

Professional Standards for Cosmetic Practice

Cosmetic Surgical Practice Working Party



This is a timely document which outlines the ethical and clinical standards that cosmetic surgeons should adhere to. In the case of female cosmetic genital surgery, the majority of these operations are undertaken outside of the NHS, often for little or no medical benefit.

Women and girls sometimes find themselves pressured by marketing campaigns compelling them to achieve a certain aesthetic that was never intended by nature. We support the recommendations of this report and the way in which women have been placed firmly at the centre of care.

Dr Tony Falconer

President of the Royal College of Obstetricians and Gynaecologists

Good cosmetic practice covers a range of activity from provision of information, communication, informed consenting, through appropriate education and training of the physician/surgeon and other members of the team to use of properly maintained equipment and premises, documentation, collection of data and regular audit. These aspects are all elucidated in the document.

Professor Harminder S Dua

President of The Royal College of Ophthalmologists

Cosmetic surgery is an increasing area of healthcare in which the public is at particular risk of suffering substandard treatment and potentially unpleasant and irreversible complications. This report outlines the standards, behaviours and competencies that practitioners of these procedures should follow. It is therefore most welcome.

Sir Richard Thompson

President of the Royal College of Physicians

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Acknowledgements

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- Association of Breast Surgery
- The British Association of Aesthetic Plastic Surgeons
- British Association of Oral and Maxillofacial Surgeons
- British Association of Plastic, Reconstructive and Aesthetic Surgeons
- ENT UK
- Training Interface Group in Reconstructive Cosmetic Surgery
- Faculty of Dental Surgery
- Faculty of General Dental Practice (UK)
- The Royal College of Obstetricians and Gynaecologists
- The Royal College of Ophthalmologists
- The Royal College of Surgeons of England
- Patient Liaison Group of The Royal College of Surgeons of England
- The British Association of Dermatologists

Working party observers

- General Medical Council
- Care Quality Commission

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- Royal College of Nursing

Acknowledgements

The working party would like to thank the following for their comments on the standards

- Independent Healthcare Advisory Service
- British Academy of Cosmetic Practice

Chair's foreword

In the United Kingdom cosmetic practice is unique in that it sits almost entirely outside the National Health Service (NHS) and encompasses practice that spans several medical specialties and healthcare disciplines. This means that the standards of practice are, in comparison with other areas of healthcare, relatively unclear. The Cosmetic Surgical Practice Working Party was, as its name suggests, established to consider cosmetic surgical practice. However, this remit was broadened by the Working Party to consider cosmetic practice as a whole in order to reflect the role of the wider surgical team. This document therefore draws on expertise from the medical, dental and nursing professions to produce clear, widely applicable professional standards.

The purpose of this document is to bring together and build on a number of existing standards documents that cover or specifically address cosmetic surgical practice. This document is not intended to replace or change the existing regulatory requirements of the professions but instead aims to draw out and harmonise some of the common standards across the three healthcare professions that have previously varied in content or detail.

The medical royal colleges and professional organisations are not regulators. Nor are they legislators. It is for the government to decide if it would like to regulate the sector more closely. However, the medical professions have a responsibility to highlight the issues and to provide the standards that we would expect both ourselves and our colleagues to meet.

Mr Stephen Cannon

Chairman

Executive summary

The demand for cosmetic surgery and non-surgical cosmetic treatments is rising in the UK with reports of a 5.8% rise in cosmetic surgery procedures in 2011.¹ Virtually all cosmetic practice occurs in the independent sector outside the remit of the NHS. Arguably, this leads to less close regulation of the sector. Doctors from a range of specialties are trained to undertake surgery. Non-surgical procedures such as laser treatment or injectables (eg Botox[®]) may be administered by those with no healthcare qualifications whatsoever.

In this document it is recommended that only licensed doctors, registered dentists and registered nurses should provide any cosmetic treatments (including laser treatments and injectable cosmetic treatments). The level of training and experience required would vary depending on whether the procedure is invasive or minimally invasive. Invasive procedures would only be carried out by licensed doctors on the General Medical Council's (GMC's) specialist register. Minimally invasive procedures would only be carried out by doctors, dentists and nurses who have undertaken appropriate training.

This document is the result of a working group comprising experts from across the remit of cosmetic practice and sets out professional standards, behaviours and competencies for doctors, dentists and nurses who currently offer or intend to offer cosmetic procedures. It will also be relevant to patients, service providers and regulators.

In drawing together the standards for all cosmetic practitioners, the working group highlights the following common standards. Practitioners must:

- make their professional qualifications clear to patients
- inform patients about the full financial implications of the procedure that they are requesting before signing a consent form
- ensure marketing is honest and responsible and adheres to standards laid out by the relevant professional regulator
- have in place procedures for handling patient complaints
- have in place indemnity insurance that is adequate for the procedures that are undertaken
- have completed life skills training in compliance with the UK Resuscitation Council guidelines and ensure patients have access to help at all times.

Practitioners should adhere to the process of patient care outlined in this document, which highlights the importance of preparing the patient before the procedure, ensuring the patient has a full

understanding of the risks involved in the procedure, consideration of the need for a psychological assessment and the pre and postoperative requirements of the procedures.

Organisations that provide cosmetic procedures have a responsibility to support practitioners to fulfil their professional commitment to provide high standards of care.

1

Introduction and background

1.1 Background

The impetus for this work was the publication of the National Confidential Enquiry into Patient Outcome and Death report *On the face of it*.² That report dealt largely with the organisations offering and providing cosmetic surgery. However, The Royal College of Surgeons of England (the RCS) believed that it exposed a lack of consistent professional standards in the field of cosmetic surgical practice. Therefore the RCS established a working party of key professionals to develop these standards.

