Response template for submissions to the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*

You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

The consultation questions from the consultation paper are outlined below. Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

Submissions can be emailed to:

Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Dr Anoop Rastogi
Organisation (if applicable)	Vice President Australasian College of Cosmetic Surgery and Medicine
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. **Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?**
Not adequately at present. Cosmetic surgery, like any other specialised field of practice requires specific training and experience if it is to be performed artfully, safely and to a standard that satisfies the rightful expectations of patients/consumers. Procedures such as liposuction, cosmetic eyelid surgery, facelift surgery, etc. are highly nuanced and necessitate specialised procedure specific education if they are to be successfully performed. While rotations through public hospital based surgical terms will provide core surgical competency, almost no exposure to cosmetic surgical procedures can be gained in the taxpayer funded public hospital system as the vast majority of cosmetic procedures are performed in the private sector. The latest Australian Breast Devices Registry report indicates that 93% of all cosmetic breast procedures occur in the private sector. This figure will be even higher for facelifts and liposuction. Consequently, public hospital-based training cannot and does not provide adequate training in cosmetic surgery. Cosmetic surgical training, instead necessarily occurs almost exclusively in the private sector. Unfortunately, there is currently no uniform minimum standard prescribed for cosmetic surgical training and no uniformly identifiable credentials by which patients can discern adequately trained and experienced cosmetic surgeons from their inadequately trained or experienced colleagues. Further, since the title 'cosmetic surgeon' is not a protected title, patients cannot rely on this title to ensure that their chosen practitioner is adequately trained. The Australasian College of Cosmetic Surgery and Medicine (ACCSM) has an excellent cosmetic surgery fellowship training program which produces highly trained and competent cosmetic surgeons, on whom the public can safely rely. However, there is currently no formal mechanism by which AHPRA or the AMC can recognise this program.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
Implementation of the Endorsement model for practitioners performing cosmetic surgery should be adopted to protect the public. Those endorsed medical practitioners who have met a National Accreditation Standard should be on a public register.

3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
The ACCSM has an excellent code of practice, which can be used to inform and broaden current guidelines.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?

5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
To a great extent. Establishing an endorsement model would protect patients from adverse outcomes as a proactive step by AHPRA and the medical board rather than the current model, which assists them in redress once harm has occurred. Those practitioners, who are endorsed to practice cosmetic surgery, would have the appropriate training and experience in cosmetic surgery. An AHPRA administered Cosmetic Surgery Register identifying doctors who are endorsed for cosmetic surgery would provide clarity to patients so that they can be assured that they are being treated by doctors who are operating within their scope of practice. A title restriction should be linked to a competency-based accreditation Standard/Register as proposed by the College (ACCSM) by means of the Endorsement pathway provided for in Section 98 of National Law.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?

Yes.

Establishing an endorsement model would provide clarity to the consumer, about the specific skills and qualifications of practitioners holding the endorsement. It would identify those practitioners who have the core surgical training and competence, and *specific* cosmetic surgical training and competence as well as on-going professional education in cosmetic surgery.

13. What programs of study (existing or new) would provide appropriate qualifications?

The Australasian College of Cosmetic Surgery and Medicine provides a 2-year cosmetic surgical fellowship program, open to doctors with demonstrated, pre-existing core surgical competency. The fellowship provides procedure specific training in procedures such as liposuction, facelift, cosmetic breast surgery, body contour surgery, etc. This is delivered through a comprehensive theoretical curriculum, hands on training, logbook requirements and research requirements.

Competency is examined and confirmed via four assessment instruments:

1. Successful passage of the ACCSM Surgical Fellowship exam. This is a five-hour external paper administered by the ACCSM in conjunction with the American board of cosmetic surgery. It constitutes the final written examination for the Cosmetic Surgical Fellowship.
2. Successful passage of the final Surgical Fellowship Viva examination
3. Procedural competency assessed by the Clinical preceptor reports
4. Successful completion of logbook requirements

The college also requires adherence to the cosmetic surgery CME program and fellows are bound by the ACCSM code of conduct.

14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?

16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
Informed consent guidelines are currently well described by the medical board.
24. If not, what improvements could be made?
If the endorsement model is adopted for cosmetic surgery, it would allow the public to identify doctors who are trained and competent in cosmetic surgery, provide protection for patients before something goes wrong, facilitate AHPRA taking action more readily against doctors who may be practicing outside of their scope of practice, and by being competency- based and independently set and assessed, be fair to all practitioners and not favour any particular group of doctors on the basis of their non-cosmetic surgical training and qualifications
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform

consumer choices?
No, the current registers do not inform the public in any meaningful way as to whether a practitioner has specific cosmetic surgery training and experience.
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
AHPRA could provide a register of identified practitioners who have the necessary training in cosmetic surgery to perform such procedures safely
28. Is the notification and complaints process understood by consumers?
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
30. Please provide any further relevant comment about the provision of information to consumers.
It should be clear to consumers which doctor is trained *specifically* in cosmetic surgery, irrespective of their other previous training.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
It is vital that consumers are made aware of the *specific* experience and qualifications of their cosmetic surgeon, in order for them to make informed choices regarding their surgery and choice of surgeon. I support the proposal for a national competency-based accreditation Standard for doctors performing cosmetic surgery. There should be a register of Endorsement of those who have met, and maintain the national standard. Restriction of the title 'Cosmetic Surgeon' should be applied to those medical practitioners who appear on the Register, administered by AHPRA. The Australasian College of Cosmetic Surgery and Medicine is a training body, specifically focused on training practitioners in Cosmetic Medicine and Surgery. This college is ideally equipped to train practitioners and enable them to maintain their level of competence and skill.

