AUSTRALASIAN COLLEGE
OF COSMETIC SURGERY

ACCS ROUNDTABLE WHITE PAPER

JUNE

2008

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Executive Summary

This White Paper presents the key points of the discussion of 13 clinical, insurance and industry regulatory representatives at a round-table event on 16 June 2008.

The event is part of a continuing series, hosted by the Australasian College of Cosmetic Surgery, to enhance engagement and provide a platform to gain valuable insight from the medical profession on issues of concern to industry, consumer, regulatory and other key stakeholders.

It is hoped that by bringing together stake-holders representing various disciplines – medical associations, government and universities – these discussions ultimately will contribute to raising standards and protecting patients, the College's aim.

The roundtable was divided into two parts. In Part 1, the participants explored the roles and responsibilities of doctors with respect to the delegation and administration of S4 medicine in the cosmetic context with particular reference to botulinum toxin (Botox, Dysport).

In Part 2, the participants considered whether cosmetic surgery and medicine should be recognised as a separate medical specialty. The College believes patients would be better protected and more able to make informed decisions if they were able to choose practitioners who have undergone specialist training, assessment and accreditation specifically in cosmetic surgical and medical practice. Currently this specialised area of practice is not recognised and therefore patients are unable to do this.

Moderator

Ann-Maree Moodie, Managing Director
Boardroom Consulting Group

Participants

Dr John Barrett, New Zealand College of Appearance Medicine (NZCAM) (participating via teleconference)

Marilyn Cassetta, RN BSCN CPSN
International Board Member for American Society of Plastic Registered Nurses and Head of the Teaching Faculty for the ACCS Diploma of Cosmetic Nursing

Maurie Corsini, Underwriting Manager
MIGA

Dr Mary Dingley, President
Cosmetic Physicians Society of Australasia (CPSA)

Dr Daniel Fleming, President
Australasian College of Cosmetic Surgery (ACCS)

Michelle Kearney, Editor In Chief
Australian Cosmetic Surgery Magazine

Richard Lawrance, NSW & ACT State Manager
Royal Australian College of General Practitioners (RACGP)

Celia Leary, MRCNA, Nurse Manager
Royal College of Nursing Australia (RCNA) representative

Pamela Lee, Risk Services Manager
MIGA

Gaye Phillips, CEO
Australian Society of Plastic Surgeons (ASPS)

Andrew Took, National Manager
Medico-legal Advisory Service, Avant

Cathy Webber, Principal Advisor Legal & Governance
Royal New Zealand College of General Practitioners (RNZCGP) (participating via teleconference)

Rachel Welch, Acting Director of the Legislative Policy Unit
Queensland Health

Observers

Rosalyn Fairall, RN / Royal College of Nursing Australia (RCNA) representative

Dr John Flynn, CEO
The Australasian College of Cosmetic Surgery (ACCS)

Stephanie Lovett,
NSW Director of Enforcement and Compliance
Australian Competition and Consumer Commission (ACCC)

Venue

Park Hyatt, Sydney

PART 1

EXPLORATION OF THE ROLES AND RESPONSIBILITIES OF DOCTORS WITH RESPECT TO THE DELEGATION AND ADMINISTRATION OF S4 MEDICINES IN THE COSMETIC CONTEXT WITH PARTICULAR REFERENCE TO BOTULINUM TOXIN (BOTOX, DYSPORT).

Current legislation: Drugs Poisons and Controlled Substances

Under the Drugs Poisons and Controlled Substances (DPCS) Reg 5 (3) - a nurse is authorised to possess and administer those Schedule 4 poisons that are necessary for administration to a patient under the care of that nurse in accordance with:

(a) the instructions and upon the authorisation of a medical practitioner or dentist for that specific patient

(b) the conditions of a permit to purchase or obtain and use a poison or controlled substance for the provision of health services.

There was a general consensus that there needs to be appropriate training for doctors and nurses about their specific roles and responsibilities. Particularly, there was agreement that there should be better supervision of nurses who've been delegated this particular task. The discussion also explored how the current legislation needs to be tightened as it has allowed opportunities to misuse these medicines. There is an increasing trend where some nurses and other individuals are supplied with S4 injectable cosmetic drugs by doctors and then administer these to patients without the doctor ever seeing the patient. All participants expressed concern about the practice and agreed that the issue of enforcement needs to be addressed.

