges accredited by the AMC: GP, physician, pathologist, radiologist, anaesthetist and surgeon are all examples.

A Specialist Plastic Surgeon has a minimum of 10 - 12 years of postgraduate medical and surgical education (after a basic medical degree), with at least five years of focused specialist postgraduate training approved by the AMC. The five year training is comprised of over *10,000 hours* of training.

Distinctly different to this, it is possible for anyone with no additional surgical training or experience after obtaining a basic medical degree to call themselves a "Cosmetic Surgeon". As it is not a recognised specialty, there is no requirement for AMC accredited training and therefore no Specialist Registration with AHPRA. The term is misleading and therefore unsafe.

b. Restrictions on medical marketing to increase transparency regarding the practitioner's expertise and training

The titles "Surgeon", "Surgery", "Plastic" and "Cosmetic" are currently misunderstood by the public and murky guidelines and enforcement make this even more difficult for patients.

As outlined above, surgeons who have achieved a Fellowship with the RACS, have undergone a further 10-12 years of specialist surgical training beyond their medical degree. FRACS includes people who are Neurosurgeons, Cardiothoracic Surgeons, Orthopaedic Surgeons as well as Plastic Surgeons.

In the eyes of the consumer, a 'Surgeon' has an assumed level of training and experience that a lot of the time goes unquestioned however, there are discernible differences between the credentials that constitute a Specialist Plastic Surgeon and a Cosmetic Surgeon.

Because of the lack of transparency in our medical marketing system, patients cannot ascertain the differences between their potential providers. With the current system, medical practitioners can capitalise on confusing jargon to convince patients that they are appropriately qualified to perform the procedures they advertise their expertise in. This lack of transparency may lead a patient to make a decision they would not have otherwise made if provided a clearer picture.

Whilst AHPRA's guidelines clearly stipulate how medical practitioners should advertise themselves the lack of enforcement and the slap on the wrists punishment is not enough to dissuade those who are practicing well outside their scope of practice.

In our interpretation of the Guidelines, it's essentially a breach for anyone to be advertising themselves as a 'Cosmetic Surgeon' as this is not a recognised title. It should then be a mandate by AHPRA and enforced by AHPRA that doctors should also only be able to advertise according to their AHPRA registrable qualifications.

Also, under section **7.3 Use of titles in advertising** the guidelines stipulate the use of a protected title is an offence under the National Law.

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Should the title 'Surgeon' be protected for use exclusively by appropriately qualified practitioners where there is appropriate AMC accredited training and AMC registrable titles?

The waters have become so muddy that it's nearly impossible for patients to clearly and simply identify the qualifications of medical practitioners offering cosmetic services. ASAPS members believe this would be simplified for patients if medical practitioners could only advertise according to their AHPRA registrable qualifications. This then provides a clear benchmark for the patients to jump off from in their decision making process.

We feel that it is vital that advertising regulations limit practitioners to the use of consistent nomenclature which in both reality and in perception correctly defines and reflects AMC accredited standards of training, qualifications and experience as well as a practitioners AHPRA registration.

Specifically, the term 'Cosmetic surgeon' requires significant restriction or better yet, removal from use as the term 'Surgeon' implies accredited training and appropriate registration, which isn't necessarily the case.

2. Standardising minimum qualification requirements for cosmetic procedures and appropriate scope of practice

Currently in Australia there are no legal requirements for a medical practitioner to have adequate training or credentials to perform surgery to improve one's appearance. Many patients do not realise this. A Cosmetic Surgeon could have attended a weekend course hearing about how breast augmentations are done by a presenter and then on the Monday he or she is legally able to pick up a scalpel and perform this procedure on an unassuming patient.

We would argue that many, if not most, Australians are under the belief that there would be legal protections in Australia that would prevent exposure to this type or unethical behaviour—unfortunately, this is not true.

I would suggest that the vast majority of patients would be uncomfortable with medical physicians with training in dermatology, obstetrics and gynaecology, general surgery, or family practice performing surgery to improve their appearance.

Our members hear time and time again when they are seeing patients who succumb to the sales pitch of a Cosmetic Surgeon that they believed was appropriately trained and credentialed because they used the title 'Surgeon', because they were wearing a white coat, because they had nursing staff. These assumptions are potentially life-threatening and these patients too often need revisions by a highly qualified Plastic Surgeon, sometimes at the cost of the public health system. However, had the right person who was adequately trained carried out the procedure in the first place, the whole situation could easily be mitigated.