Response template for submissions to the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*

You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

The consultation questions from the consultation paper are outlined below. Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

Submissions can be emailed to:

Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Shahram Sadeghi
Organisation (if applicable)	[redacted]
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?	
	1. These could indeed be improved. Currently there is no recognised specialty of Cosmetic Surgery, nor can there be, without a change in the National Law. Therefore no training programme is recognised by the AMC for cosmetic surgery, and the title "cosmetic surgeon/ physician" may be used by any medical practitioner. Patients are at risk, because they are unable to identify if the doctor offering cosmetic surgery has the relevant *specific* training and skill. Currently it is impossible to determine if a practitioner is operating within their scope of practice. 2. There is also a huge corporate interest in cosmetic procedures mostly done by nurses in small shops following sometimes facetime with a GP that mostly are not even trained in cosmetic procedures. This also puts huge threats for the patients and needs to be regulated. Unfortunately current regulations in most states allowing this sort of unsafe practice.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?	
	1. The Endorsement model for practitioners performing cosmetic surgery should be adopted to protect the public. Those endorsed medical practitioners who have met a National Accreditation Standard should be on a public register. 2. Treatments provided by injecting nurses should be more regulated and there should be direct presence of Cosmetic practitioner at the clinic.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.	
	1. This standard would ensure that practitioners not only have a core surgical competence, but also that they have reached an acceptable level of competence and skill *specifically* in Cosmetic surgery. The practitioners would be required to be part of a recertification programme specific to cosmetic surgery. To ensure patient safety, this model would need to be applied to *all doctors* who perform cosmetic surgery irrespective of their prior backgrounds.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
These notifications should be taken based on patient's safety and not based on pressure by competing colleges. However practitioners dignity and mental health also should be considered.
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
They should be more simplified, current guidelines are very lengthy and complicated and they are different bodies that regulate this area making it almost impossible to understand what is right and what is wrong. Also related colleges should take more active responsibility in reviewing practitioners advertisements.
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
As mentioned above. It should be simplified in my opinion.
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
. Establishing an endorsement model would essentially protect patients from adverse outcomes. Those practitioners, who are endorsed to practice cosmetic surgery, would have the appropriate training and experience in cosmetic surgery. This would be clear to patients, because there would be an AHPRA administered Cosmetic Surgery Register identifying doctors who are endorsed for cosmetic surgery. Patients could then be rest assured that they are being treated by doctors who are operating within their scope of practice. A title restriction should be linked to a competency-based accreditation Standard/Register as proposed by the

College (ACCSM) by means of the Endorsement pathway provided for in Section 98 of National Law.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Establishing an endorsement model would provide clarity to the consumer, about the specific skills and qualifications of practitioners holding the endorsement. It would identify those practitioners who have the core surgical training and competence, and *specific* cosmetic surgical training and competence as well as on-going professional education in cosmetic surgery.
13. What programs of study (existing or new) would provide appropriate qualifications?
13. The Australian College of Cosmetic Surgery and Medicine (ACCSM) is a well-recognised college, which has been established well over 30 years ago. This college is well equipped to provide appropriate qualifications for those practitioners to be endorsed in Cosmetic Surgery and Medicine.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Specialist title protection is reserved for medical specialists who have been recognised by the AMC. Until this point, Cosmetic surgery and Cosmetic Medicine have not been specialist pathways recognised by the AMC, because there is no burden of disease. Failing being recognised by the AMC as a medical specialty, the endorsement model would be an appropriate way in which to regulate the cosmetic surgical industry. The title 'Cosmetic Surgeon' should be protected for those practitioners who have had specific recognised training in Cosmetic surgery. It is clear that specialist surgeons as recognised by the AMC do not have specific training in Cosmetic Surgery and specialist plastic surgeons qualify with a 'gap' in the area.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?

18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?

The Medical Board's current codes and guidelines do not specifically outline a practitioners training in cosmetic surgery. Currently consumers are left in doubt as to whether their surgeon has had any *specific* training in cosmetic surgery, even if their surgeon is a specialist surgeon as recognised by the AMC.

24. If not, what improvements could be made?

If the endorsement model is adopted for cosmetic surgery, it would allow the public to identify doctors who are trained and competent in cosmetic surgery, provide protection for patients before something goes wrong, facilitate AHPRA taking action more readily against doctors who may be practicing outside of their scope of practice, and by being competency- based and independently set and assessed, be fair to all practitioners and not favour any particular group of doctors on the basis of their non-cosmetic surgical training and qualifications

25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?

