A change in the make-up of medicine

Ethics and putting the patient first are the primary considerations in deciding what is acceptable advertising of medical services by doctors

TYPE "COSMETIC SURGERY" into your Internet search engine and several hundred thousand sites will appear. All enthuse about the benefits and increasing popularity of their techniques. They identify and detail medical practitioners qualified to work their miracles on the human body. Few negatives are to be found in such promotional material, and much of the hype is not dissimilar to that used to market other lifestyle products. This is but part of the global rise of the entrepreneurial approach to healthcare. Cosmetic surgery is in demand because of the changing culture and attitude of patients. For some in today's world there is a need to satisfy a desire for what, in times gone by, would be unrealistic expectations — changes to their bodies to enhance their appearance — at least in their own eyes.

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If we take the definition used by the New South Wales Committee of Inquiry into Cosmetic Surgery, "cosmetic surgery" is any cosmetic procedure "performed to reshape normal structures of the body or to adorn part of the body, with the aim of improving the consumer's appearance and self-esteem". It "is initiated by the consumer, not medical need", and "excludes reconstructive surgery".[1] This lies outside the traditional boundaries of medicine, which saw the profession dedicated to saving lives, healing and promoting health.[2] Cosmetic surgery is not rebatable under Medicare, nor covered by health insurance. There are relatively few referrals. However, it does provide a service for which consumers are prepared to pay.

Traditionally, the medical profession has prohibited advertising in its codes of ethics. The traditional view is that doctors should develop a reputation for excellence based on a reputation among their peers, rather than by the advertising of their services directly to the public. This minimises the opportunity for patients to be misled by claims of superiority of a technique or individual. Particularly in Australia and the United Kingdom, general practitioners have long been "gatekeepers" to specialist services. This role has helped maintain quality care for patients and has probably helped to contain overall costs in the healthcare system. But with the demise of paternalism, both in society and in the professions, this way of doing things has attracted increasing criticism. Undoubtedly, this forms part of the rationale for applying trade practice law to the health sector and to advertising by doctors, and to the interpretation of such law by the Australian Competition and Consumer Commission. Under federal law in Australia the *Trade Practices Act 1974* (Cwlth) now permits advertising, unless it is likely to mislead or deceive. Direct advertising by doctors to the public is now lawful.

The article by Ring in this issue of the Journal (*page 597*)[3] asks if ethical standards are a casualty in the promotion of cosmetic surgery, and shows that this specialty is being seen as part of the beauty industry rather than a procedure for meeting health needs. The promotional strategies used do not sit well within the medical environment. The beauty industry promotes a body image that draws on vanity rather than on health. It creates expectations linked to perpetual youth, which can feed insecurities in people of both sexes, and contributes to a youth culture which treats with contempt the results of the ageing process.[2]

On the other hand, people who wish to change their image are now being informed that there are treatments available. The World Medical Association Declaration on the Rights of the Patient says that, "The patient has the right to self-determination, to make free decisions regarding him-self/herself. The physician will inform the patient of the consequences of his/her decision".[4] Should not patient autonomy include the freedom of adults to purchase these treatments, as long as the advertising surrounding them remains within the ethical boundaries of truthfulness?

Where should the boundaries lie between medicine as traditionally defined, and lifestyle-modification medicine? The Australian Medical Association (AMA) Code of Ethics encourages doctors to promote the health and well-being of their patients and prohibits doctors from behaving in their own self-interest. It also says that doctors have "a responsibility to their patients to recommend only those diagnostic procedures necessary to assist in the care of patients and only that therapy necessary for their well being".[5] Many patients would say that changing their image through cosmetic surgery is for their well-being, as it would improve their quality of life. It is a personal decision based on personal perceptions.

If we consider that cosmetic surgery is part of medicine, then the advertising and promotion of such procedures must adhere to the ethical guidelines of the medical profession.

Summary of the Medical Practitioners Board of Victoria's draft guidelines for medical advertising[7]*

- Ban the use of "before and after" photography, which is common in advertisements for cosmetic surgery.
- Limit advertising to a factual statement of services offered.
- Warn against the creation of "unwarranted or unrealistic" patient expectations of treatment.
- Continue the ban on the use of patient testimonials.
- Prohibit advertising which encourages inappropriate use of medical services and contains information or language which could cause fear or distress or make people believe their health may suffer from not using a medical service.