The lack of standardisation for minimum training level places patients at high risk for making uninformed decisions and potential harm. ASAPS members believe the minimum requirement for cosmetic surgery to ensure patient safety should be the surgical training provided by the RACS.

While there are a number of specialties operating within this arena, it is equally important that the scope of practice is consistent with training. As an example an ophthalmic surgeon might perform blepharoplasty and an ENT surgeon may perform rhinoplasty. It is however appropriate that the training and scope of practice are aligned.

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3. **Greater regulation of facilities, the requirements around the administration of anaesthesia and clarity regarding which procedures must be performed in licensed facilities offering Level 3 Surgical Services, or Level 3—Perioperative—Day Surgery Services. This should be further expanded in this setting to cover the minimum standards for facilities where minimally invasive/injectable treatments are carried out.**

There have been increasing reports of serious patient harm associated with procedures performed in an 'office setting', where either intravenous sedation and/or large and potentially toxic doses of local anaesthesia have been administered.

A Joint Day Surgery Position Paper defining day-stay procedures that outlines the minimum standards upon which national, state and territory regulations for day surgery facilities should be based. It has been prepared as a collaboration between the RACS, Australia and New Zealand College of Anaesthetists (ANZCA) and the Australian Society of Plastic Surgeons (ASPS). The Standards have been prepared to assist in the preparation of the licensure (licencing and accreditation) regulations in each Australian jurisdiction to ensure that an organisation or individual working in those jurisdictions meets minimum standards in order to appropriately protect public health and safety.

An area of particular concern for ASAPS members in relation to patient safety is the use of twilight sedation for invasive procedures such as breast augmentations so that the procedure can be performed at a less regulated facility at a lower cost.

The lure of cut price procedures can be tempting for people whose main decision driver is cost. But that the discounted rate comes from a shaving of key components such as being fully anaesthetised and supervised by a Specialist Anaesthetist.

A Specialist Anaesthetist is a fully qualified medical doctor who, after obtaining their medical degree, has spent at least two years working in the hospital system before completing a further five years of training in anaesthesia. In fact, their training is as long as that of a surgeon. Anaesthetists play a pivotal role in resuscitating acutely unwell patients, including trauma victims, and help to manage patients suffering from acute or chronic pain.

ASAPS endorses the Joint Day Surgery Position Paper believing this draws a clear line in the sand of who can administer and where the administration of anaesthetic can take place in the hope of increasing patient safety.

The regulation of facilities can certainly be expanded beyond the provision of surgical services. There should be a consideration of minimum facility requirements for nonsurgical and minimally invasive procedures. If these guidelines are in effect and more widely appreciated it would be more difficult for to perform rogue operators procedures in facilities such as hotel rooms.

4. **Who is accredited to train surgeons?**

Cosmetic Surgery isn't recognised as a unique surgical specialty and only the RACS exists as a trainer of Cosmetic Surgery which is within the curriculum of Plastic and Reconstructive Surgery. This exists, is AMC accredited and is registrable as a Specialist Plastic Surgeon with AHPRA. There is overlap with other surgical craft groups as already outlined but in these instances surgery is still being performed by fully qualified surgeons within their area of specialist training.

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5. Tightening of rules around Schedule 4 Drugs prescribing

Whilst well intended, the regulation pertaining to the prescribing of Schedule 4 Drugs via Skype has been exploited by beauty salons and other unscrupulous practitioners who are using the loophole to provide an inferior standard of care to patients who never see a medical practitioner face to face. In other instances nurses are providing treatments without oversight at all. A remote doctor is prescribing the medication but uninvolved in patient care.

The regulatory language governing the delegation of health care services to nurses varies greatly from state to state in Australia. In some states, the supervising medical practitioner must be continuously available in person or by electronic communications and other states require the presence of the medical practitioner in the same location (e.g. on-site and immediately available).

States are also silent on the term “medical director” and do not regulate the amount of time that a medical director must be present in a facility. It is not uncommon for a medical director to work between several busy practices and never actually see patients face to face.

There has been a real de-medicalization of the non-surgical space with varied non-clinical settings offering injectables and/or fillers. These include shopping malls (excluding medical practices in or attached to retail outlets), private homes, office parties, and group social gatherings. ASAPS members believe these non-clinical settings are inappropriate and would like to see a tightening of the rules around the prescribing rules of Schedule 4 Drugs.

6. Enforcement of existing and new regulations

What may be surprising to some is that many of these guidelines already exist within the Registration Standards for AHPRA. Unfortunately there is insufficient capacity for investigation and enforcement.

Unfortunately there are bad apples in every barrel and they need to be held accountable.

Yours sincerely

[redacted]

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