The Nuffield Council on Bioethics Cosmetic Procedures Call for Evidence, March 2016

Response from the Expert Council on Cosmetic Interventions (ECCI), formed from experts members of the British Association of Dermatologists (BAD), British Association of Aesthetic Plastic Surgeons (BAAPS), and the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)

Questions 9-15, The Supply and Regulation of Cosmetic Procedures

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9. Do you think that people seeking cosmetic procedures are 'patients' or 'consumers', neither, or both?

Both. There may be no medical basis for the individual to request the procedure, which is carried out within a commercial sector, implying that the individual is a 'consumer'. However, as these interventions are based on medical practices, and carry clinical risks to the individual, the individual must be regarded and treated as a 'patient'.

The public has the right to expect a consistent minimum standard of care from all practitioners who are deemed to be "qualified", irrespective of their original professional qualifications. A beauty therapist carrying out injections should have the same minimum training in injecting as a nurse, a doctor or a Consultant Dermatologist. Such training should not only focus on technical expertise, but also the generic and comprehensive skills of patient/client assessment, consent, regulatory issues, risks/complications, other therapeutic options, etc.

Similarly, any patient undergoing a cosmetic surgery procedure should be protected by the knowledge that the surgeon has gone through an appropriate training (as above and including training in maintaining professional standards) and is competent to deliver the surgery to the highest standard.

10. What information should be made available to those considering a procedure?

The public has the right to expect good quality, evidence-based practice from those who deliver non-surgical cosmetic procedures. The practitioner should work within their competences; in order to do so the practitioner must have some insight and understanding of clinical circumstances which fall outside of these boundaries and be able to identify situations where it is appropriate to refer on.

As such, all patients should be provided with information on the practitioners' training and qualifications, and how these compare to the full spectrum of training and qualifications currently available.

In the absence of a mandatory register, a voluntary register of practitioners undertaking non-surgical procedures is essential. Entry on the register would involve adherence to a code of conduct,

minimum training requirement, ongoing CPD and appraisal. Patients should be made aware of the practitioner's status on the register and what the register entails.

Patients should also be fully briefed on the potential risks of any procedure they are considering. This should be mandatory, not provided on request. Such mandatory information should be evidence-based, and written in plain language to cover 1) the scope/aim of each leaflet, 2) details of the "treatment"/procedure, 3) alternative "treatment"/procedure options, if applicable, 4) potential risks and side effects with indication on their severity and prevalence, 5) self-care for after the treatment. Ideally such materials should attain the Information Standard certification, and be referenced within the consent forms. For surgical procedures the information should be generic with relevant specialities all contributing to make forms that are crystal marked for plain speech, and in addition to being mandated to be given to the patient should be freely available via the Royal College website either directly or via links to the appropriate speciality associations.

Patients should be advised of whether or not the practitioner could recognise and deal with any complications that might arise, or if an onward referral would be required.

Patients should be able to access information regarding how many of the chosen procedure the practitioner has carried out, and how many adverse events have been reported.

For both surgical and non-surgical procedures a record of consent must be held by the provider. It might be added that as with surgical consent, part of the process for this consent should be clear information on the potential risks of the procedure.

13. Should there be any guidelines or regulation on who can provide non-surgical cosmetic procedures?

Yes, this is essential.

The Expert Council on Cosmetic Interventions (ECCI) is a tripartite group consisting of the British Association of Dermatologists (BAD) which incorporates its specialist interest group the British Cosmetic Dermatology Group (BCDG), the British Association of Aesthetic Plastic Surgeons (BAAPS) and the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS). The ECCI considers the following to be imperative:

1) Voluntary register of practitioners

As stated above, in the absence of a mandatory register, a voluntary register of practitioners is crucial. Entry on the register would involve adherence to a code of conduct, minimum training requirement, ongoing CPD and appraisal. The standard to be met by an individual practitioner will be set by the ECCI in collaboration with stakeholders, and their professional body if one exists for that practitioner.

