



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

19 July 2007

Michael Thorn
Policy Analyst and Researcher
Medical Council of New Zealand
PO Box 11649
WELLINGTON

By e-mail: mthorn@mcnz.org.nz

Dear Michael

Draft statement on cosmetic procedures

Thank you for the opportunity to provide comments on the third draft of the Medical Council's statement on cosmetic procedures.

I strongly support the changes that have been made to the third draft of the statement. As you are aware, I have been concerned for some time about the lack of external oversight for doctors practising cosmetic surgery in New Zealand. I therefore commend the Council for addressing this issue by requiring practitioners to undergo an independent competence assessment before practising in this area. I am confident that this requirement, which is consistent with the purpose of the Health Practitioners Competence Assurance Act 2003 (HPCAA), together with the need for regular audit, will be effective mechanisms for ensuring practitioners are competent to practise in this area, thereby protecting the health and safety of the public.

Overall, I consider that the statement will be effective in giving doctors practical guidance on the level of skills, experience and training that is necessary to practice in this area. However, I have a number of minor comments to make on the revised draft, as follows:

Paragraph 1

Paragraph 1 is a helpful statement of the purpose of the document. It also states that the statement may be used by the Tribunal, my Office and the Council's professional conduct committees as a relevant professional standard.

In my submission dated 22 March 2007, I suggested that the statement should identify the legal repercussions for those doctors who practise outside their area of competence. The changes to paragraph 1 go some way towards signaling the legal status of the statement. However, in my view, the reference to the Council's professional conduct committees is unnecessarily narrow. The Council can refer to the statement as a relevant standard in carrying out any aspect of its functions, including competence reviews and recertification. I therefore suggest that you amend the second sentence in Paragraph 1 to make it more general:

“The statement may be used by the Health Practitioner’s Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which your conduct is measured.”

Potential for Conflicts

Paragraphs 2 - 4 highlight the potential conflicts that can arise when a doctor is providing cosmetic procedures. In my view, it would be helpful to include a second heading between paragraphs 1 and 2 which states “potential for conflicts”. This will specifically alert doctors to the risks that are being identified in these paragraphs.

Paragraph 8

Paragraph 8 places the onus on the individual doctor to ensure that he or she has the necessary training, expertise and experience before practising in this area. This is consistent with the legal duty that all health practitioners have to exercise reasonable care and skill in the treatment of their patients. However, to specifically acknowledge the legal duty of care, I suggest that you amend paragraph 8 to state:

“A doctor is responsible for ensuring that he or she has the necessary training, expertise and experience to perform a particular cosmetic procedure *with reasonable care and skill.*”

In my earlier submission, I stressed the need to alert doctors to the legal repercussions that can arise from non-compliance with the statement. One option would be to footnote paragraph 8 with a reference to section 36(4) of the HPCAA, which allows the Council to initiate a competence review if “there is reason to believe that the practitioner's competence may be deficient”.

Paragraph 9

I support the changes that have been made to category 1 in paragraph 9. For the purposes of right 4(2) of the Code of Health and Disability Services Consumers’ Rights (the Code), this will now mean that invasive cosmetic procedures can only be performed by a doctor who:

- has a relevant surgical scope of practice;
- has taken individual responsibility to obtain the necessary training, expertise and experience in the relevant procedure; and
- has had his or her competence to perform the procedure independently assessed, as part of a fellowship or the equivalent.

As discussed above, I consider that the requirement for independent assessment is a key factor in providing the public with appropriate protection. I am aware that this

additional requirement will be met with some resistance by the profession and I commend the Council for taking a strong stance on this issue.

In my earlier submission, I noted that it was unclear which surgical scopes of practice would be considered “relevant”. I note that the third draft does not offer any further definition. Although it would be helpful for practitioners to have some guidance on which surgical scopes are considered “relevant”, I acknowledge that the more general reference gives the document more flexibility to be applied on a case by case basis.

I agree that the new subcategory for dermatologists is appropriate. However, I query whether the words “cutting the skin and into subcutaneous fat” may require further definition. As it is currently drafted, this definition is capable of very broad interpretation. My preference would be for the statement to definitively list the invasive procedures that can be carried out by dermatologists (eg, liposuction).

Paragraph 11 – advertising

I note from Mr Pigou’s letter that the Council intends to draft a separate statement setting appropriate standards for all doctors in relation to advertising. I support this initiative. However, in my view, advertising also needs to be specifically addressed in this statement, as it often plays a key role in prompting consumers to seek cosmetic services and it can contribute to consumers fostering unrealistic expectations.

I suggest that you specifically refer to the impact advertising has on this area of medicine in paragraph 11. For example:

“Steps should also be taken to ensure that the patient has realistic expectations and that any preconceived ideas based on advertising and media sources have been addressed.”

Paragraph 13

Paragraph 13 states that informed consent should be obtained “some time prior to the day of the procedure”. I agree that it is important for the consent discussion to occur before the day of surgery and that there should be a cooling off period (paragraph 14). I query, however, whether the words “some time prior to the day of the procedure” offer doctors sufficient guidance on appropriate timeframes.

For the informed consent process to be valid there must be an exchange of relevant information in an appropriate environment. The information should be provided within a reasonable period before the procedure so that the consumer remains aware of the risks and benefits at the time of treatment. The reasonableness of the timing for such discussions will depend on the circumstances in each case but the responsibility lies with the provider to ensure that the consent remains valid before services are provided. Accordingly, my preference would be for paragraph 13 to state:

“A patient’s consent should be obtained at a pre-procedure consultation within a reasonable period before the day of the procedure and consent must be reconfirmed on the day the procedure occurs.”

Paragraph 15

Paragraph 15 appropriately sets out the written information that should be provided to patients at the time of the initial consultation. In my view, it is also important for doctors to provide information about their relevant qualifications and experience, including evidence of their independent assessment under paragraph 9. I referred to this point on page 7 of my 22 March 2007 submission, in the context of case 01HDC01835. In my view, information about the doctor's qualifications and experience is information that a reasonable consumer would expect to receive under right 6 of the Code. This information could be provided as part of the package of written materials or by having qualifications clearly posted in patient waiting areas.

Paragraph 16

I support the specific reference to recognised ethical standards in paragraph 16 and agree it is appropriate to remind doctors of the need to tailor the informed consent process to the individual.

Paragraph 22

I strongly support the requirement that doctors practising in this area undergo clinical audit and reporting. However, I suggest that amend paragraph 22 to provide some guidance on the expected frequency of such reviews. In the United Kingdom, for example, exempted surgeons (discussed on page 5 of my 22 March 2007 submission) are required to undertake regular patient satisfaction surveys and provide a record of these to the Healthcare Commission at least annually. I suggest that the first sentence of paragraph 22 could state:

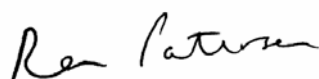
“Doctors who perform cosmetic procedures must participate in *annual* clinical audit or reporting on a number of clinical indicators.”

Statement for patients

Finally, I support the Council's suggestion that a separate resource for patients should be developed. I agree that it is important for the relevant terminology to be defined so that patients have a good understanding of who is entitled to practise in this area and how the registration system works (see page 5 of my 22 March 2007 submission). It would also be helpful for patients if the statement referred to their rights under the Code. I would be happy to be involved in consultation on this resource.

Thank you again for the opportunity to comment on the third draft of the statement. I am confident that the revised statement will result in greater public protection and improved quality of care in this difficult area.

Yours sincerely



Ron Paterson
Health and Disability Commissioner