Response to the General Medical Council's consultation on 'Guidance for doctors who offer cosmetic interventions'

A statement from

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About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialities, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

Background

'Cosmetic surgery' refers to an operation or invasive medical procedure, performed to enhance a patient's physical appearance, to improve an aesthetic ideal, rather than reconstruct defects for medical reasons (1). Cosmetic surgery is rarely available through the NHS, and is primarily performed in the private sector and, as such, represents a multibillion-pound industry (2). There must be overriding physical or psychological reasons for considering it as a treatment option on the NHS (3).

Following concerns about the quality of implants used in cosmetic breast surgery (4), an independent review of cosmetic practice performed in the private sector was completed in 2013, *The Keogh Review of the Regulation of Cosmetic Interventions* (5). The review concluded that existing regulation did not provide enough protection against many of the potential risks from cosmetic procedures. It made a number of recommendations designed to improve the care provided for patients. The Royal College of Surgeons of England, together with numerous stakeholder organisations, formed the Cosmetic Surgery Interspecialty Committee (CSIC) to address the recommendations in the review. The CSIC has presented key proposals for a framework that will provide improved protection for patients undergoing cosmetic interventions (1). In March 2015, ASiT published its response to the CSIC recommendations (6), and subsequently attended the CSIC stakeholder meeting in June 2015.

Response to the General Medical Council's 'Guidance for doctors who offer cosmetic interventions'

ASiT has welcomed the General Medical Council's (GMC) consultation following *The Keogh Review of the Regulation of Cosmetic Interventions*. ASiT has provided a voice for surgeons in training in the United Kingdom and Republic of Ireland for almost 40 years, with representatives from all regions, training grades and specialties on their Council. ASiT regularly surveys membership on issues relating to surgical training. We are therefore in a unique position to offer feedback, not only on how policy-change translates to practice on the ground, but also to help to monitor its ongoing progress. Our work on European Working Time Directive (7), Bullying and Undermining (8), Less Than Full-time Training (9) and other pertinent issues have been influential at the top tables of policy on surgical practice. This statement is based on the consensus opinion of the Association on the GMC's 'Guidance for doctors who offer cosmetic interventions' (10), with representation from all ten surgical subspecialties and particular emphasis on those specialties most commonly involved in cosmetic surgical procedures. The following conclusions have been reached:

- ASiT welcomes this opportunity to intervene to protect patients and improve patient safety. We fully agree that the existing regulatory framework is currently insufficient in this regard, and we are committed to its development.
- We welcome the assertion that all surgical interventions should be provided by suitably qualified doctors, either on the specialist register within the

related specialties themselves, or directly supervised by a responsible doctor who is.

- We have concerns regarding the application of the accreditation process, specifically surrounding the independence of bodies conducting accreditation processes. It is unclear whether established practitioners will be subject to the full rigour of this process, or whether it is solely newly registered Certificate of Completion of Training (CCT) holders who will be required to complete the process. We feel strongly that in the interest of patient safety the accreditation process should be for all practitioners who offer cosmetic interventions, not just newly appointed CCT holders, and should form part of the revalidation process.
- Currently, only plastic surgery, otolaryngology and maxillofacial surgery have an aesthetic surgery component within their curricula, with completion necessary for the award of CCT. Cosmetic surgery, however, is practised very widely, and a strict definition is necessary. A patient who wants a procedure to improve their appearance may have a traumatic, congenital or post-surgery cause and corrective surgery and interventions are aesthetic in their approach, restoring normal form and function. The term cosmetic should be reserved for patients who have an appearance which is on the normal spectrum for the population but who wishes to alter it in a way that they personally find more acceptable. The risk benefit ratio for cosmetic surgery is much more finely balanced, with the potential to cause irreparable damage with minimal gain to the patient. To suggest that patients requiring aesthetic and reconstructive interventions to restore the form altered by

trauma, tumour or birth defects be grouped in the same category significantly underestimates the very real challenges that such patients face.

- However, there are undoubtedly transferable skills that are developed during training within non-aesthetic NHS practice in all specialties that should be acknowledged by the accrediting body. For this reason, the current grouping of procedures for accreditation by the CSIC appears to result in more groups than is necessary.
- The division of surgical skills into credentialed modular units risks undermining the recent significant advances in training curricula. A serious concern of ASiT is that the overall value of a CCT-level trained and ethically responsible surgeon, with a demonstrable track record in governance and transparency is eroded. The wider issue of credentialing has long been discussed (11), and surfaced more recently with the publication of the Shape of Training Review (12). It is proving difficult to determine how credentialing could be effectively delivered, and ASiT has posed questions for consideration regarding the practicalities of credentialing in general (13-14).
- We believe the wider recommendations in relation to the governance of implantable medical devices, appropriate medical indemnity and corporate responsibility are key to the creation of a safe, transparent and robust framework that patients can trust.
- Increasing the gap in the provision of training in aesthetic surgery between NHS and the independent sector risks promoting a disparity in the value of applying standards and good practice models in both.
- We feel there is a lack of clarity related to the acquisition of knowledge, skills and performance contained with the GMC guidance document. The guidance

states that doctors should "recognized and work within the limits of your competence", and "should seek opportunities for supervised practice", there is no specific mention of the standards of training required. Surgeons maintain a logbook of all procedures, and surgical trainees in the United Kingdom and Ireland maintain a comprehensive record of progress in the form the Intercollegiate Surgical Curriculum Project (ISCP) portfolio. Those undertaking procedures should be made to contribute to those validated methods with a recognized trainer. ISCP has extended to include reflective practice and non-operative technical skills for surgeons (NOTSS), which is crucial to developing a competent and responsible practitioner. This cannot be substituted by attending a course, or being watched by another unconventionally trained colleague. This material should act as the cornerstone of annual appraisal in relation to such areas, particularly in the early years of adopting such cosmetic practice.

- In relation to question posed in the guidance document 'Do you agree that doctors should seek opportunities for supervised practice before they carry out interventions on their own or as a team leader or offer to supervise others?' the explanation given as to why this 'should' as opposed to 'must', states that it takes into consideration a doctor who is providing a new technique. The recent NICE guidance on interventional procedures (15) gives clear advice on the process that must be undertaken when introducing novel procedures in order to protect patient safety. A practitioner who has worked to develop a new procedure would be in the setting of someone with a track record of competence with extensive knowledge and working

links with a governance structure. ASiT feels that this provides a large loophole that could undermine the value of high quality training in this field.

- ASiT readily accepts the importance of trust in the profession, and the need for efforts to improve transparency and whilst we support 'the contribution to clinical audit and national programmes to monitor quality and outcomes', we have previously outlined our concerns related to the effects of the publication of consultant-specific rather than unit-specific outcomes on impact of surgical training (16-17). We feel there should be expansion of outcome measures to include patient satisfaction measurement, and that those practitioners undertaken cosmetic interventions should contribute to a mandatory national register of procedures undertaken and complications which arise.

In conclusion, while ASiT welcomes the GMC consultation following the Keogh report highlighted, in a similar vein to the response ASiT submitted to the CSIC for the Royal College of Surgeons of England, we are concerned that training has not been targeted as an area within this consultation. Robust and comprehensive standards in relation to surgical training have been prioritised by all stakeholders in recent times, with the primary aim of improving patient safety. To allow such an expanding market as cosmetic medicine to flourish without imposing equivalent standards will further widen the governance gap between high quality care and that, which is currently offered.

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ASiT has published a number of statements that are available at: http://www.asit.org/resources/articles