
Feature Article

Cleaning Up The “Wild West Aesthetic Industry” ... Sheriff GMC Bans Botox Remote Prescribing

Many commentators have likened the current state of the U.K. aesthetic industry to the ‘Wild West’ of Hollywood spaghetti westerns with plenty of troublesome cowboys, where regulation is poor and practices are going on which most regard as although not strictly unlawful, certainly not 100% safe, moral or ethical.

So it seems quite apt that *Sheriff GMC* rode into town this summer and declared that he was banning the remote prescribing of Botox (and other botulinum toxin brands) by U.K. Doctors; about time too many have said.

This ‘clean up’ has certainly shaken the saloon bar up a bit and many of its occupants are left wondering what they’re going to do now to keep their various business models going.

Consulting Room™ Director Ron Myers said of the GMC move;

“This unequivocal statement from the GMC would seem to be the final nail in the coffin for remote prescribing business models of Botox for cosmetic purposes. The NMC have been clear on this for a while, but the GMC now comes into line and should **halt the march of non-prescribers of any speciality seeking to offer this treatment via a remote consultation business model. This decision has become increasingly important as we have even seen these prescription medicines getting into the hands of people without any medical qualifications.**”

“Remote prescribing was introduced to save lives in remote communities, not to treat wrinkles;” said **Former BAAPS President, Consultant Plastic Surgeon Nigel Mercer** when summing up the situation.

In this article we will look at the development and outcome of events, what it means for many within the industry and some ways forward for those involved.

Background

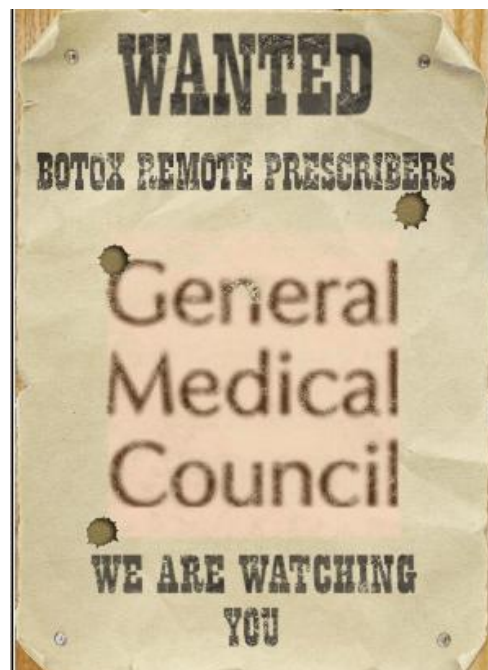
On 12th July 2012 an official press release was issued by the **General Medical Council (GMC)** following an appearance by Niall Dickson, GMC Chief Executive on BBC London News which had run an undercover investigation into the botulinum toxin remote prescribing services of Dr. Mark Harrison and his company Harley Aesthetics. In the investigation Dr. Harrison was seen talking about his methods for performing remote consultations, including some which were performed retrospectively following treatment of a patient by a non-prescribing nurse. He also detailed methods that nurses could use to obtain ‘stockpiles’ of toxin products, a practice which is forbidden for nurses and even independent nurse prescribers, by sourcing scripts in the names of family and friends through his company supply chain which goes against laws governing the scenario where a drug is prescribed for one individual and used on another.

We first broke this story, gathering industry opinions from doctor and nurse groups, as well as regulators in our blog. You can read the full background [here](#).

In the official statement the GMC said;

“Doctors are to be banned from prescribing Botox by phone, email, video-link or fax under new guidance from the General Medical Council (GMC).

The change means that **doctors must have face-to-face consultations with patients before prescribing Botox and other injectable cosmetics** to ensure they fully understand the patient’s medical history and reasons for



wanting the treatment. Under current GMC guidance doctors must adequately assess the patient's condition before prescribing remotely and they must be confident they can justify the prescription. Where doctors cannot satisfy these conditions, they must not prescribe remotely.