The Cosmetic Surgical Practice Working Party (the Working Party) met first on 5 November 2010 to discuss the scope and direction of its work. It was agreed that the standards produced should encompass minimally invasive procedures including lasers and injectable treatments as well as invasive cosmetic surgery.

The report was shared with key external stakeholders including representatives of the cosmetic practice industry, and their comments were considered carefully by the Working Party.

1.2 Previous work on this topic

- *Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer* (Department of Health, 2007)
- *Provision of Cosmetic Surgery in England* (Healthcare Commission, 2007)
- *Good Medical Practice in Cosmetic Surgery/Procedures* (Independent Healthcare Advisory Service, 2010)

The European Committee for Standardization (CEN) has begun work to produce Europe-wide standards in the provision of cosmetic surgery.³ This work is still at a draft stage but is intended to provide a detailed focus on the organisations and individuals that provide the services. The standards have been put to public consultation (in January 2012) and it is thought they will be published by the end of 2012.

1.3 Definitions, language and categories

The term 'cosmetic surgery' and 'cosmetic practice' are used throughout this document. These terms, rather than 'aesthetic surgery' or 'aesthetic practice', were chosen because they match common English usage and patient perception more closely.

Definitions of ‘cosmetic surgery’ and ‘aesthetic surgery’ abound and each has its merits. The Working Party believed that it was important to agree a definition that it would work to, and adopted the following definition:

Operations and all other invasive medical procedures where the primary aim is the change, the restoration, normalisation or improvement of the appearance, the function and well-being at the request of an individual.^a

In order to target standards according to relative risk, the Working Party categorised cosmetic treatments as follows:

- **Level 1a: Invasive**
Medium–high risk; may require general anaesthetic; may require an overnight stay.
- **Level 1b: Invasive**
Low–medium risk, usually only requires local anaesthetic, out patient.
- **Level 2: Minimally invasive**
Lower risk, usually non-permanent/reversible,^b day case, local anaesthetic if any.

Most cosmetic procedures are performed outside the NHS. Therefore this document assumes that patients will be paying for the procedure.

1.3.1 Cosmetic gynaecological surgery

The Royal College of Obstetricians and Gynaecologists (RCOG) has strong concerns about cosmetic genital surgery. There is particular concern over the growing number of procedures performed on young women. In girls under the age of 18 the labia may still be developing and therefore change with time. Clearly there will be some women with congenital and acquired genital anomalies, such as those associated with disorders of sex development, birth injury, sexual assault, cancer and dermatological conditions where gynaecological advice is indicated. There are also different considerations for transgender women. RCOG supports the concept of patient and professional autonomy. It believes that any decision to provide cosmetic genital surgery should be based on clinical grounds. High levels of anxiety regarding body image where appearance is within the normal range should trigger psychological referral.

^a The CEN definition has been used in the context of ‘cosmetic surgery’ as defined in this document rather than its original context of ‘aesthetic surgery’ as defined by the CEN.

^b Although permanent blindness, chronic granuloma, tissue necrosis, scarring, permanent dyspigmentation and other side effects can occur



1.4 To whom do these standards apply?

The Working Party recommends in this document that only licensed doctors, registered dentists and registered nurses should provide any cosmetic treatments (including laser treatments and injectable cosmetic treatments). Although it is legal for laser treatments and injectable cosmetic treatments to be administered by people who do not fall into these groups, this is not endorsed by the Working Party which urges anyone administering such treatments to follow these standards.

In this report the term ‘practitioner’ is used to denote the doctor, dentist or nurse carrying out the procedure and is applied irrespective of the profession to which the individual belongs. Where the terms ‘doctor’, ‘dentist’ and ‘nurse’ are used the members of that specific profession are being referred to.

1.5 What does this report seek to address?

This report focuses on the professional standards, behaviours and competencies that doctors, dentists and nurses should be expected to demonstrate while providing cosmetic procedures. Those individuals have a responsibility to practise only in environments (facilities and processes) that they believe to be safe. This report therefore also covers issues relating to environment where this would help to guide individual practitioners.

1.6 Who should read this report?

This document is for doctors, dentists and nurses who currently offer or intend to offer cosmetic procedures. However, it is expected that these other groups will also find it useful:

- Patients and their families
- Departments of health in England, Northern Ireland, Scotland and Wales
- Healthcare organisations that offer cosmetic procedures
- Healthcare regulators
- Medical/healthcare indemnity providers
- Public liability insurance providers.

2

The state of cosmetic healthcare practice in the UK

Figures from the British Association of Aesthetic Plastic Surgeons indicate that 43,069 cosmetic surgical procedures were carried out by its members in 2011. The total number by all practitioners in the UK is expected to be at least three times this figure. Though similar statistics are not available for non-surgical procedures, eg laser treatment, botulinum toxin or intradermal filler injection, it is certain that these procedures are far more popular than invasive surgery, and that these procedures account for a significant portion of cosmetic practice in the UK. Statistics from the American Society of Aesthetic Plastic Surgeons suggest non-surgical procedures are up to five times more common than invasive procedures.⁴

Most cosmetic procedures are carried out in the independent sector; very few procedures are carried out in the NHS. Cosmetic surgery is almost always self funded by the patient. This can lead to financial vulnerability and may be one of the factors associated with unrealistic expectation of positive gains after the procedure(s).

Invasive surgery is restricted to licensed medical practitioners. From October 2010 class 3b and 4 laser treatments have been de-regulated in the UK, shifting the burden of regulation from the government to the industry and patients.

