ACCS Submission to Medical Council of New Zealand

"DRAFT - Statement on cosmetic procedures"

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Preamble

Cosmetic procedures have become more popular with the public in recent times and new techniques and better training has made them more accessible. It is only reasonable for practitioners to be expected to achieve accreditation in these new areas. However it is often the case that certain medical craft groups have been given unwarranted precedence and recognition in this field.

The reality is that medical practitioners of many disciplines practice the various cosmetic procedures and all require some additional specific training to be properly accredited. Creation of categories, and lists of 'allowable practitioners' should not be arbitrarily determined and should surely be based on the level of specific training received, experience and competency demonstrated. The proposal of the Medical Council of New Zealand with respect to your Category 1and 2, will limit the choices of patients and expose them to a situation whereby your patients only have access to practitioners from medical disciplines **which do not offer training in cosmetic procedures.** At the same time prohibit doctors from ACCS who have undergone specific cosmetic training and who maintain on going accreditation in this discipline.

The Australasian College of Cosmetic Surgery (ACCS) supports and commends the Medical Council of New Zealand (MCNZ) in its efforts to create a system for protection of patients and applying some regulation to cosmetic surgery. Patients have a right to expect access to doctors who are competent in cosmetic procedures by virtue of genuine training and experience in the procedures they perform.

ACCS supports the broad concept of the draft statement and offers another insight and suggestions for improvement of the draft. A clear solution is a system based on competence and ongoing CME and not by virtue of membership of any particular medical college, organization or society.

Purpose

Safety of patients should always remain the priority of all doctors and regulators. This can best be achieved by raising standards of practice through proper training and accreditation. Therefore it is submitted that the purpose of the Statement is best served, by recognition of training and experience of practitioners no matter to which professional group or College they may belong.

It would seem this approach is implicit in the statement of the function of Council "to set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession." Rather than set standards of competence the current proposal, particularly in your Category 1 procedures, will result in a monopoly in cosmetic procedures for groups of doctors who do not offer formal training in cosmetic practice. Your proposal will expose your patients to doctors potentially without training but who happen to belong to favoured medical groups. An example would be an ENT specialist (who has FRACS qualification) commencing to perform breast augmentation or an Ophthalmologist (FRACS) deciding to commence practice in abdominoplasty without any formalized and accredited further training. An example here is of an Obstetrician Gynaecologist who has recently commenced performing Blepharoplasty without any accredited training. At the same time Fellows of ACCS who have received specific training but who may not be FRACS will be restricted. This obviously would be an absurd situation.

Contrary to what is sometimes said, the ACCS is a multidisciplinary group consisting of ENT, General and Plastic surgeons, specifically trained Cosmetic Surgeons and Cosmetic Physicians, Dermatologists, General Practitioners, Ophthalmologists. The particular strength of this is that each of the ACCS Fellows has achieved not only special skills in their original field of practice but has also undertaken specific training in cosmetic procedures.

Expectation of training, skill and expertise

This section is agreed to contain the ideal elements of a system to help protect patients. The challenge lies in the assessment of adequacy of point 6. There needs to be developed a process to assess training, validity of experience, and above all competence in cosmetic procedures. Claims to cosmetic expertise by virtue of training in another discipline should not be considered appropriate.

The Categorisation System

Why do cosmetic procedures require a categorization system? Such a structure is not replicated in other areas of medical practice so one must question why cosmetic practice requires this imposition. Are the benefits of such a system more directed to restriction and control of practitioners rather than toward patient safety?

The categorization system as proposed has some significant flaws and the most significant being categorization according to the type of providers involved. “The Council has classified different procedures in accordance with the types of providers involved, the type of facility in which they are performed and the level of risk to the consumer.”

Many cosmetic procedures are performed by doctors from a variety of medical disciplines. For example, blepharoplasty might be performed appropriately by an Ophthalmologist, Dermatologist, General Surgeon, Cosmetic Surgeon, Cosmetic Physician, Plastic Surgeon, ENT specialist. The procedure may be performed equally well or equally poorly by members of any of the above groups.