The **new guidance**, which came into force on 23rd July (2012), updates and strengthens these rules. **It introduces a complete prohibition on prescribing cosmetic injectables, such as Botox, without a physical examination of the patient. Doctors who continue to prescribe Botox or similar products remotely will be putting their registration at risk.**

The guidance, which will be issued to every doctor in the UK, states: **'You must undertake a physical examination of patients before prescribing non-surgical cosmetic medicinal products such as Botox, Dysport or Vistabel or other injectable cosmetic medicines. You must not therefore prescribe these medicines by telephone, fax, video-link, or online.'**

For the largest number of individuals affected by this GMC announcement, namely nurses, this really isn't what you could call 'new' news, as their regulator, the **Nursing & Midwifery Council (NMC)** stated to its members over a year ago in April 2011 that;

"The advice, *'Remote prescribing and injectable cosmetic medicinal products'* makes clear the NMC's position that **remote prescriptions or directions to administer should not be used to administer injectable cosmetic medicinal products such as botulinum toxin (Botox®).**"

So the NMC have been clear on this stance for some time, in fact similar earlier drafted statements from them go back 5 years to 2007 (see bottom of page one of this [PDF document](#)), meaning that nurses themselves ought to have already been aware that practicing botulinum toxin injections using remote prescribing services went against NMC standards. But clearly with no real precedence in terms of severe reprimand following fitness to practice hearings and widespread mis-information, the situation has carried on until now.

Discussing this **Mai Bentley RGN NIP, Director of Training at Intraderm Limited** told us;

"The GMC, NMC and MHRA have been totally aware of this situation for over two years but no significant action has been taken until now. We have tried hard to raise awareness amongst nurses about the many problems associated with some remote prescribing services but this was not welcomed by some doctors, nurses and companies within the aesthetic industry. **We have always been concerned that many nurses have been misled as to the legalities of some remote prescribing services but with little support from the appropriate governing bodies and the aesthetic industry, this has been impossible to address in the correct manner.**"

She went on to explain some of the terms used in the NMC guidance, including the definition of 'directions to administer';

"A direction to administer is basically the instructions that a nurse must follow to administer a drug. It tells the nurse the name of the drug, the diluent required, the amount of diluent to use, the route of the drug e.g. intramuscular, orally etc, the dose to be given and so on. It must be for a specific named patient and must be signed by the prescriber and placed in the patient notes. It must comply with NMC Standards for Medicines Management 2007.

The direction to administer should ALWAYS be given to a non prescribing nurse before she administers a drug in any setting not just an aesthetic one.

They (the NMC) are saying that a direction to administer given remotely i.e. by telephone or other remote means is only acceptable for emergencies...a direction to administer should normally be given to a nurse after a face to face consultation with the patient. Again, it is the word REMOTE that is important."

Equally the **General Dental Council (GDC)** took a stance on this over 12 months ago when it issued a statement to its members in May of 2011 stating:

'You must undertake a physical examination of patients before prescribing non-surgical cosmetic medicinal products such as Botox, Dysport or Vistabel or other injectable cosmetic medicines. You must not therefore prescribe these medicines by telephone, fax, video-link, or online.'

General Medical Council
Guidance

“Remote prescribing should not be routinely used to facilitate treatment, or in the provision of non-surgical cosmetic procedures such as the prescription or administration of injectable cosmetic medicinal products.”

So it seems that it's taken a public media investigation into a high profile Doctor, like Mark Harrison to make the GMC come into line with statements from the NMC and GDC in order to then make the whole industry (nurses, insurers and suppliers alike) sit up, take notice and examine this practice. What does this say about the GDC and NMC if everyone is happy to ignore what they say and carry on a practice regardless, but as soon as the GMC says no, everyone listens? This just continues to underpin [recent reports](#) which damned the NMC as an ineffective regulator of nurses one could argue.

Whatever your views on the legalities of remote prescribing in facial aesthetics; with insurers and the NMC being explicit for some time now, why has it taken the GMC statement for everyone to suddenly look at this issue from a “risk management” perspective if they have been involved in this model for some years? It's hard to tell, but it does show the influence that some individuals can have over others in persuading them to follow them in pursuit of their business model and monetary aims.

Some estimate that Dr Mark Harrison (via his company Harley Aesthetics) built up a group of over 400 nurses receiving remote prescriptions for botulinum toxins at a cost of £30 per telephone call. Dr. Harrison was recently suspended by the GMC for his practices pending a hearing. He is not alone though and many other Doctors and Dentists have sought to replicate this profitable model and have also prescribed for podiatrists, physiotherapists, and beauty therapists, along with other specialties and non-medics.