There was consensus for effective actions by the States to enforce guidelines and close the loophole on this practice. The ACCS will take the consistent message that has emerged from this forum to let the authorities know that this is a problem. The ACCS believes the law is quite clear, it is currently being abused and it must be addressed.

"The law is pretty clear cut. If it is a schedule 4, it needs to be dispensed under a doctor's prescription. However, what we're talking about today is with regards to cosmetic nurse injectors and the importance of the doctor actually doing a consultation with each patient before they meet the nurse injector and, in fact, have the injection. I think it is very important that this does occur because there appears to be a loophole."

Michelle Kearney, Editor In Chief
Australian Cosmetic Surgery Magazine

"Botox, Dysport and most of the dermal fillers are S4 injections and they must, absolutely must be prescribed by a doctor. In order for a doctor to write a prescription they must have consulted the patient. Unfortunately this doesn't always happen but it absolutely must."

Dr Mary Dingley, President
Cosmetic Physicians Society of Australasia (CPSA)

"Avant's position is that it would be prudent practice for a doctor to see each patient before each treatment of Botox to satisfy themselves that Botox is and subsequently remains appropriate treatment and, prior to prescribing, to discuss the potential risks with the patient."

Andrew Took, National Manager
Medico-legal Advisory Services for Avant

"We do have a situation at the moment where some nurses will administer these medicines without a doctor being present and without a doctor ever having seen the patient. These nurses obviously must obtain these medicines from a doctor at some point, however the responsibility for formulating the treatment plan seems to be totally taken by the nurses that really can't occur. The doctors absolutely must see the patients and absolutely must prescribe it."

Dr Mary Dingley, President
Cosmetic Physicians Society of Australasia (CPSA)

ACCS Roundtable discussion: (from left) Stephanie Lovett, Rachel Welch, Dr Daniel Fleming, Maurie Corsini, Pamela Lee, Alan Jones, Dr John Flynn, Roslyn Fairall, Celia Leary, Marilyn Cassetta, Dr Mary Dingley, Ann-Maree Moodie, Gaye Phillips, Michelle Kearney and Richard Lawrance.

"The only reason anybody is motivated to have this in a hair salon or a beauty salon of any sort is the monetary gain of their percent of for lining up their patients all day long. And that interest is not out of the altruistic interest in that patient getting the best result they can get, it is because 'I'm going to get 30 per cent if I fill this chair up'."

Marilyn Cassetta, RN BSCN CPSN
International Board Member for ASPRN and Head of the Teaching Faculty for the ACCS Diploma of Cosmetic Nursing

"I think there are three issues. One is that doctors must satisfy themselves that the patient is an appropriate person to receive Botox. Secondly, the doctor needs to be appropriately trained. Thirdly, if he or she is going to delegate to a nurse, the nurse needs to be under direct supervision and the nurse needs to be appropriately trained."

Dr John Barrett, President
New Zealand College of Appearance Medicine (NZCAM)

"This is a unique situation I've not seen before. Nurses, and even beauty therapists, have an ability to inject schedule 4 drugs in order to make money and are using loopholes in the law to avoid the inconvenience, as they would see it, of having the "client" seen by a doctor first.

"Those doctors who are involved in supplying the drugs are as much to blame. It seems there is a consensus that it is essential, and indeed, legally necessary, for the doctor to be involved and the patient to be under the doctor's direct supervision. "

Dr Daniel Fleming, President
Australasian College of Cosmetic Surgery (ACCS)

"From a College of GPs point of view our main concern is with the patients of cosmetic medicine and surgery, because they will also be the patients of the local GPs or nearby GPs. Whilst access is an issue, so is quality of care - just because patients have difficulty accessing care it doesn't mean that the care should be of a lesser quality. So standards are key here and developing standards and enforcing the standards is key as well."

Richard Lawrance, NSW & ACT State Manager
Royal Australian College of General Practitioners (RACGP)

"Part of the solution to this is actually in raising awareness, informing and educating the patient so that they have full knowledge when consenting i.e. that there is full and open disclosure by the medical practitioner to the patient as to what will be administered, the quantity, by whom and what risks or side effects are associated or can occur from the procedure / medication.