Anaesthetic safety is a particular risk item but one cannot categorize the risk profile of procedures based solely on this. Many operations may be performed under different types of anaesthetic. For example, blepharoplasty may be appropriately performed under general anaesthetic, local anaesthetic with or without sedation. Liposuction may be performed under general anaesthetic or under tumescent anaesthesia. International studies have shown that liposuction under tumescent anaesthesia and performed in adequately equipped doctors rooms is one of the safest procedures but liposuction performed under GA in hospital has a significant mortality rate. (reference available on request)

Requirements for the safe administration of anaesthetic are already documented widely and these represent an element of risk which is largely independent of the cosmetic procedure being performed. Cosmetic procedures are invariably performed on an essentially well and healthy patient and so occupy the lowest risk category.

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Accreditation of facilities is appropriate with respect to anaesthetic safety and issues such as infection control, management of emergencies but has little relevance to the abilities of the individual practitioner to perform a particular procedure. There are sufficient documented processes for accreditation of facilities at different levels. There is a National Standard for Accreditation of Rooms in Cosmetic Practice in the process of development in Australia at the moment. This is being undertaken by a multidisciplinary body on which ACCS is represented.

Category 1

Your example of category 1 includes the possibility of Breast augmentation being performed by an Ophthalmologist or a maxillo facial surgeon. Since there is no traditional link between this operation and the medical disciplines mentioned, this could never be accepted as appropriate without demonstration of further special training ***in that particular operation.***

The criteria that category 1 " may only be performed by a doctor registered in a relevant scope of practice and who has the necessary expertise and experience in the procedure being performed" contains a major flaw. Cosmetic surgery is not yet recognized in New Zealand as a distinct specialty as this draft statement implies. It therefore applies a definite advantage to those doctors with current experience provided that they are also in a recognized scope of practice. There is no ability for very experienced and competent doctors who are not members of such a scope of practice. There is also no scope for new doctors to train in cosmetic practice since they will not be able to accumulate the necessary expertise. It is understandable why the MCNZ has received little co operation from RACS, since if that College does nothing it will enjoy a monopoly given to it by your Council.

It stands to reason then that the criteria for any doctor being allowed to perform a particular procedure should be the ability to demonstrate training, experience and competency regardless of their background specialty or existing Fellowships.

Procedures are often ranked according to risk but using this value alone denies the risk inherent in the operator if he or she has not been trained in the procedure. Overall risk is lowered in situations where the operator is specifically trained and experienced in a given procedure and where risk management strategies are in place. These include full consultation with the patient, advice as to potential risks and benefits, achieving proper informed consent.

High volume Liposuction is defined by international standards as 'removal of quantities of fat in excess of 5 litres of supernatant fat.'

Another inherent problem of lists is that items may be omitted or added or shifted from one list to another. It would be required to have some level of consultation to assist in these deliberations.

Recognition as a Scope of Practice

ACCS does provide formal and supervised training in cosmetic surgery and maintains a compulsory, yearly recertification and CME programme. ACCS will be frozen out of your system under the draft statement.

- **I would like to identify now the intention of ACCS to apply for recognition as a Scope of Practice in New Zealand and will action this with a priority. As the assessment process will take some time I would request the MCNZ allow for temporary interim recognition for the purposes of Category 1 procedures until our application is properly heard.**
- **The College will be pleased to discuss in its verbal submission to Council the evidence of its processes, procedures and safety record which is the basis on which this interim measure is justified.**

Advertising and Promotion

ACCS agrees with this section of the draft. Policing of these sentiments may prove challenging. I have included as an appendix the ACCS Advertising Code which you will see not only addresses your Council's concerns but indeed goes further. The Council is invited to use or modify this Code for its purposes.

Medical titles can indeed be confusing for patients particularly when the possession of traditional titles bears no hint of any expertise in cosmetic procedures merely that a doctor has qualified in a different field. The only accreditation specific to cosmetic surgery is that of ACCS. However, no single group should be in a position to monopolise cosmetic surgery and so possession of a particular title should not be the critical factor. There needs to be an assessment based on competence separate from any particular professional background.

ACCS does not seek a monopoly as others do. A monopolistic system will patently not serve the interests of patients and would be unfair to other doctors. The only workable and demonstrably fair system is based on competence.

Obtaining consent

Proper informed consent is essential to good practice and to patients best interest. ACCS supports this concept and I include as a further appendix the College's "Guidelines for informed consent". The Council is invited to use or modify these guidelines for its own use.