The cosmetic application of many procedures has developed as an extension of their use for treatment of disease or significant deformity. However, use solely for cosmetic indication does not necessarily diminish the inherent risk of a procedure. Furthermore, the differentiation between 'cosmetic' and 'associated with a recognised condition' can often be blurred, making it difficult for those without a breadth of specialist knowledge to apply these procedures appropriately or offer more appropriate alternative therapies, be they surgical, medical or psychological.

Medical training in the UK is designed primarily to serve the NHS and as such there are limited opportunities for doctors, dentists and nurses to train in specific cosmetic procedures during the normal course of their training. Training in the generality of cosmetic surgery is provided during plastic surgical specialty training. Many who train in plastic surgery will seek additional training if they wish to develop their own cosmetic practice. Moreover, there is no such thing as a 'cosmetic' specialty for either doctors or dentists, making it difficult for patients to know if their practitioner is appropriately qualified or experienced in that particular field.



3

Standards for all cosmetic practitioners

There are a number of existing standards documents that cover or specifically address cosmetic surgery practice. This chapter is not intended to replace or change these documents or the existing regulatory requirements of the professions. Instead it aims to draw out and harmonise some of the common standards across the three healthcare professions that have previously varied in content or detail. A list of documents can be found in the appendix. The following documents are the most generic:

For doctors:

- *Good Medical Practice* (General Medical Council, 2006)
- *Good Surgical Practice* (The Royal College of Surgeons of England, 2008)

For dentists:

- *Standards for Dental Professionals* (General Dental Council, 2009)

For nurses:

- *The Code: Standards of conduct, performance and ethics for nurses and midwives* (Nursing and Midwifery Council, 2008)
- *Aesthetic Nursing: RCN guidance on best practice* (The Royal College of Nursing, 2008)
- *Competencies: an integrated career and competency framework for nurses in aesthetic medicine* (The Royal College of Nursing, 2005)

3.1 Communication and providing information

3.1.1 Qualifications of the practitioner

The practitioner should make clear to the patient his or her professional qualifications, eg registration with the relevant regulator and, where appropriate, entry onto the specialist register and what this entails. Creating the impression of specialist knowledge without specialist registration must be avoided. Cosmetic medicine and surgery are areas of practice but not recognised specialties. Terms such as ‘cosmetic surgeon’, ‘cosmetic doctor’, ‘cosmetic physician’, and ‘cosmetic dentist’ should therefore be avoided.

3.1.2 Pre-procedure discussion

During the pre-procedure stage (see 4.2), the practitioner should make clear his or her professional qualifications, eg registration with the relevant regulator and, where appropriate, entry onto the specialist register. The pre-procedure discussion should include:

- In-depth discussion of the procedure between the patient and practitioner. This should be a two-way conversation, with the practitioner listening to and modifying the patient's existing understanding of the procedure. This process allows unrealistic expectations to be discussed. The practitioner should discuss and document:
 - the patient's reasons for seeking the procedure
 - an unambiguous, objective description of what the patient is trying to change, eg use of terms such as 'bigger' or 'smaller' rather than 'nicer' or 'better')
 - the patient's understanding of the procedure
 - the patient's expectations of outcome, including the anticipated impact on his or her day-to-day life
 - history of previous cosmetic procedures and their outcome, particularly the patient's satisfaction with the previous surgery
 - history and nature of body image and appearance concerns, including impacts on psychological well being (eg, anxiety, depression, social anxiety), social and/or occupational functioning and relevant psychiatric history, such as eating disorders and signs or symptoms suggestive of body dysmorphic disorder
 - recent significant life events.
- Any guidance documents should use either accurate diagrams or real patient photographs and not models. Software should not be employed to modify or enhance the image to make it misleading.

By the end of the conversation the patient should clearly be able to describe:

- what is involved in the procedure and recovery
- what likely outcome might be expected and the extent to which this meets his or her expectations
- the risks and what complications might occur in the short and longer term and how these will be managed and paid for
- the option of doing nothing
- alternative options and their implications.

There should then be:

- more thorough psychological or psychiatric assessment should concerns be raised in pre-procedure discussions

- a cooling-off period (Note: Level 1 procedures must not be done on the same day as the initial consultation and there should be a cooling-off period of at least two weeks)
- the right of the patient to change his or her mind right up to the point of the procedure being started.

As a patient what can you do?

- Discuss the procedure with your GP.
- Check your practitioner's registration.
- Contact the professional organisation to which your practitioner belongs to check his or her membership.
- Write down any questions you have.
- Think in advance about what outcome you would like so that you can discuss it with your practitioner.
- Ask about follow-up care and how long it will take to recover.

3.1.3 Consent form

Before the procedure is undertaken a standard consent form should be completed in writing. This should include sources of written information about the procedure the patient has chosen, the likely outcome and what aftercare might be required. The commercial terms and conditions should also be provided separately. It is important that this written information makes clear what extra charges might be incurred in the event of complications where extra treatment or revisional procedures may be required.

Although it is important to provide written information this is no substitute for a full and comprehensive discussion about the procedure. This conversation must be held with the practitioner who will perform the procedure as is normal for other forms of surgery.

3.2 Fees

Patients should be informed about the full financial implications of the procedure that they are requesting. Fees should be transparent and set out in advance. It should be made clear what follow-up care might be required and how and when this will need to be paid for.

The results of some procedures are not permanent and may only last a limited number of months or years. This should be clearly explained to the patient so that the financial implications of repeat procedures to maintain results are understood.

Sometimes procedures will not go as planned and revisional procedures or emergency care might be required. It should be absolutely clear, in advance, whose responsibility it would be to pay for this additional care; equally, it should also be made clear that the NHS will not intervene to correct privately provided cosmetic procedures even when the outcome is poor.

The details of all fees including why additional fees may be levied after the operation should be given to the patient in writing before the procedure takes place. Invasive surgery is likely to cost significantly more than minimally invasive procedures and these details should be provided before the day of surgery and be integrated into the consent process.