"I would hope that this now closes the door to Doctors who are prescribing remotely to Beauty Therapists and other non-medics."

Yvonne Senior, Co-Founder of the Private Independent Aesthetic Practices Association (PIAPA).

We have raised awareness of these issues in several blogs over the years looking at whether [beauty therapists should be allowed to inject Botox and dermal fillers](#) and equally [Podiatrists](#) – and when we try and pin this down, there is often a similar scenario to the above with someone “championing the cause” for a particular specialty and actively persuading insurers to cover them. Examples include Molly Hanson-Steel and her organisation CTIA (Cosmetic Treatments & Injectables Association) which backs beauty therapists and Fluent Health Academy promoting facial aesthetic (fillers and toxin) training courses to podiatrists.

Emma Davies RGN and founder member of the British Association of Cosmetic Nurses (BACN) stated;

“We have been concerned for some time with Doctors presenting convincing, but misleading reassurances to nurses, that remote prescribing was legal and met NMC standards. We are relieved that the practise has been exposed and we can move forward with absolute clarity.”

Dr. Samantha Gammell, President of The British College Of Aesthetic Medicine (formerly the British Association of Cosmetic Doctors) said in a statement;

“The aim of the British College Of Aesthetic Medicine is to advance the effective, safe and ethical practice of aesthetic medicine and we therefore welcome the new General Medical Council (GMC) guidelines on remote prescribing. We understand that the new guidelines make specific reference to injectable cosmetic medicines such as Botulinum Toxin and therefore there can be no further claims of ambiguity by any medical professional.”

Sally Taber, Director of the Independent Healthcare Advisory Services (IHAS) and responsible for the management of the Standards and Training principles for www.TreatmentsYouCanTrust.org.uk, also responded by saying;

“www.TreatmentsYouCanTrust.org.uk applauds the move from the General Medical Council (GMC)... The inappropriate practice of remote prescribing by Doctors has to date been one of the biggest issues within the cosmetic injectable industry. Following its launch nearly two years ago, the Department of Health backed register of regulated cosmetic injectable providers www.TreatmentsYouCanTrust.org.uk has campaigned for the GMC to review its remote prescribing guidance and close the loophole which had put patients at risk by providing unqualified providers without a clinical background with Botox®.”

So where do we go from here?

This isn't the end for non-prescribing nurses who have a significant botulinum toxin business model, as many options still exist for them to continue their operations in line with both NMC and GMC guidelines. All options however pose a challenge and in most cases there is an additional financial burden or loss to be incurred.

Many have stated that non-prescribing nurses should just become Independent Nurse Prescribers (INPs) or Nurse Independent Prescribers (NIPs), however the V300 NIP course is not the answer for everyone for a variety of reasons, including the costs (upwards of £2,000), the time commitment, the level of independent study needed (equivalent to degree level) and the prerequisite qualifications required to enrol in the first place. Independent Nurse Prescriber and Owner of Regenix Medical Aesthetics Clinic Andrew Rankin who embarked on his prescribing qualification in 2007 explains why there is more to this route than many initially think;

"Being able to prescribe is about more than just convenience though. It allows the prescriber to enhance their practice and importantly, enhances the client's experience. For instance, if a client is treated for acne prescription only topicals might now be considered. If pain control is a problem, perhaps lidocaine is now an answer. Does the client suffer from cold sores – prescribe oral acyclovir for them. These are just a few examples of how prescribing can be used to enhance patient care. As nurses we need to be able to justify and evidence our decisions, therefore my advice would be to approach the course, and work with your DMP (Designated Medical Practitioner), with these thoughts in mind."

So called "buddy prescribing" systems do also appear to be a potentially workable (if less profitable) route for non-prescribing nurses going forward, but will require a lot of trust and organisation on both sides of the operation. The exact mechanisms of action for this model are the hottest topic of debate currently amongst nursing groups, but it's likely that NIPs will take the business of script provision services away from Doctors in the future, as the time versus reward ratio for Doctors is not financially attractive for face-to-face consultation services.