"A medical practitioner is not to supply an S4 drug to a nurse for administration to a patient who is not under the direct care of that medical practitioner. A nurse may not administer an S4 drug to a patient unless written authorisation has been given by a medical practitioner to administer the drug to that specific patient. Refer ASCM protocol for the use of S4 drugs for cosmetic procedures by nurse practitioners.

"Other issues that need also to be considered include:

- *Equity of access e.g. fly in fly out particularly with rural and remote patients having time or allowed time for an initial consult prior to the procedure to allow the patient time to consider the information provided as part of the open disclosure*
- *Monitoring the standard of care when the care is provide by someone other than the doctors*
- *Insurance and whether the patient is covered under the doctor's medical indemnity insurance or the nurses insurance and whether the doctor's insurance covers the actions of the nurse. Does the insurance policy provide full cover or are there gaps in the cover*
- *Level and quality of training for the nurse practitioner and how this would be enforced and monitored to ensure the training is current and to the required standard at all times?*
- *Need to address the situation where a medical practitioner may buy the medication and on sell to a 3rd party e.g. nurse practitioner*
- *The medical notes need to include documentation by the doctor of the medication, the dosage and the date it has been administered, et cetera.*

"So the patient or prospective pool of patients should be informed to an agreed standard and thus aware. This would help address some of the risk from the patient's perspective as well as from the medical profession and the insurer's perspective."

Pamela Lee, Risk Services Manager
MIGA

"Nurse practitioners are a relatively new professional category in Queensland. Under Queensland's Health (Drugs and Poisons) Regulation 1996 a nurse practitioner is able to supply controlled drugs, which include S4 medication, under a drug therapy protocol. The standard drug list under the current drug therapy protocol for nurse practitioners does not provide for botulinum toxin as a controlled drug that may be supplied by nurse practitioners.

"However the regulation itself does not prohibit the inclusion of any particular controlled drugs and medicines in drug therapy protocols. While very unlikely, it is possible that such medication could be included in the future into drug therapy protocols with the appropriate legislative approvals, which would then permit nurse practitioners to prescribe them."

Rachel Welch, Acting Director of the Legislative Policy Unit
Queensland Health

"I would like to commend the ACCS for developing a diploma of cosmetic nursing. It is certainly a step in the right direction to ensure nurses receive appropriate training and education, particularly with reference to the roles and responsibilities for the delegation of S4 medicines in the cosmetic context."

Marilyn Cassetta, RN BSCN CPSN
International Board Member for ASPRN and Head of the Teaching Faculty for the ACCS Diploma of Cosmetic Nursing

PART 2

ADDRESSING WHETHER COSMETIC SURGERY AND MEDICINE SHOULD BE RECOGNISED AS A NEW MEDICAL SPECIALTY.

The College believes that Australian consumers would be better protected and more able to make informed decisions if they were able to choose practitioners who have undergone specialist training, assessment and accreditation specifically in cosmetic surgical and medical practice. Recognition of cosmetic surgery and medicine as a distinct specialty will provide clarity for consumers so that they can make informed choices.

Independent research, conducted by Galaxy on behalf of the College, has demonstrated, quite clearly, that the Australian public wants to be able to identify who is and who is not a specialist in cosmetic surgery and cosmetic medicine. In fact, an overwhelming 96 per cent of Australians polled, between 18-64 years, believe cosmetic surgery should be recognised as a specialty with training and qualifications approved by appropriate medical authorities.

It is important to understand the application is not about recognising the College itself and is not an attempt to gain a monopolistic advantage. In fact, the recognition of the new specialty will provide a framework in which any organisation of doctors in the Australia will be able to apply to be approved as an accredited provider of a qualification in the new specialty. They will have to submit their training scheme, qualifications and accreditation processes for assessment to see whether they reach the necessary standard.

The College proposes that the recognition of this specialty will allow Australian consumers to determine who has reached the specific standards relevant to cosmetic medicine and cosmetic surgery, which at the moment they cannot do because no qualification has been properly assessed for this purpose. This is true for plastic surgeons, dermatologists, facial plastic surgeons and others who may hold themselves out to be cosmetic surgeons, however well trained they may be in their other area of expertise.

Given the tremendous growth of the discipline, which is projected to continue, a decision to delay or forgo recognition of the specialty of cosmetic surgery and medicine will perpetuate the regulatory vacuum that currently exists to the detriment to patient safety.