Practitioners, and the organisations for which they work, must not seek to hasten a patient's decision to undergo a procedure by the use of financial inducements, eg time-limited special offers or discounts. There should be no requirement for a deposit to be paid for any treatment until the patient has been examined and counselled by the practitioner who is going to perform the procedure. This is to avoid undue pressure being put upon the patient until he or she has had an opportunity to discuss fully his or her cosmetic problem with the person competent to do the operation or procedure.

3.3 Marketing

Practitioners, and the organisations for which they work, should ensure that marketing is honest and responsible and that it complies with the guidance contained within the Committee of Advertising Practice's help note *Cosmetic Surgery Marketing*.⁵ This help note sets out guidance relating to marketing communications that refer to the doctors performing surgery, the procedure itself and the clinics where procedures take place.





- Claims about practitioners must be commensurate with their training, qualifications and experience that relates to the procedures advertised.
- Surgery should be described accurately. For example, it should not be referred to as 'minor surgery' if the complexity, duration of the operation, the pain or the length of the recovery time suggests otherwise.
- Unrealistic claims about the results of the surgery should not be stated or implied.
- Claims about clinics must be realistic and not misleading.

Financial inducements for cross referral or offering compensation for introduction are not acceptable. Time-limited discounts are also unacceptable.

Any advertising for cosmetic procedures should be for the sole purpose of conveying factual information to the patient. Advertising should not be used for the purpose of conveying additional information, outside of the factual information, that may unduly influence a patient's decision. Individual practitioners involved in advertisements for cosmetic procedures should work within the standards laid out in the relevant standards document (ie *Good Medical Practice*, *Good Surgical Practice*, *The Code: Standards of conduct, performance and ethics for nurses and midwives* or *Standards for Dental Practitioners*). Organisations that advertise should only advertise the services provided and not encourage unnecessary or excessive procedures.

3.4 Record keeping

Practitioners are responsible for ensuring the quality of record keeping and the methods by which the records are stored and disposed.

The Academy of Medical Royal Colleges had agreed standards for medical note keeping which should be followed (*A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital*). Nurses are expected to meet the standards set down by the Nursing and Midwifery Council (*Record keeping: Guidance for nurses and midwives*).

Medical records must be kept confidential and held securely whether in paper or electronic format. Independent sector organisations, or individuals where relevant, should meet as a minimum the standards of the NHS (*Records management: NHS code of practice*) and the requirements of the Data Protection Act 1998.

It is advisable that practitioners use standardised recording forms for consent and complications. Use of such forms helps ensure that the record is complete.

3.5 Team working

Almost all practitioners will work in teams alongside clinical and non-clinical staff. It is important that practitioners work constructively with their colleagues because this is proven to produce a safer environment for patients.

Practitioners who undertake surgical procedures should use the National Patient Safety Agency's version of the WHO *Surgical Safety Checklist*.⁶ This checklist outlines the steps to take before the procedure, at a time-out point just before the surgical intervention, and at the end of the procedure. In addition it is recommended that before each list a team briefing is performed and a debriefing is undertaken at the end of the list.⁷

With regards to Level 2 procedures any suitably trained person may administer pharmaceutical agents such as botulinum toxin but only those qualified as independent prescribers may prescribe prescription-only medicines. Nurses should refer to the Nursing and Midwifery Council advice on remote prescribing and injectable cosmetic medicinal products.⁸ Those not qualified as independent prescribers should work as part of a multi-disciplinary team led by a registered and appropriately qualified doctor or dentist. Financial incentives for remote prescribing of pharmaceutical agents should be discouraged in this context.

3.6 Professional support

Practitioners should learn from their experience by discussing cases with colleagues. In the NHS this is usually done through audit, morbidity and mortality meetings and multi-disciplinary team working. Where possible, this should be replicated within the independent sector. Where practitioners work alone they should take part in professional networks to allow discussion with colleagues.

Each independent hospital should have a medical advisory committee that supports the organisation's responsible officer and provides a structure for professional support for doctors in the organisation. Each medical advisory committee should ensure that practitioners are adequately trained and qualified (including accreditation where relevant) to undertake the procedure. Where a medical advisory committee exists in an organisation offering cosmetic surgery there should be a cosmetic surgery representative on the committee.

Practitioners should also be able to obtain peer support through their specialty associations or societies.

3.7 Emergencies

Practitioners must have completed up-to-date basic life skills training in compliance with the Resuscitation Council (UK) guidelines.⁹

All practitioners undertaking cosmetic treatments, whether surgical or non-surgical, must offer continuity of aftercare, or have in place arrangements so that in their absence patients have access to help at all times.

3.8 Indemnity and insurance

All cosmetic practitioners offering procedures must have indemnity insurance that is adequate for the procedures that are undertaken. It is recommended that all practitioners working in the UK hold insurance from a UK provider or at the very least have equivalent indemnity coverage from a non-UK provider. Practitioners should show their patients evidence of the level of their indemnity.

It is further advised that practitioners offering services to UK patients where the procedure takes place outside the UK should also have equivalent indemnity coverage.

If the practitioner holds indemnity insurance for practice other than their cosmetic practice they should ensure that they have informed their insurer about their cosmetic practice and had their premiums adjusted accordingly.

Practitioners should ensure that they or the organisation for which they work has public liability insurance.

3.9 Complaints

Practitioners should ensure that the *The Code of Practice for Management of Patients' Complaints* from the Independent Sector Complaints Adjudication Service is adhered to fully. These procedures should be easily available to patients and literature should be provided at the first consultation.

