Use of IPL (Intense Pulsed Light) therapy by beauty therapist (09HDC01064, 2 November 2009 and 09HDC01350, 4 December 2009)

Beauty therapist ~ IPL (Intense Pulsed Light) ~ Hair removal ~ Informed consent ~ Rights 4(1), 7(1)

A practitioner of Chinese medicine who also provided beauty therapy using intense pulsed light (IPL) was found to have breached the Code of Health and Disability Services Consumers' Rights after two complaints were received from women who experienced blistering.

As the complaints were received close together, concerned the same service provider, and raised similar issues, they were investigated in tandem.

Complaint 09HDC01064
The first woman consulted the practitioner about IPL hair removal treatments to her upper lip and lower leg. She was advised that she would require six treatments, for which she pre-paid. After her first treatment she was provided with an information sheet "After Care for Light Treatment" in English and Japanese. She was asked to read the sheet carefully. The practitioner, a director of the clinic, went through the information sheet with the woman and emphasised the importance of avoiding warm water and some foods during the treatment programme.

The information sheet also warned that clients undertaking IPL hair removal may develop red, swollen skin and blisters after the treatment and that scabs may form. The skin in the treated area would become darker but would peel off naturally in one week. The sheet instructed clients not to rub any areas that became red and irritated and to apply antibiotic cream if blisters developed.

The clinic also had a two-page document, headed "IPL permanent hair removal procedure". This document outlined the treatment steps to be undertaken by the IPL operator. Step 7 stated, "First test the skin, then undergo immediate observation of the skin's reaction, the appropriate response in this time is whether the skin or the hair roots are red, sometimes there is a faint burnt smell."

The practitioner was not a member of the Association of Beauty Therapists NZ Ltd. He had studied Chinese medicine and medicinal beauty in China, and had been providing beauty therapy treatments at his clinic for 11 years. He had performed IPL hair removal for over three years on nearly 1,000 clients and had had some formal training.

The practitioner did not perform any pre-treatment skin tests on the woman, but before each treatment he asked if she had experienced any problems. The first four treatments were uneventful, but the woman had some redness after the fifth treatment and advised the practitioner of this. When the sixth treatment commenced, she immediately experienced severe pain. Her legs felt hot and prickly.

Within 36 hours of the treatment, blisters developed on the woman's legs. She sought treatment for the blisters from a medical clinic and telephoned the practitioner to

advise him of this. He asked her to call into the clinic so that he could look at the blisters and offer assistance. However, the woman went to see a dermatologist, who advised her that she had been given too much energy during the procedure. This had led to prolonged erythema (redness), blistering and possible scarring. The woman then returned to the clinic for the practitioner to examine the scarring to her legs. He agreed to fully refund her fees.

Complaint 09HDC01350

Another woman consulted the clinic about IPL hair removal treatments to her lower legs. She was also advised that she would require six treatments. She pre-paid, and was given the "After Care for Light Treatment" sheet in English and Japanese, which she said she read carefully and understood.

Again the practitioner did not perform any pre-treatment skin tests, but before each treatment asked whether she had experienced any problems. After the third treatment this woman's legs were very painful and blisters appeared. At her fourth visit, she told the practitioner about the blisters. She was advised that this was a normal reaction and her skin would return to normal within a few weeks. She arranged to have further treatments to her legs and knees at extra cost. The remaining treatments were provided using lower power and, although painful, caused no further problems.

A month after her final treatment this woman saw a television programme about the other woman who had suffered skin blisters following IPL treatment at this clinic. She returned to the clinic, advised the practitioner that she had scarring to her legs and asked for her fees to be refunded. He examined her legs, but was reluctant to refund her fees.

She went to see a dermatologist a week later. The dermatologist found areas of striped hyperpigmented scarring on the side of her left calf, and a small area on her right calf. He advised her that the operator had used too much energy during the procedure, but the scarring would improve with time.

Conclusions

IPL treatment involves a risk to the consumer, and should only be performed by those with appropriate training, expertise and experience. The Association of Beauty Therapists NZ Ltd (the Association) recognises this and advises its members that the training and ongoing education in the use of IPL machines is the responsibility of the machine distributors. The Association Secretary, commenting on an earlier similar complaint[1] to HDC, advised that the Association has a number of members who distribute IPL machines and they conduct "extensive and continued" training to the beauty therapy clinics they supply. The Association believes this training and follow-up should be mandatory.

Although the information sheet provided to the two women in these cases advises about the known associated risks of IPL, the first woman was not given this information until after she had agreed to the series of treatments and had had her first treatment. Therefore, she was unable to make an informed choice about whether to consent to the treatment.

[1] 07HDC09713 (June 2008) available from HDC's website, www.hdc.org.nz

Furthermore the clinic had appropriately provided policies and procedures on IPL treatment which were not followed. It has a 14-step written procedure for the guidance of IPL machine operators performing permanent hair removal treatment. This includes the need to test the client's skin for sensitivity before starting treatment, and to adjust the IPL energy according to the client's skin and hair type. The IPL operator did not follow those steps for either of the women in these cases.

As a director of the clinic, the practitioner should have been aware of the policies, including the requirement to carry out skin tests — a requirement he did not follow.

In case 09HDC01064, the practitioner was found to have breached the Code of Rights in relation to providing services of an appropriate standard and obtaining informed consent. In 09HDC01350, he was found to have breached the Code of Rights in relation to providing services with appropriate care and skill.

Recommendations
It was recommended that the practitioner undergo further training and review his procedures. He discussed the skill and safety aspects of these cases with the clinic staff and directors, amended the clinic procedure manual, and undertook further training with the IPL machine supplier. He was also asked to apologise and subsequently did so. The Ministry of Health and the Association of Beauty Therapists were advised of the findings.

Use of title "Dr"
The matter of the practitioner advertising himself as "Dr" on the clinic's website, on the basis that he studied Chinese medicine and medicinal beauty in China, was also addressed. The practitioner was advised that it is a serious matter for an unqualified person to use a description that implies he or she is a registered health professional. The IPL operator removed the title "Dr" from the website.

The Ministry of Health was notified.