The ACCS currently has an application before the Australian Medical Council, the government body charged with recognising new specialties in Australia, to recognise the specialty of cosmetic surgery and cosmetic medicine.

If the specialty is recognised, a situation will then exist whereby competition will be ensured because a range of different groups will be able to apply to be recognised under this new specialty. Standards would be maintained, because all groups would have to meet the designated benchmark before being so recognised. The College believes this is the best way forward that will indeed raise standards and protect patients. Such an outcome will also be consistent with public opinion.

During the discussion, there was a strong degree of consensus to move forward on these issues to raise standards. Most participants supported the view that the establishment of a new medical specialty would be beneficial for patients. Only the Australian Society of Plastic Surgeons believed the creation of a new specialty was unnecessary.

"I would like to congratulate the College on the moves they've been making to create a specialty in cosmetic surgery and cosmetic medicine and I'm sure it will be successful."

"In New Zealand the big hurdle for cosmetic surgery is getting separate vocational branch recognition and I believe that that will happen in due course. But I think essentially at the moment the New Zealand Medical Council is waiting to see what happens in Australia."

Dr John Barrett, President
New Zealand College of Appearance Medicine (NZCAM)

"From the patient perspective, recognised qualifications for doctors working in the field of cosmetic medicine and surgery has merit as it provides the patient with a level of certainty in relation to the qualifications of the doctor they have selected for the cosmetic procedure they require. We think a recognised cosmetic and surgery specialty is a logical way forward.

"Logic tells us the better position for the patient who requires cosmetic medicine / surgery is that they can be confident they are seeing doctors that have undertaken a recognised set of standards in training and obtained recognised cosmetic and surgery specialty qualifications versus non recognised qualifications in this field of practice. From an insurer's point of view it would also make underwriting cosmetic risks simpler because at present doctors who approach us for insurance for cosmetic work may have either varying cosmetic qualifications or may not necessarily have recognisable qualifications in the field of practice. Our ability to refuse cover to such doctors is limited therefore we would absolutely support an outcome where standardised and recognised cosmetic and surgery specialty qualifications was the norm."

Maurie Corsini, Underwriting Manager
MIGA

"Avant believes patients should be provided with or have ready access to information regarding the skills, training and accreditation of a medical practitioner offering cosmetic surgery. However, Avant holds no view as to whether cosmetic surgery and cosmetic medical practice should be recognised as a new medical speciality."

Andrew Took, National Manager
Medico-legal Advisory Services for Avant

"The Australian Society of Plastic Surgeons' position is that, and this is not news to anyone, that the AMC has a provision that enables this application process to take place. So we just allow that provision to go through. It is not our business to stop it in any way.

"The Australian Society of Plastic Surgeons does not agree that there is the need to create a new specialty in cosmetic surgery. The Royal Australasian College of Surgeons has an existing AMC accreditation to train doctors in the specialty of plastic surgery which encompasses both reconstructive and aesthetic procedures.

"All applications to the AMC are assessed on their merits. ASPS respects the integrity of the AMC process."

Gaye Phillips, CEO
Australian Society of Plastic Surgeons

"The RACGP is often invited to comment on recognition of a new medical specialty and we're certainly not adverse to considering the Australasian College of Cosmetic Surgery's AMC application because we can see that the ACCS could work in very easily with the Faculty of Special Interests the RACGP is forming.

"This Faculty will form Chapters in areas of specific clinical interest that will not be restricted to GPs or GP groups. They will be open to membership from other medical groups as well, and there is considerable overlap between general practice and the ACCS curriculum. Ultimately a Chapter could offer a Fellowship in the specific interest, which could be adopted by the various Colleges participating. So it is something we're interested in discussing and we're open to the application for specialty recognition."

Richard Lawrance, NSW & ACT State Manager
Royal Australian College of General Practitioners (RACGP)

"I think that the most important thing is patient safety. If there was an accepted national standard of training, experience and accreditation, it can only really have a positive effect on the industry as a whole and really the number one thing is about patient safety. When we get calls we give them numbers to call, we give them the numbers of the ACCS, ASPS, the CPSA and we recommend that they see a number of practitioners even with those accreditations, because just because you have an accreditation and you have experience, does that mean that you're competent? I don't know the answer to that but I certainly think that if there was one national governing body, whether it is setting up a specialty or whatnot, it would have a very positive influence."

