Consenting individuals

Providers should be aware that patient consent for aesthetic treatments must be more than merely cosmetic, argues **Greg McEwen**, partner at law firm BLM

It's been over three years since the government committee chaired by NHS medical director Sir Bruce Keogh published its final report into the regulation of cosmetic interventions. The report contained some 40 recommendations for change within the industry, including changes to the way in which patient consent is obtained. In April this year, the GMC published further guidance for doctors who offer cosmetic interventions. So has Keogh's report produced the desired effect? And has the practice of consenting patients for cosmetic procedures changed, and how?

Around the time the Keogh Report was published in 2013, the Royal College of Surgeons' Cosmetic Surgical Practice Working Party produced a document entitled *'Professional standards for cosmetic practice'*. In turn, those 'professional standards' referred on the issue of consent to earlier applicable guidance produced by the General Medical Council in June 2008, entitled 'Consent – patients and doctors making decisions together'.

The 2008 GMC guidance is not specific to cosmetic or aesthetic practice. However, in considering the responsibility for seeking a patient's consent, it clearly recognises the possibility of consent being taken by someone other than the practitioner performing a procedure and covers the potential for delegation, at the time a reasonably widespread practice.

There was early evidence of change in thought within the cosmetic industry in the 2013 Professional Standards. At paragraph 5.2.2 it was noted that:

"Consent is a process that begins at the first consultation. The practitioner should check for consent at every stage of the pre-procedure processes.

"..[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."

> If you are the doctor who will be carrying out the intervention, it is your responsibility to discuss it with the patient and seek their consent – you must not delegate this responsibility. It is essential to a shared understanding of expectations and limitations that consent to a cosmetic intervention is sought by the doctor who will perform it, or supervise its performance by another practitioner

The 2013 professional standards recommend that for invasive procedures (e.g. surgery, liposuction) consent ought to be a two-stage process, with at least two weeks between the stages to allow the patient to reflect on his or her decision. Furthermore, it is also recommended that the operating surgeon should see the patient personally immediately before the procedure, in order to re-emphasise the consent, and should take consent at least once "even if consent has been obtained previously from another practitioner".

So an effort is made by the 2013 professional standards to make sure the operating surgeon themself gains consent from the patient at least once. Subject to certain safeguards, though, the 2013 professional standards still allowed for the pre-operative consultation to take place with someone other than the operating surgeon. Essentially, so long as the operating surgeon "re-emphasised" the consent immediately before the procedure, this delegation is still legal.

Bringing things up to date, the General Medical Council published a document on 12 April 2016 entitled 'Guidance for doctors who offer cosmetic interventions'. This came into effect on 1 June 2016. That guidance contains the following passage on consent:

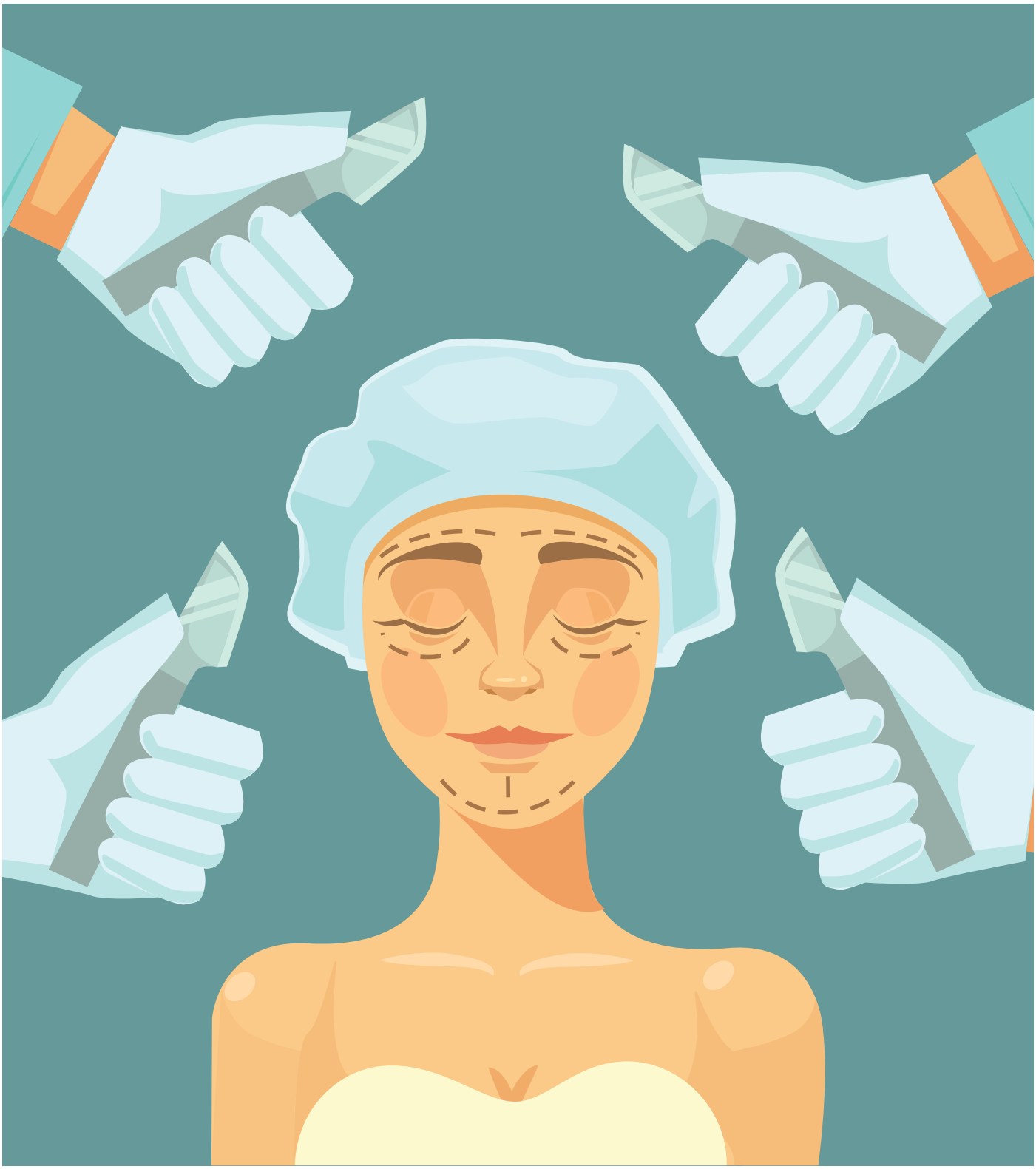
"If you are the doctor who will be carrying out the intervention, it is your responsibility to discuss it with the patient and seek their consent – you must not delegate this responsibility. It is essential to a shared understanding of expectations and limitations that consent to a cosmetic intervention is sought by the doctor who will perform it, or supervise its performance by another practitioner."

Thus it appears that delegation is now expressly disapproved.

Thus, it can be seen how the guidance has evolved since 2008, to promote best practice within the industry. Over time, industry practice has varied (and to an extent continued to do so up until relatively recently) from case to case, clinic to clinic and depending on the particular procedure for which the patient consulted. Now though, the once fairly widespread situation of a patient meeting their surgeon for the first time on the day of surgery is now unlikely to satisfy the more stringent requirements of the latest GMC guidance. Those providers that are slow to catch up are at risk of patient complaints, GMC investigation and court claims.

Situations providers should beware of include:

1. A patient has a pre-operative consultation for a cosmetic procedure with a practitioner who does not perform that particular type of procedure. They receive a full explanation of the risks and benefits and opt to proceed. They then meet their surgeon on the day of the procedure.
2. A patient has a pre-operative consultation for a cosmetic procedure but for one reason or another the consenting practitioner is not available to carry out the procedure on the day and it is undertaken by somebody else, who meets the patient for the first time on the day.



Both of these examples are arguably capable of falling within the applicable guidance from 2008 and latterly 2013 (so long as the doctor performing the procedure "re-emphasises" consent on the day). Since June this year however, practice such as this is likely to fall foul of the prohibition on delegation.

Ultimately of course, this is one of the outcomes that Keogh's report set out to achieve – a tightening of standards across the industry. This was to be combined with a new focus on indemnity and redress, with an emphasis on adequate recourse and redress for patients who suffer an adverse event. In the end, the emphasis on regulation, informed choice and redress will be to the advantage of not only consumers but also practitioners; in the long-term, the industry as a whole should benefit from an enhanced reputation. In the meantime however, clinics and practitioners who fail to embrace these new standards may, along with their indemnifiers, find themselves facing an increase in claims from dissatisfied patients. ■