AESTHETIC MEDICINE: MEDICOLEGAL AND PROFESSIONAL ISSUES

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ABSTRACT

The place of Aesthetic practice in the Art and Science of Medicine raises questions. This paper attempts to define a professional position. The definition of aesthetic medicine is difficult and many diverse ones have been proposed. We need to come to an agreement to a common working definition in Singapore. One working definition provided by the Medical Protection Society is "treatments or procedures which have as their primary purpose the alteration of the non-pathological external appearance of the patient. In embarking on this branch of medicine, the focus needs to be on patient welfare and we should not be distracted by the profit motive. Society trusts the medical profession to regulate itself and abide by its traditional professional standards. Should this public confidence in the medical profession be eroded, the foundation on which every doctor-patient relationship is based upon will be undermined. While change is inevitable, there is a need to preserve what is good in tradition, uphold standards of professionalism and seek to pass on this good tradition to future cohorts of doctors and patients.

DEFINITION AND SCOPE OF AESTHETIC MEDICINE (AM)/SURGERY

The place of Aesthetic practice in the Art and Science of Medicine raises thorny questions. The definition of aesthetic medicine is difficult and many diverse ones have been proposed. We need to come to an agreement to a common working definition in Singapore.

One defence organisation uses this definition: "*treatments or procedures which… have as their primary purpose the alteration of the non-pathological external appearance of the patient". (Medical Protection Society)*[1]

In practice, the scope of aesthetic medicine/surgery can range from simple cosmetic dermatological and hair procedures, to body contouring surgery, to procedures that claim to reverse ageing.

One estimation puts the turnover for the aesthetic industry at $160 billion a year in a global industry comprising make up products, skin and hair care products, diet pills and cosmetic surgery.

In aesthetic medicine, the physician has moved from cure of diseases and relief of suffering, to enhancing bodily image and feeling good. The societal and media emphasis on externality is so pervasive that patients now expect the medical profession to provide aesthetic services.

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The unstoppable evolution of aesthetic medicine has led to a groundswell of interest amongst the public, and doctors of various disciplines. This is happening all over the developed world where basic healthcare and public health needs can be taken for granted. This means a significant sector of the market is able to move up Maslow's hierarchy of human needs. At the peak of this pyramid of needs is that of self actualisation which most would take it to mean "looking good on the outside and feeling good on the inside."

CHANGE IN VALUES SYSTEM

It is a paradox when doctors who spend many years in training and working hard at saving lives, is paid less than those who make their clients look beautiful. The change in the value system of our patients, and in turn of ourselves, is challenging the very core of the medical profession's own value system, which the profession is trying to preserve. Individually and collectively, doctors have to resolve this tension.

The fear is that if doctors choose business imperatives at all costs and above all professional values, the profession may tip over and all trust and respect will, consequently, be obliterated. Doctors risk becoming technicians, and patients being mere customers[2].

Part of this shift from preventive and curative work to aesthetic practice is due to an oversupply of doctors, and compounded by the concentration of patients in government polyclinics and managed care dominating the private healthcare market.

It is clear that aesthetic medicine is a "beauty want" rather than a "health need".

MANAGING EXPECTATIONS OF RISK AND OUTCOMES & PATIENT SELECTION

The patient requesting aesthetic procedures often harbours unrealistic expectations. Each patient is unique in that he or she sees a different end point in what he or she considers as beautiful. Indeed, beauty is in the eyes of the patient.

Whether the outcome of an aesthetic procedure is deemed satisfactory or not is dependent on the pre-procedure mutually agreed goals during consent taking. If the agreed goals are not clearly stated during consent taking, and documented as such, then even the most technically perfect outcome may still result in patient dissatisfaction and expose the aesthetic practitioner to litigation[3].

There is a tendency for underestimation of risk by patient by regarding this as a purely cosmetic procedure. Cosmetic surgery is perceived by the American public to be more temporary and less technically difficult than plastic or reconstructive surgery[3]. There is also an understatement of risk,

recovery period and long term results by practitioner[4].

Hence, it is likely there is a difference in opinion between the patient and the doctor. This will lead to frequent dissatisfaction with the outcomes. Such mismatch of expectations can lead to conflict complaints, and court proceedings.

While the patient may request for a particular form of treatment, the doctor should advise the patient against it and refrain from proceeding further, if in his professional opinion he considers it inappropriate, harmful or illegal. If both parties are going ahead with the procedure, a full written informed consent should be obtained and documented[4].

An experienced doctor will listen to his instinct, honed from years of experience. He will do well to turn away those unrealistic patients. This is especially so in cases which may be suffering form dysmorphic body disorder or borderline personality disorder. At times, a psychiatric assessment may be helpful, although most patients will take insult at the suggestion that they have a psychological and not a physical problem[5,6].

The temptation is to give in to the patient as the doctor has incurred high costs in terms of clinic rental and furnishings, aesthetic equipments (usually bought through hire-purchase) and training costs. There may be a tendency towards over-servicing as well[4].

PUTTING THE SCIENCE IN BEAUTY

This has been well described by Professor Satku, Director of Medical Services, Ministry of Health, Singapore:

> "The real challenge we now face is to ensure that the aesthetic services we provide are grounded in scientific merit.
>
> Many procedures that constitute aesthetic medicine do have a strong scientific basis. This includes even Botox injections for wrinkles and laser treatment for hair removal. But as we look at some other aesthetic procedures, the scientific evidence is weak, and in some instances, the procedures border on being a sham.
>
> Thus, the practitioners of aesthetic medicine have a duty to carefully consider the supporting evidence and only employ procedures that are reliable and give good outcomes. *Where there are uncertainties, potential problems or significant side effects, one must tread carefully. The procedures must be carefully evaluated, the risk clearly communicated, and the procedure and outcome carefully monitored and consistent with good observational studies. In this way, we will be able to do our work right and do it well*[2].