Michelle Kearney, Editor In Chief
Australian Cosmetic Surgery Magazine

"Queensland Health considers it best practice that any health service is provided by appropriately accredited and trained individuals. Queensland Health has no view as to whether cosmetic surgery should be a separate specialty."

Rachel Welch, Acting Director
Legislative Policy Unit, Queensland Health

"Cosmetic surgery or aesthetic surgery is not one of the nine recognised surgical sub-specialties. The ASPS argues that merely because they have in recent years included some aesthetic training in their program this automatically means the whole gamut of cosmetic surgery and cosmetic medicine is somehow subsumed in the specialty of plastic and reconstructive surgery and therefore there is no need for a new specialty.

"This is not so. Once the new specialty is recognised all of the professional bodies representing doctors performing cosmetic procedures (including the ACCS and ASPS) will have to apply to have their qualifications assessed. There will be a large number of standards specific to cosmetic surgery and cosmetic medicine which will have to be met. These standards have not yet been reached by any RACS qualification, including plastic and reconstructive surgery."

Dr Daniel Fleming, President
Australasian College of Cosmetic Surgery (ACCS)

"We have said and continue to say that the ACCS application to the AMC is a matter for ACCS. There is a process to follow and ASPS will respect the umpire's decision.

"The Australian Society of Plastic Surgeons has not gone to the AMC to request the creation of a new specialty because we believe that the specialty already exists. That is the point I'm making. That is the clear point of difference."

Gaye Phillips, CEO
Australian Society of Plastic Surgeons

*"Well, we do not agree with that. The creation of a new specialty would formalise the standards for **all** of the divergent groups of medical practitioners who already offer cosmetic medical services. This can only raise standards. Why would ASPS oppose this process? The suspicion is that the ASPS' position is based on self interested commercial considerations rather than those of improving patient safety. If this not the case I would urge ASPS to support the recognition of the specialty or provide some reasons, other than monopolistic ambitions, why patients should not be protected in this way."*

Dr Daniel Fleming, President
Australasian College of Cosmetic Surgery (ACCS)

"I could not pre-empt the ASPS submission."

Gaye Phillips, CEO
Australian Society of Plastic Surgeons

"Personally I have shared with everyone that I work with plastic surgeons but it is my personal opinion that whether it be a dermatological surgeon, facial plastic surgeon, cosmetic surgeon as we know, a GP/surgeon, cosmetic medical doctor, "I am all for getting better standardisation across the board. I think somehow, some way there has got to be accountability out there and right now it is a free for all.

"I think that a patient, at the end of the day, if there is a standardised specialty and you have to be eligible, you have to be qualified, you have to show significant knowledge and skill in order to enter that, I don't care what the discipline is, I think at the end of the day that would be the smartest and safest thing because right now it is a free for all."

Marilyn Cassetta, RN BSCN CPSN
International Board Member for ASPRN and Head of the
Teaching Faculty for the ACCS Diploma of Cosmetic Nursing

"Now what we do know is that cosmetic surgery and cosmetic medicine already exist as an area of separate specialised practice. I think we can agree on that. There are so many doctors from different backgrounds who are working in it. It receives so much media attention. More than any other area of medicine I think. There are New South Wales Government committees of enquiry into it. Queensland has special legislation to cover it, there are separate insurance categories for it and so on. So in reality the specialty does exist it is just not recognised yet.

*"The College feels strongly that the recognition of this specialty will allow the public to determine who has reached the specific standards in cosmetic medicine and cosmetic surgery. At the moment they cannot do this because **no** qualification, including that of RACS, the ASPS and the ACCS, has yet been assessed, or indeed can be assessed, by the AMC for this purpose. This will continue to be the case until the specialty is formally recognised.*

"Importantly this is what the public wants. We know this from research conducted by the Galaxy organization. Recognition is needed to allow clarity for patients so that they can make informed choices. If there is any doubt in this let's just consider what will happen if the specialty is not recognised. The free for all will continue indefinitely and patients will continue to be confused and disadvantaged.

"We believe the AMC has an historic opportunity to lead the way in this field and to allow patients this ability to discriminate, to raise standards and to protect them. I am disappointed that ASPS is the only participant here who is opposed to the recognition of the new specialty and hope they will reconsider and put the interests of patients ahead of their own."

Dr Daniel Fleming, President
Australasian College of Cosmetic Surgery (ACCS)

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