The **British Association of Cosmetic Nurses** explained legal practicing guidelines for its members by saying;

"Nurses who have undertaken the Nurse Independent Prescribing (NIP) Course and satisfied the examiners at the NMC, and maintain both their general nursing qualification and NIP qualifications are legally able to prescribe and administer botulinum toxins and all other prescribable items within their area of competence, and have equal prescribing rights to all UK doctors. The NIP qualification has a pass mark of eighty percent for pharmacology and one hundred percent for mathematics.

Non-prescribing qualified nurses working in partnership with doctors or nurse prescribers are also working within the correct legal framework, when their patients are consulted by the prescriber who then delegates an order to administer to the nurse. This consultation process involves a physical face to face full consultation and examination by the prescriber."

But what about the Doctors, those previously providing remote consultations services will now suddenly also find themselves with a hole in their revenue stream and no great desire to move their services to more time consuming and less profitable face-to-face consultations. However with an anticipated increase in the number of nurses choosing to embark on NIP courses it is expected that many will move into offering their services as a Designated Medical Practitioner (DMP), a required 'mentor' or supervisory service needed by those enrolling on a V300 course, which can generate approximately £1,000 - £1,500 per candidate with no limit on the number a Doctor can assist.

Now that the 'rules' on remote versus face-to-face consultations for botulinum toxins have been defined, you'd think all would be clear but frankly it seems to be something of a can of worms as it's prompted yet more and more questions in terms of whether a Doctor or NIP needs to carry out a face-to-face consultation before every single treatment (to produce the script and directions to administer), or whether ongoing or repeat prescriptions are possible and if so how many.

Take the following example; a member of the public, we'll call her Claire, goes in for her first appointment for botulinum toxin treatment. She sees the prescriber (in this case a Doctor) face-to-face, a script is issued for glabellar line treatment which is then administered by a separate person (non-prescribing nurse or any other non-prescriber).

As would be considered standard best practice for a new client, Claire is called back for a review with the nurse two weeks later. It's not uncommon that a slight adjustment might need to be made as the dose/positioning of the units may not have been sufficient to achieve the desired results. However, this requires the issuing of a new script and a new specific direction to administer for the non-prescribing nurse, surely? So does this mean that Claire has to wait some more time for another face-to-face consultation with the prescribing Doctor for her top-up?

Then say after 3 months, Claire goes back to see the nurse because she's a little unhappy that it didn't last very long, so another dose adjustment is required. Presumably this would need yet another face-to-face consultation to be arranged with the prescriber in order to issue a suitable script with another specific direction to administer with the altered doses to achieve a longer lasting effect?

Now, what if in another 4 months time Claire goes back to see the nurse again and decides that she also wants her crow's feet treated (an unlicensed indication). As this is a new indication, presumably Claire would need yet another face-to-face consultation with the prescriber to assess her suitability for treatment in that region and another specific direction to administer to comply with NMC guidelines for the non-prescribing nurse?

All in, Claire, our patient has had 4 separate face-to-face consultation appointments and 4 separate treatment appointments, not very convenient for her for one thing! So, are we saying that repeat prescriptions without the prescriber seeing the patient are all fine and fully comply with NMC practice to deal with this situation or that in this case as there is a dosage change each time, borne out in the direction to administer then a new face-to-face consultation is indeed needed each time?

The devil truly is in the detail here and must be 100% clarified to ensure that (in the event of a problem) the prescribers (doctors, NIPs, dentists), the non-prescribing nurse injecting the toxin and the consumer are all fully protected by medical indemnity cover and that their respective medical bodies are happy with the protocol used.

A spokesman from the GMC press office said, when questioned about repeat prescriptions and the new guidance;

“Our guidance says face to face consultations are necessary to ensure safe and appropriate treatment. Before prescribing any injectable cosmetic, a doctor must have a face to face consultation with the patient. **This means doctors can't sign 'repeat' prescriptions without seeing a patient however they may write a single prescription which specifies it be dispensed in stages.**”

Confused? Yes, so are we. Would this cover Claire and her changing dose requirements or is this just a simple way of facilitating ongoing repeat prescriptions for Botox where there is no change to the adjunctive direction to administer? The key in all of this is that practitioners should not be trying to find 'loop holes' as otherwise we're just going to end up straight back in a Wild West shoot out between those practicing at the edges of the 'law' based on their interpretation of the guidelines whilst the rest watch in despair and disdain. It's important that the industry work together to layout acceptable practice.