Providing care

ACCS supports this section

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Audit and Review

ACCS supports this concept and I have included in an appendix the College Recertification and CME programme. This programme is mandatory for College Fellows and is a yearly requirement. The programme is specific to cosmetic surgery.

Cosmetic Surgery as a distinct specialty

Cosmetic Surgery has been recognized internationally as a distinct discipline. In USA there has been formal acceptance of Cosmetic Surgery by the Supreme court of California. The American Board of Cosmetic Surgery has been recognized as a Accreditation Board. In UK the Department of Health has recognized the distinction of cosmetic surgery and has further recognized that the Royal College of Surgeons does NOT provide education in this field and has required such a programme to be developed.

There are distinct College's or Academies of Cosmetic Surgery in USA, South America, Europe, Korea, Asia- Pacific, Japan, Hong Kong, as well as Australia. For New Zealand to move to deny cosmetic surgery as a distinct area of expertise would be to go against international trends.

- Cosmetic surgery is also deemed by the public to be a separate specialty and this is evidenced by the numerous publications in the lay press devoted to cosmetic surgery.
- The Australian Yellow Pages phone directory have recognized this and have instituted a new listing category of 'Cosmetic Surgery'.
- Medical indemnity organizations have recognized the separateness of cosmetic surgery by providing insurance categories specifically for cosmetic surgery.
- The Medical Council of New Zealand recognizes cosmetic surgery as a separate discipline by virtue of the fact of their developing a 'Statement on Cosmetic Procedures' and a process for accreditation in that new discipline
- The main naysayers, the plastic surgeon associations recognize cosmetic surgery as different from Plastic and Reconstructive Surgery. Their own web site makes this distinction and advertisements of many of their members carry the editorial copy claiming expertise in ' Plastic, Reconstructive, **AND** Cosmetic Surgery'.

Australasian College of Cosmetic Surgery

Appended is a document "Introduction to the Australasian College of Cosmetic Surgery". This details the College and a number of measures the ACCS has instituted to address these same issues. Foremost in the ACCS process is specific cosmetic training over a two year period following successful completion of three year basic surgery training. Trainees are assessed each term and must pass 4 separate examinations prior to being eligible for Fellowship. As a further protection for patients the College also maintains Procedure Specific Registers. For doctors to be listed on these registers they must have an experience of 50 cases ***in each procedure***.

ACCS does not seek a monopoly in cosmetic practice as do some other groups. ACCS considers that regulators have been mis- informed about the nature of and requirements for appropriate cosmetic practice and the implications of this are significant. ***RACS does not provide specific cosmetic training*****.** Not all Plastic Surgeons provide cosmetic surgery services. Some have obtained specific training in addition to their RACS training but many have not.

That there are any standards at all in cosmetic practice is due to ACCS and its specific programmes and insistence on continuing medical education and yearly re certification specifically in cosmetic practice. It is the ACCS that requires the highest standards of cosmetic surgery training and accreditation in Australia and New Zealand.
The ACCS has begun the process for accreditation by the Australian Medical Council and is represented on the Boards of Medical Indemnity Organizations and Health Rights Commissions in various States.

The CME programme of ACCS is accredited by the Medical Board of NSW and is compulsory for its Fellows and focused specifically on cosmetic practice. ACCS has a peer reviewed journal in cosmetic surgery and hosts an annual conference which regularly attracts over 500 delegates. This conference is a highlight on the international calendar of events.

Summary

It is submitted that the statement of the Medical council of New Zealand contain the following elements;

Cosmetic procedures should be recognized as a distinct group of procedures performed by a variety of medical practitioners of differing backgrounds.

The right to practice in this area to be based on demonstrated training, experience and competency specifically in cosmetic surgery ***regardless of the background specialty of the doctor involved.***

All practitioners should be required to maintain competency ***in cosmetic procedures.***

All patients should be afforded medical consultation and appropriate information regarding their proposed procedures, including the risks and benefits, alternative treatments, including the option of no treatment.

Proper informed consent must be obtained prior to any procedure.

As a stakeholder in this issue ACCS registers its interest in proceedings and will provide input and support to genuine debate at all stages. The overall goal is always “Raising standards, protecting patients”

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