2) Adherence to HEE curriculum

Practitioners must adhere to the Health Education England (HEE) curriculum for non-surgical cosmetic procedures, which acts a training standard for all practitioners of non-surgical cosmetic interventions. Crucially, the standards cover both clinicians and non-clinicians, meaning that they apply to everyone practising these procedures, not just doctors and nurses.

3) Standard setting and oversight

With the curriculum in place, it is also paramount that all relevant professional groups work together to develop an agreed model both for setting standards and for oversight of the sector. Under the model proposed by the ECCI, the ECCI's key roles would be to:

i) set standards and codes of practice across the sector;

ii) lead evidence-based research and facilitate implementation of its practice;

iii) scan the horizon for emerging technologies/therapies and advise on risk mitigation;

iv) collaborate with educational authorities and the nascent Joint Council on Cosmetic Practice (JCCP) in order to quality-assure training, appraisal and CPD;

v) act as a key professional advisory body to develop appropriate and proportionate strategies which address current and emerging issues within the sector

vi) collaborate in oversight of the voluntary register

4) Clear Signposting for Practitioners

Various practitioner groups must fall into a hierarchy of categories, including: medical, dental, nursing, pharmacy, allied health professional, beautician, other. The overseeing professional body for each of these groups must declare whether or not they feel it is within the scope of practice for their members to engage in nonsurgical cosmetic practice. If not, then they must clearly signpost for their members what the ECCI and JCCP require in terms of code of conduct, education/training, voluntary registration etc. It will then be clear what is expected from all of those engaging in nonsurgical cosmetic practice, including those without guidance from their professional groups.

5) Code of Conduct

The General Medical Council's 'Guidance for all doctors who offer cosmetic interventions', due to be released imminently, will form the basis of the code of conduct, which may also include additional stipulations, such as that practitioners use only FDA approved products.

14. What are the responsibilities of those who develop, market, or supply cosmetic procedures?

Manufactures must take responsibility to ensure that individuals to whom they distribute their products are suitable. Some companies currently require medical, dental or nursing degrees as a minimum standard. Going forward, companies should ensure that the practitioner they supply to is on the voluntary register. Those on the voluntary register should limit use to FDA approved products. An audit trail of products should be evident for each patient.

The way in which many of these procedures are advertised implies that they without risk, and on a par with less invasive beauty treatments such as facials and waxing. Existing advertising recommendations and restrictions should be updated and better enforced.

The use of financial inducements and time-limited deals to promote cosmetic interventions should be prohibited to avoid inappropriate influencing of vulnerable consumers.

As per the Keogh review, for non-surgical procedures a record of consent must be held by the provider. It might be added that as with surgical consent, part of the process for this consent should be clear information on the potential risks of the procedure.

15. Do you believe that current regulatory measures for cosmetic procedures are appropriate, too lax, or too restrictive?

The current regulatory measures for non-surgical cosmetic procedures are too lax by some way.

This type of cosmetic procedure does not fall under any medical regulatory system. If it is carried out by professionals registered with a medical regulator then those professionals must still act within the rules of their profession. If the procedures are carried out in premises that fall under the regulation of the Care Quality Commission then the environment in which they are carried out would also be regulated. However, there is no requirement that such procedures must be carried out by medical professionals – and in fact no requirement that people carrying them out must have attained any kind of standard in training at all. A large proportion of these treatments will be carried out in salons and beauty parlours by people with limited training in injections, human anatomy and dermatology, rather than by medical professionals with specialist skills.

Such practitioners may be unaware of potential risks in the procedures they are carrying out They may also not see the complications arising out of any procedures they administer as many people are likely to seek treatment from their doctor. Although most reputable businesses in this area will have indemnity insurance there is no statutory obligation for them to do so, unlike for medical professionals. This group of practitioners is less likely to be aware of how to access safety data, adverse event information or how to report adverse events than medical professionals.

As such, we welcome a training curriculum and urge for tighter regulation of the industry.

For surgical procedures, as these are all undertaken (in England and Wales) in a setting that is subject to CQC regulation the current recommendations as set out by the College's response to the Keogh report, if fully instituted will ensure that the regulations are neither too lax nor too restrictive, but set at a level whose ultimate aim is protecting patient safety and ensuring the highest quality of care.