TRAINING ISSUES

There is currently no local structured training programme that offers accreditation to raise the level of competency and recognition.

Constant skills upgrade is necessary both for the doctor and his staff. This can be expensive as most training available is overseas. For quality assurance, the staff needs to be continuously trained, to be able to explain and assist in procedures efficiently, as well as assist in managing post treatment enquiry[7].

SAFETY ISSUES

> "However, safety remains the key factor that no industry player can breach. If any budget airline compromises the safety factor and an accident occurs, the trust in the industry will be lost and the industry will crumble…. At the same time, all that we have stood for: high ideals, high professionalism and ethical standards must never be compromised. If collectively we allow this to be breached, it is akin to an accident in the airline industry."[2]

Public and patient safety has to be our first consideration. The first and foremost principle must always be "first, do no harm". This is most important as there is no disease in aesthetic medicine[8].

MEDICAL ADVERTISING INFORMATION TO PUBLIC

Indirect advertisements through media interviews, magazine write ups and talks at ladies' luncheons must meet the ethical guidlelines set by the Singapore Medical Council and the Public Hospital and Medical Clinics Act (Publicity) May 2004.

There is a tendency to play on the insecurities associated with superficial consequences of ageing[9]. Marketing strategies are based on the slogans of "ageing is ugly; ugliness as a disease and cosmetic surgery the cure" may be seen as exploitative and not "subject to the ethics of genuine medical profession"[10].

On the issue of medical advertising and endorsement, the Australian Medical Association has taken a position:

> "The promotion of a doctor's medical services as if the provision of such services were no more than a commercial product or activity is likely to undermine public confidence in the medical profession"[15].

The Committee of Inquiry into Cosmetic Surgery conducted in 1999 by the NSW HCCC concluded that a number of promotional practices "may be in breach of professional standards and fair trading laws"[16].

ISSUES IN REGULATION

At present the profession has been urged to self regulate, set professional standards and training required, accredit the practitioners, and monitor the outcome. The aim should be to promote science and discard questionable practices, and to criticise unethical practices. Only when self-regulation fails will the authorities step in[2].

There is a worry if an increasing number of general practitioners switch to aesthetic practice.

There is also the problem of whether to allow doctors to call themselves aesthetic physicians when aesthetic medicine is not a recognised specialty.

Current issues in regulation are:

- A working definition of Aesthetic Medicine.
- Ethical guidelines which are based on and conforms to the Singapore Medical Council Ethical Code and other guidelines like the Good Medical Practice of the General Medical Council UK[14].
- Medical indemnity and other medicolegal issues.
- A review of the acceptable standards of practice .
- Patient communications: risks, benefits and recovery period, etc.
- Clinical practice guidelines to doctors.
- Level of training required.
- Level of continuing professional development.
- Turf War - Fighting for turf often leads to disparaging remarks made to a patient who doctor hops and frequently leads to complaints and litigation. Backstabbing only leads to higher medical indemnity fees for all practitioners. A multi-disciplinary approach to self-regulation may avert a turf-war that beset such attempts at consensus in North America (AC Markey). In Singapore, a body similar to the Cosmetic Surgery Interspecialty Committee[13] could be convened overcome issues of overlap[11].
- Practitioners must be committed to scientific study and publications in peer reviewed journals.

FOR A SAFER PRACTICE AND BETTER NIGHT'S SLEEP (HYGIENE FACTORS)

It is good to remind oneself of

- working within the regulations and guidelines for advertising;
- the need to be religious about keeping good photo documentation and clinical notes;
- taking informed consent which should be explained to patients and well documented;
- knowing your own limitations, and referring to another practitioner if the patient's needs are beyond your scope, post treatment complications can occur unexpectedly; Learn to mange complications well;
- be covered with the right category of medical insurance[7].

As in all businesses, practising aesthetic medicine has its pros and cons. It has a higher start up and operating cost, and a slow learning curve coupled with increased risk of patient complaint.

PRACTICAL QUESTIONS FOR THOSE CONTEMPLATING AM

Some doctors have asked themselves and their peers regarding what to do if they want to start an aesthetic practice.

The following are a suggested list of questions to think through before embarking on any newly-learned procedure.

- SCIENCE: Is this procedure scientifically sound?
- MEDICOLEGAL: Consider carefully your legal and ethical responsibilities.
- MEDICOLEGAL: Do I know my legal liabilities due to the special nature of cosmetic practices?
- MEDICOLEGAL: Have I paid the correct subscription category in order to avoid not being covered when sued?
- FINANCIAL: Can I recover the costs of equipment in order to survive? Can I avoid financial distress, cashflow problems, monthly total costs - monthly turnover. NPV, IRR, Payback period.
- Will I put undue pressure on the prospective client?
- FINANCIAL: Can I recover the losses (from opportunity costs of time spent undergoing training & dollar costs of training courses)?
- Some procedures have a steep learning curve. By the time you learnt it, it may go out of fashion - end of product cycle.
- SELF EXAM: Am I trained to handle complications when they occur?
- SELF EXAM: Do I want to handle patients' unrealistic expectations?
- Can I handle the negative publicity when things fall apart? Aesthetic cases attract limelight. Even large institutions are not spared the scrutiny[12].

CONCLUSIONS

Society trusts the medical profession to regulate itself and abide by its traditional professional standards. Should this public confidence in the medical profession be eroded, the foundation on which every doctor-patient relationship is based upon will be undermined.

While change is inevitable, there is a need to preserve what is good in tradition, uphold standards of professionalism and seek to pass on this good tradition to future cohorts of doctors and patients.

The focus needs to be on patient welfare and we should not be distracted by the profit motive.

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