If a patient does complain he or she should be able to access the clinical notes quickly and for a minimal fee.¹⁰

4

Training, experience and CPD

All practitioners should work within their sphere of competence. This means that they should feel satisfied that they are competent and can demonstrate that they have undertaken the necessary training and have sufficient supervised experience to undertake the procedure.

Neither cosmetic practice nor cosmetic surgery is a single specialty for doctors. Instead it is an area of interest allied with mainstream non-cosmetic care. Therefore procedures are often not directly covered through formal training and there are no definitive training requirements for each procedure. The European Committee on Standardization (CEN) is undertaking a project³ that is primarily concerned with the standard of facilities from which cosmetic surgery should be delivered. The European Union of Medical Specialists has indicated that it does not regard issues of surgical training as competent business for CEN – it is the responsibility of the national training bodies and the competent authorities of the member states.

4.1 Training

There are no specific training routes for cosmetic surgery; there is also not a GMC specialist register for cosmetic medicine. Surgeons undertaking cosmetic surgical procedures should be on the appropriate specialist register, in one of the recognised surgical specialties, or ophthalmology (European Specialist Medical Qualifications Order 1995, schedule 2).¹¹ Minimally invasive procedures (Level 2) may be performed by a range of people and therefore there is no statutory training route. That said, training can be obtained and a range of providers offer courses to doctors, dentists, nurses and others. There is no single body that accredits and assures the quality of such courses but some medical royal colleges and specialist associations and societies do accredit courses that fall within their remit.

If a course has not been accredited then the following characteristics should be sought:

- Commercial sponsorship of the activity should be clearly stated and must have no inappropriate influence on the educational programme's content and structure.
- The activity contributes to continuous learning and addresses a clear learning need.
- The learning outcomes are specifically defined and are appropriate.
- The teaching methods used are relevant to the defined learning outcomes.
- The activity organiser has proven relevant expertise.
- The presenters/teachers/facilitators have proven, relevant expertise, skills and knowledge.
- Effective assessment processes are in place.
- Records of attendance are kept and should be provided on request.



Attendance at training courses is insufficient to become competent in a procedure. Direct training and supervised practice is also necessary. Therefore it is highly recommended that all practitioners undertake a period of formal or informal mentorship.

Specialty fellowships are available, although these are solely for doctors and dentists. The Joint Committee on Surgical Training's (JCST's) Training Interface Group in Reconstructive Cosmetic Surgery was established to oversee and set standards for training in the interface specialties of plastic surgery, otorhinolaryngology, oral and maxillofacial surgery, ophthalmology and breast surgery. The principal aim of this group is to integrate cosmetic surgery into mainstream training alongside the promotion of the same standards of governance as is found in either the NHS or private practice.

The British Cosmetic Dermatology Group, under the auspices of the British Association of Dermatologists, oversees and sets standards for training of minimally invasive cosmetic procedures for dermatology trainees. Aspects of these are included on the dermatology curriculum established by the specialist advisory committee and the Joint Royal Colleges of Physicians Training Board (JRCPTB), and are therefore a requirement for trainees to achieve a Certificate of Completion of Training (CCT) in dermatology.

4.2 Invasive surgical procedures (Level 1)

Level 1 procedures are invasive surgical procedures. These procedures may only be carried out by licensed doctors on the GMC specialist register^c in an appropriate specialty. A qualification to be on the specialist register is not sufficient to demonstrate competence to perform cosmetic surgery. Relevant training and supervised experience are also required.

It is estimated that up to 30% of doctors are practising in a field of medicine other than their registered specialty. Nevertheless, it is expected that doctors undertaking cosmetic surgery do so only if they have relevant training in a closely related specialty, eg ENT surgeons would normally only be expected to undertake cosmetic surgery relating to the face and neck. It is also expected that these doctors practise at least at the level of the holder of a CCT in the relevant specialty.

4.3 Minimally invasive procedures (Level 2)

Minimally invasive procedures should only be carried out by doctors, dentists and nurses who have undertaken training and supervised practice before working independently.

^c An exception is made for doctors who were undertaking cosmetic surgery in the independent healthcare sector before 1 April 2002 and are not on the specialist register, subject to conditions set out in the Care Standards Act 2000.

A standard of knowledge and training in these procedures can be expected from those with a CCT in specialties that include minimally invasive procedures in their JRCPTB-approved curriculum, eg dermatology. Furthermore, those on the specialist register for dermatology can offer expertise in skin health and skin disease, with the breadth of knowledge to understand and offer alternative procedural or medical therapies, as well as diagnose and treat complications that may arise. For cosmetic injectable providers, we expect any register to be accredited by the Professional Standards Authority for Health and Social Care accreditation scheme for voluntary registers.

Where possible, training courses or programmes should be accredited or provided by an established professional body, eg a medical royal college.

4.4 Continuing professional development

All practitioners engaged in cosmetic practice must keep their skills up to date by undertaking relevant continuing professional development (CPD). Each profession has a CPD obligation although they differ in their exact requirements. However, all practitioners should ensure that the cosmetic part of their practice is adequately reflected in the balance of their learning even if this means exceeding the requirements for their profession.

All practitioners should consider CPD that includes basic understanding of psychological processes with specific reference to body image disturbance.

Practitioners should also learn from the feedback they receive from their patients. All organisations offering cosmetic procedures should have complaints and patient feedback processes in place. Practitioners should review this feedback in order to make improvements to their practice.

4.4.1 Doctors

Each medical royal college and faculty has its own CPD requirements. However, in general, doctors are expected to accrue at least 50 credits (50 hours) each year. This CPD should be balanced to include activities relevant to all roles. Learning should be from a variety of sources including CPD that is external to the doctor's contracted organisation. Doctors should reflect on each activity, including what impact it might have on their practice.