And that is exactly what the British Association of Cosmetic Nurse (BACN) is hoping to do. They hope to be releasing guidelines for their members during mid-August. Speaking on behalf of the team behind this initiative is NIP Andrew Rankin; he told us;

“The key areas that we have focused on are in fact based on the questions raised by members. We cover in detail the issues of repeat prescribing and the need for patient specific directions. Demarcation of responsibility that surrounds delegation is covered and the issues of assessment and documentation are included. We have brought together several NMC standards to achieve a BACN best practice guideline. It is a working document and therefore subject to change in the light of future needs. Indeed through the process many ideas have come to light which represent work (and progress) for the future.

We have tried to take a pragmatic approach, realising that it takes time to enrol upon and complete the V300 course. However we are obliged to make NMC guidelines our priority in formulating the document. It will necessarily be restrictive therefore to those whose business model relied upon remote prescribing. Thus the objective for the non-prescribing nurse could be seen to be either to follow these guidelines whilst undertaking the prescribing course or to utilise a different business model, probably involving a true business partnership with a prescriber.

(One issue not covered in the guidelines is that of what is a reasonable charge. The guidelines are not the place for this but the group will nevertheless be considering this point with a view to issuing guidance.)”

Andrew concluded on a personal note by saying; “My sincere hope is that this is just a first step to achieving a unified approach to medical aesthetics, not only amongst nurses but, by bringing partners closer together, within the industry.”

Another way in which this is possible is through the insurance provisions available to UK practitioners, hence only those working in line with the NMC, GDC and GMC guidelines covering the remote prescribing ban should be granted medical indemnity policies.

For example, **Eddie Hooker, CEO of the largest insurer for the industry, Hamilton Fraser Cosmetic Insurance** said in a statement at the time of the GMC announcement that; “Hamilton Fraser Cosmetic Insurance **has always made its position clear in respect of remote consultations and the prescription of medicines in the absence of the patient. All malpractice insurance policies offered to our clients are conditional on the practitioner following the professional guidelines laid down by their governing bodies, in this case the GMC, GDC and NMC.**”

So in the case of their historical stance one wonders if there was a question all along over the validity and value of insurance cover given to nurses operating using remote prescribing services in the past and whether their insurance would even have covered them in the event of a claim as they would not have been practising in line with NMC guidelines.

To clarify the ongoing position, Hamilton Fraser go on to say;

“We welcome the recent clarification from the GMC on this issue. **Hamilton Fraser will only indemnify the practitioner if they are acting under the direction of an authorised prescribing practitioner, such as a doctor, dentist or nurse prescriber, and the patient has had a face-to-face consultation with that prescribing practitioner.**”

Mr Hooker went on to point out;

“I should also say that we will not be policing remote consultations, this is down to the governing bodies. We will point out to practitioners that **should a claim be presented by a patient that was treated without a face-to-face consultation the claim may not be honoured.** The prescribing practitioner that issues the script without the consultation may also be reported to their governing body by the insurers and any disciplinary hearing’s defence costs cover provided under their insurance policy (if we are insuring them) will be withdrawn.”

Ron Myers indeed believes that the key to ‘policing of the industry’ and ‘filling in the loopholes’ lies with the insurers and underwriters of the policies. He said in a recent [blog](#);

“If practitioners can’t get insured, they most likely will not offer the service. The more we can do as an industry to educate the insurance brokers issuing the bits of paper (i.e. the indemnity policies) and be crystal clear on the practitioner groups who should not be involved (and the mechanisms of access to drugs if non-prescribers), the closer we’ll get to a practical solution in making sure that the industry is at least restricted to the professionals who have the fullest possible support from the aesthetic industry in general.”



Lorna Jackson

Lorna has been Editor of The Consulting Room™, the UK’s largest aesthetic information website, for nine years.

She has become an industry commentator on a number of different areas related to the aesthetic industry, collating and evaluating statistics and writing feature articles, blogs, newsletters and reports for The Consulting Room™ and various consumer and trade publications, including *Aesthetic Medicine*, *Cosmetic News* and *Aesthetic Dentistry Today*.

If you have any comments or suggestions regarding this article, please email clinicarea@consultingroom.com