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The AMA believes that, as a general principle, advertisements must be honest, must not exploit patients' vulnerability or lack of medical knowledge, and should provide only factual information. Any advertisement for a doctor's services should present information that is reasonably necessary for making an informed decision about the appropriateness and availability of the medical services offered.[6]

In recognition of the need for a middle ground between the traditional ban on advertising and the current deregulated environment, the Medical Practitioners Board of Victoria has produced draft guidelines which will provide clear guidance for doctors who wish to advertise their services. A summary of the guidelines is presented in the Box.[7]

Whether we agree with changes in contemporary views which have allowed doctors to enter the free market of advertised services, or prefer the traditional culture, the one interwoven thread which must run unbroken through the fabric of medical practice is that of standards of ethical practice and the primacy of the patient.

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4. World Medical Association Declaration on the Rights of the Patient <www.wma.net/e/policy/17-h_e.html> (accessed 22 May 2002).
5. Australian Medical Association. Code of ethics, 1996. Canberra: AMA, 1996.
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Scatter irradiation in childhood causes thyroid cancer

Exposure of the thyroid gland to any irradiation requires lifelong follow-up supervision

ONE OF THE QUESTIONS most frequently asked by patients about to receive radioactive iodine as therapy for non-malignant conditions is whether it will result in bodily cancer. This question has been satisfactorily answered in the negative,[1,2] so strong reassurance can be given.

No such reassurance can be given for the malignant effects of therapeutic external beam irradiation on the thyroid gland.

In childhood, the sensitive thyroid gland can be exposed to therapeutic irradiation directly, as in the treatment of localised neck tumours such as lymphoma or sarcoma and in total-body irradiation before bone marrow transplantation. Where the thyroid gland is not directly the target of therapy, it can be affected by scatter irradiation, as occurs during prophylactic cranial irradiation of the central nervous system in haematological malignancies. Thus far, no measures have been found to protect the thyroid gland from external irradiation in these settings.

In this issue of the Journal (*page 584*), Somerville and her colleagues report the first Australian experience in a study encompassing a large number of children recruited to the Late Effects Oncology Clinic of the Children's Hospital at Westmead.[3] The period of study covers 10 years. The sample population was divided into a group who received direct irradiation and another, designated as "scatter", in which there was exposure to the upper half of the body as external beam irradiation but no direct irradiation of the thyroid gland.

The study was designed to emulate the approach that would commonly be used by a clinician seeking evidence of change in the thyroid gland. Palpation was used to delineate size and other characteristics. The customary thyroid function tests were carried out. These findings were supplemented by high-resolution ultrasound examination of the neck, and, if the findings warranted, fine-needle aspiration biopsy was undertaken. Suspicious findings from any of these evaluations led usually to surgery, but an abnormal ultrasound result was the chief indication for surgery.

Some surprising and important revelations have come to light:

- Palpation of the thyroid gland was unreliable and misleading in a significant proportion of patients, with a preponderance of non-discovery.
- Ultrasound examination was almost always abnormal when the thyroid gland was palpable, and abnormal in more than 50% of patients in which the gland could not be felt.
- Thyroid function tests gave little warning of malignancy, and the elevation of thyroid-stimulating hormone in inadequately supplemented patients, although noted, gave no pointer to the status of the thyroid gland as a whole or the underlying presence of malignancy.
- Fine-needle aspiration biopsy was carried out in a few patients, but did not materially influence their management.

The authors advocate total thyroidectomy for multiple nodules on ultrasound examination or where new nodules appear after partial thyroidectomy.

Twenty-five patients from the direct-irradiation group had abnormal ultrasound results and underwent surgery, whether or not the thyroid gland was palpable; six of them harboured malignancy. On the other hand, in the scatter group, of 24 patients with similarly abnormal ultrasound results 12 were affected. Not only were localised recurrences frequent, but additional cancers in other areas of the body were noted by the authors, so vigilance in this respect is required. When surgery was carried out, the histological appearance of glands exposed to both types of irradiation