Undertaking relevant CPD will be a requirement for appraisal and revalidation.



4.4.2 Dentists

The GDC has set rules for dentists on CPD. Dentists must complete at least 250 hours of CPD over a five-year cycle. The GDC advises that:

CPD is any activity which could reasonably be said to have benefited you professionally, so you should use your own judgment when choosing your subjects and activities [...] We also recommend that you keep up to date in areas such as legal and ethical issues, and handling complaints.¹²

4.4.3 Nurses

In order to renew registration with the Nursing and Midwifery Council, nurses have to sign a notification-of-practice form, undertake 450 hours in their capacity as a nurse during the three years prior to the renewal of registration, undertake at least 35 hours of learning activity relevant to practice during the three years prior to the renewal of registration, and maintain a personal professional profile of the learning activity.¹³

5

Process of patient care

5.1 Facilities

Cosmetic practice should only be carried out in premises registered with either the Care Quality Commission (CQC), the Healthcare Inspectorate Wales (HIW), Healthcare Improvement Scotland, or the Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI). However, registration and monitoring are point-in-time activities and practitioners should only undertake procedures if they are satisfied that the premises continue to meet the standards of these bodies.

Practitioners should familiarise themselves with the guidance produced by the regulator relevant to them.

- In England: *Guidance about compliance, Essential standards of quality and safety* (CQC, 2010), particularly outcomes 10 and 11.
- In Wales: *Independent Healthcare Technical Guide*, (HIW, 2009) in particular standards 4, 5 and 19.
- In Scotland: *Independent hospitals national care standards* (National Care Standards Committee, 2009).
- In Northern Ireland: *The Quality Standards for Health and Social Care*, (DHSSPSNI, 2006).

Practitioners should not undertake any procedures in unlicensed premises such as, but not limited to, ad hoc domestic settings. The concepts of 'Botox® parties' or 'filler parties' are wholly incompatible with these standards.

Cosmetic surgery tourism, where a patient travels abroad (either from the UK or to the UK) for the procedure to be carried out, requires careful consideration. When the surgery takes place in a different country it is more difficult for effective aftercare to be provided. Also, additional problems might arise if an emergency occurred during or after the procedure.

5.2 Pre-procedure requirements

Before a procedure is undertaken practitioners should be assured that the patient is prepared. As a minimum the practitioner should be assured that the patient:

- is fit to undergo the procedure
- has consented to the procedure including:
 - understanding the procedure and having a realistic expectation of the likely outcome
 - understanding the risk and possible complications

- has undergone a brief psychological assessment (as outlined in 3.1.2) and, if appropriate, referral for a more thorough assessment, for example where there is a history of multiple cosmetic procedures or if his or her expectations of outcome are unrealistic
- has informed or has actively chosen not to inform his or her general practitioner and/or general dental practitioner.

The cosmetic practitioner has a duty to inform the patient's general practitioner and/or general dental practitioner unless the patient has specifically stated that he or she does not want this to happen.

5.2.1 Case selection

Practitioners should consider the general health of the patient and the appropriateness of the procedure before proceeding with any treatment. In particular, practitioners should discuss any other existing medical conditions, ongoing medication or other planned procedures. Practitioners should advise patients of any lifestyle changes that should be undertaken before the procedure goes ahead such as losing weight or giving up smoking.

Practitioners should not agree to carry out a procedure if they believe that there is a significant risk that it would have a detrimental effect on the patient's health, even if the patient argues that he or she understands and accepts the risk.

Practitioners should have the breadth of knowledge to understand surgical, procedural and medical alternatives in order to best advise the patient, as well as diagnose and treat any complications that may arise.

5.2.2 Consent

All cosmetic procedures involve the risk of an adverse reaction or outcome. These risks must be properly and thoroughly explained to patients so that the practitioner is satisfied that consent is being given with a full understanding of the risks involved. Consent is a process that begins at the first consultation. The practitioner should check for consent at every stage of the pre-procedure processes.

Different processes should be followed depending on the relative risk level and severity of the procedure. However, in general, the practitioner performing the procedure should obtain consent

from the patient at least once in person and a signature indicating consent must be obtained at least once on the day of the procedure.

The Working Party recognises that this is over and above that expected in the NHS but cosmetic practice is a special case where both the practitioner and the patient need to have a common understanding of the expected and likely outcome.

The three regulators, GMC, GDC and NMC, have produced guidance on consent:

- *Consent: patients and doctors making decisions together* (GMC, 2008)
- *Principles of Patient Consent* (GDC, 2009)
- *Consent* (via website) (NMC, 2010).¹⁴

All practitioners must make themselves familiar with the relevant guidance.

The GMC guidance describes a basic model for obtaining consent:

- a. The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
- b. The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option that he or she believes to be best for the patient, but must not put pressure on the patient to accept this advice.
- c. The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to him or her. The patient decides whether to accept any of the options and, if so, which one. The patient also has the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.
- d. If the patient asks for a treatment that the doctor considers would not be of overall benefit to him or her, the doctor should discuss the issues with the patient and explore the reasons for his or her request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, the doctor does not have to provide the treatment but should explain the reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.

Level 1: Invasive procedures

These procedures carry the most risk. As a minimum, consent should be a two-stage process with significant time (at least two weeks) between the stages to allow the patient to reflect on the decision. The operating surgeon should take consent at least once even if consent is obtained previously with other practitioners. Moreover, the surgeon should personally see the patient immediately before the procedure in order to re-emphasise the consent. If there is any doubt, the patient should be referred for a more detailed psychological assessment, or offered additional counselling sessions before committing to the procedure, and these may be undertaken in the presence of a friend or a relation.

Level 2: Minimally invasive procedures

Minimally invasive procedures are still subject to risk but it is acceptable that consent be obtained on the same day as the procedure. Consent should still be thorough and taken by the individual undertaking the procedure. Written consent is required for the first procedure but oral consent would be acceptable for the same procedure if it is repeated, although this should be noted in the patient's records or on the original consent form. If there is any uncertainty the practitioner should insist on a cooling-off period of at least 24 hours to allow the patient to consider the procedure.

5.2.3 Relationship with the patient's general practitioner

Patients should discuss their plans for a cosmetic procedure with their general practitioner (GP) in advance. This is particularly the case for invasive surgical procedures.

Practitioners should ask patients if they have discussed their intention to undergo a cosmetic procedure with their GP. If the patient has not done so the practitioner should advise him or her to do this before proceeding with the treatment. The patient has the right to refuse to do this and the practitioner should respect this but the patient should be asked to sign a statement reflecting the discussion and his or her decision.

In the case of Level 1 procedures, following the procedure the practitioner should write to the patient's GP detailing the procedure, any medicines prescribed and any complications that have arisen. This should be offered as an option for all patients undergoing Level 2 procedures. Consent should be obtained from the patient before his or her GP is informed.

5.2.4 Psychological assessment

Practitioners should be aware that patients with a psychiatric condition have an increased risk of dissatisfaction. However, screening patients who have psychiatric conditions does not mean that everyone else is likely to have a good outcome. The expected outcomes of cosmetic surgery are largely psychosocial; for example many people discuss their motivation in terms of increasing their self confidence in social situations. Successful outcome is related to the capacity for the procedure to meet the patient's goals, and patients may be highly dissatisfied even with a good surgical result where it does not have the psychological impact they expected. This is also a group who are ill prepared to cope with a less than optimal surgical result.

A well-conducted consultation (as set out in section 3.1) provides the basis for clear concordance between the patient and the practitioner in terms of what they are trying to achieve and shared expectations of outcome. This is sufficient preparation for the majority of patients. It is neither possible nor necessary for every patient to undergo a detailed psychological assessment with a clinical psychologist. **However, all practitioners should consider if they should refer a patient to a clinical psychologist before proceeding with further consultations or treatments and referral pathways should be in place.**

This should be considered where there is a clear mismatch between what the practitioner can provide and what the patient is trying to achieve. Psychologists can help to frame the patient's goals and identify any timing issues: people often present for surgery where life events make them more vulnerable than they might normally be. The goal of psychological assessment is not always to screen patients out of surgery but to ensure that the necessary preparation has been made and that treatment is offered at the right time to increase the probability of achieving the changes that the patient is seeking.

Within the larger group of patients seeking cosmetic procedures are a smaller sub-group who are particularly vulnerable. They may have a current or previous psychiatric history and include people with personality disorders or body dysmorphic disorder (BDD). An excessive investment in or preoccupation with appearance about multiple areas of the body, attempts to carry out procedures themselves or excessive checking in front of the mirror should raise concern. Practitioners might find it useful to undertake further training that helps them to make this assessment. The National Institute for Health and Clinical Excellence (NICE) guidelines for obsessive compulsive disorder and



BDD¹⁵ also contain further advice and recommended referral pathways for practitioners working in this field.

Surgery associated with gender reassignment may only be undertaken following a referral from a psychiatrist experienced in that field and with a second opinion from an independent psychiatrist also with experience in that field.

5.2.5 Cosmetic gynaecological surgery

The Royal College of Obstetricians and Gynaecologists (RCOG) has strong concerns about cosmetic genital surgery, particularly over the growing number of procedures performed on young women. In girls under the age of 18 the labia may still be developing and therefore change with time. Clearly there will be some women with congenital and acquired genital anomalies, such as those associated with disorders of sex development, birth injury, sexual assault, cancer and dermatological conditions where gynaecological advice is indicated. There are also different considerations for transgender women. RCOG supports the concept of patient and professional autonomy. It believes that any decision to provide cosmetic genital surgery should be based on clinical grounds. High levels of anxiety regarding body image where appearance is within the normal range should trigger psychological referral.

5.3 Operative requirements

Practitioners must take responsibility for ensuring that all necessary personnel and equipment are available and fit for purpose before proceeding with the procedure. This includes:

- operative equipment
- anaesthetists and other operating room staff
- recovery nursing support
- equipment in the event of an emergency such as resuscitation equipment and drugs
- doctors to provide on-call cover where the procedure requires an overnight stay.

5.4 Postoperative requirements

5.4.1 Recovery

All patients should be observed immediately after the procedure is carried out to ensure that they are recovering as expected. The facilities and length of observed recovery will vary depending on the level of procedure.

5.4.2 Out-of-hours care

Where necessary, out-of-hours care should normally be provided by the practitioner or the facility where the procedure took place. The practitioner retains responsibility for the care provided. The arrangements for out-of-hours care should be clearly explained to the patient as part of the consent process.

5.4.3 Aftercare

Cosmetic procedures should not be provided without aftercare. All patients should be able to contact the practitioner if they have any concerns about side effects following the procedure. A contact number should be provided to patients in case of emergency. All Level 1 procedures should have postoperative appointments.

Before the procedure takes place practitioners should explain to the patient, and provide information in writing, what aftercare is likely to be required and how much of this is covered by the initial fee. Patients should be aware of how long the effects of the procedure are likely to last. Some procedures will require reoperation at a later date and this should be made very clear to the patient before the procedure takes place.

Level 1a procedures

All patients should be provided with a discharge letter including:

- details of the procedure performed
- any instructions for aftercare, eg dressings or medication
- details of follow-up appointments.

A letter should also be sent to the patient's GP unless the patient refuses permission for this.

5.4.4 Emergency provision

All procedures carry a risk of an emergency arising. Practitioners should have appropriate training relating to basic life support that is in line with the Resuscitation Council (UK) Guidelines.⁹

If the procedure is being done at a managed facility practitioners should be aware of the emergency arrangements in place. These should be in the form of a service level agreement. If the practitioner is working independently they should make such arrangements. Financial arrangements should be made to cover the costs of the emergency treatment required as a result of a cosmetic procedure.

6

Appraisal and regulation

6.1 Doctors

All doctors undertaking cosmetic procedures must be registered and licensed with the GMC. Only doctors on the specialist register or covered by the exemption^d may undertake invasive cosmetic surgery. Doctors have a responsibility to work within their competence and it is expected that they would be on the specialist register in the specialty that relates to the procedures they perform.

From approximately 2013 all doctors will be subject to periodic revalidation. For doctors who practise in the NHS (even if this is in addition to working in the independent sector) they will relate to a responsible officer who will, every five years, make a recommendation of revalidation to the GMC. This will be based on the results of annual appraisal and other sources of clinical governance information. Doctors who work wholly in the independent sector will either relate to a responsible officer of the organisation with which they have practising privileges or will be able to obtain responsible officer services through designated organisations such as the Independent Doctors' Federation, or the Federation of Independent Practitioner Organisation's consultant appraisal services, based on the GMC's *Good Medical Practice* framework for appraisal and revalidation.

The annual appraisal should cover the whole of a doctor's practice and it is the doctor's responsibility to ensure that his or her supporting information reflects the entirety of his or her practice, including any cosmetic work.

It is not yet clear how revalidation will be noted on the specialist register but it may be that the field of current practice will be indicated. It may be possible to describe sub-specialty/extra-specialty practice such as cosmetic surgery.

6.2 Dentists

There is currently no specialist list for 'cosmetic dentistry' held by the GDC. However, all dentists must be registered with the GDC and be able to demonstrate that they are competent to provide the care they deliver and show that the patient is fully aware of all treatment options. In the case of invasive procedures, patients must also be aware of the biological downside of any care that may be proposed. The GDC also considers that the peri-oral use of botulinum toxin and fillers can be considered as part of the practice of dentistry.

The GDC has stated its intention to introduce revalidation for dentists and is currently considering options for how this will be done with the possible introduction in 2014. As part of revalidation, it is

^d An exception is made for doctors who were undertaking cosmetic surgery in the independent healthcare sector before 1 April 2002 and are not on the specialist register, subject to conditions set out in the Care Standards Act 2000.

likely that dentists will have demonstrated annually that they are competent in their practice at that time.

6.3 Nurses

All nurses undertaking cosmetic procedures must be registered with the Nursing and Midwifery Council and fulfil the requirements of registration on an ongoing basis. To stay on the register, nurses must renew their registration every year. Nurses have to submit a notification-of-practice form that confirms the number of hours practised and number of hours of CPD undertaken. Further details can be found in *The Prep Handbook*.



7

Organisational support for professional standards

Organisations that provide cosmetic procedures have a responsibility to support their practitioners to fulfil their professional commitment to high standards of care.

7.1 Facilitating regulation

Organisations that offer cosmetic procedures need to make themselves familiar with the requirements of the professional regulators.

7.1.1 Doctors

Organisations must be prepared for medical revalidation to begin. All doctors who have any NHS practice will relate to an NHS responsible officer. Those that do not will relate to a responsible officer in the organisation with which they have practising privileges. Larger organisations should consider offering responsible officer services to doctors in their organisation.

However, even if all doctors are in the organisation covered by a responsible officer, elsewhere organisations should have structures in place to support revalidation. In particular the organisation should support whole practice appraisal by making available outcomes data and information about untoward incidents and complaints. Organisations should also support the administration of colleague and patient feedback exercises being run by other organisations or facilitate such exercises within the organisation.

Organisations may also wish to support CPD by holding learning events focused on cosmetic practice.

7.1.2 Dentists

Dentists who provide cosmetic procedures should ensure that they can demonstrate competency in the areas in which they practice and, even without the introduction of revalidation, that this evidence is contemporaneous, relevant and ongoing rather than simply within the five-year cycle associated with current CPD requirements.

Organisations may wish to support this requirement by providing appropriate postgraduate education events that highlight not only modern methods of management but also the ethical implications of providing invasive elective cosmetic treatment.

7.1.3 Nurses

Nurses who provide cosmetic procedures should ensure that they are working within Nursing and Midwifery Council rules, standards, guidance and advice and are acting within the limits of their competence. Employers should check that nurses' registration and indemnity insurance are up to date. Revalidation and appraisal will be introduced for nurses although the details are still to be worked out and there is no agreed date for implementation.

7.2 Facilitating audit

There are a limited number of external (national/regional) audits and registries that cover cosmetic surgery procedures. Practitioners should contribute to these where possible. Where audits do not exist practitioners should undertake personal audit in order to identify areas for improvement. Organisations should make data available to enable contributions to external audits and to undertake personal audit. This should include not only physical outcomes such as infection rates but also psychosocial outcomes such as impacts on patients' psychological wellbeing and their satisfaction with the aesthetic outcomes of the procedure.

7.3 Dealing with concerns

Where concerns about a practitioner arise, organisations should initially assess the issue locally. In many cases the matter may be dealt with internally or in partnership with other organisations where the practitioner works. If the matter is serious, cannot be resolved or does not improve, the organisation must involve the relevant professional regulator. For doctors, the GMC is putting into place regional employment liaison advisors to help organisations to make an assessment on what steps to take.

8

Appendix

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Produced by RCS Publications

The Royal College of Surgeons of England
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Registered charity number 212808

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