The AHPRA website, and public register of practitioners does not provide adequate information to consumers to safely choose their cosmetic surgeon. There should be a list of endorsed practitioners available for consumers to readily identify those practitioners who are adequately trained in cosmetic surgery.

27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?

AHPRA could provide a register of identified practitioners who have the necessary training in cosmetic surgery to perform such procedures safely

28. Is the notification and complaints process understood by consumers?

29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?

30. Please provide any further relevant comment about the provision of information to consumers.
It should be clear to consumers which doctor is trained *specifically* in cosmetic surgery, irrespective of their other previous training.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
It is vital that consumers are made aware of the *specific* experience and qualifications of their cosmetic surgeon, in order for them to make informed choices regarding their surgery and choice of surgeon. I support the proposal for a national competency-based accreditation Standard for *all* doctors performing cosmetic surgery. There should be a register of Endorsement of those who have met, and maintain the national standard. Restriction of the title 'Cosmetic Surgeon' should be applied to those medical practitioners who appear on the Register, administered by AHPRA. Since the Australasian College of Cosmetic Surgery and Medicine is the *only* training body in Australia specifically focused on training practitioners in Cosmetic Medicine and Surgery, this college would be best equipped to train practitioners and enable them to maintain their level of competence and skill.

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You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

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Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Amy Scott
Organisation (if applicable)	
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
No. They do not have an expected standard of training and experience. There currently is not a recognised specialty of Cosmetic Surgery.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?

7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
I think it is essential if the public is to be protected. Cosmetic surgery is not a specialty and so there are no official specialists. Other than word of mouth and the practitioner's own website and marketing, the public has no way of knowing ifthey are trained in cosmetic surgery or not. If doctors who are properly trained and competent are endorsed to practice cosmetic surgery by the authorities, the public would be able to choose an endorsed doctor. Why would Ahpra and the Medical Board NOT want to protect the public in this way?

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Yes
13. What programs of study (existing or new) would provide appropriate qualifications?
I do not know but obviously, it must be specifically about cosmetic surgery.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Only doctors or specialists who are endorsed in cosmetic surgery should be allowed to call themselves cosmetic surgeons.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
.
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?
No. As explained earlier, with no specialty and no endorsement for cosmetic surgery yet, the public register provides no relevant information about a practitioner's cosmetic surgery expertise or otherwise.
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
Introduce an endorsement for doctors who have met a competency standard in cosmetic surgery and show this on the public register.
28. Is the notification and complaints process understood by consumers?
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
30. Please provide any further relevant comment about the provision of information to consumers.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
It seems obvious that endorsement should be introduced. It will protect the public from untrained and unsafe practitioners. It is hard to think of any reason the public or anyone without a vested interest would not welcome it.

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The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Magdalena Simonis
Organisation (if applicable)	
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?

The current guidelines provide a good framework however they do not apply to non-doctors such as beauty therapists and nurses who perform minor cosmetic procedures and who also sometimes provide the services for the doctor themselves, when working within the same practice.

Making sure that the guidelines are adhered to is difficult. People who choose to have cosmetic procedures are driven by a desire to achieve a specific cosmetic ideal. The desire for a satisfactory aesthetic outcome, sometimes overrides the patient's willingness to validate the credentials of the practitioner – especially, if more affordable. The advertising guidelines and good code of conduct for medical practitioners is not applicable to nurses and beauty therapists – some of whom work with and outside of cosmetic surgery practices.

2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?

An holistic approach should be taken when dealing with patients under the age of 18 and all patients under this age should be screened for a mental health disorder. There is a disproportionately high representation rate of conditions such as obsessive compulsive disorder, body dysmorphic disorder, anxiety, eating disorder, depression, self-harming behaviours in young people seeking cosmetic surgery whether it be minor or major. Cultural phenomena such as surgical makeovers on numerous television programs and unrelenting pressures on teens to conform to beauty standards make it increasingly difficult to agree on what constitutes a "normal" appearance and contributes to the questionable desire to improve one's appearance or even crosses the line to psychopathology.

As well as an holistic approach to the request and the young person, a cooling off period of at least seven days between the patient giving informed consent and the procedure as outlined below:

For patients under 18 a cooling off period is the following:

• for minor procedures, the cooling off period must be a minimum of seven days

• for major procedures, the cooling off period must be a minimum of three months.

The RACGP recommends that in the case of patients aged under 18 years of age, specialist adolescent counselling prior to surgery or other aesthetic modifications should be recommended. A cooling off period of three months with appropriate educational material should be mandated for this group.

Section 4.1 Consent states that the practitioner should also provide written information in plain language. All patient consent needs to be considered and informed. The RACGP recommends that communications with patients who do not speak English as their primary language be offered a translator to assist in understanding the information provided and/or be provided written information in their primary language to support informed consent. All patients have a right to understand the information and recommendations they receive from their medical practitioner.

Of interest, the British Society of Paediatric and Adolescent Gynaecologists (BritSPAG) has recommended that not major surgery be undertaken for cosmetic reasons in girls under the age of 18 years. This recommendation was made in 2013 and still stands, and was established in direct response to the sudden surge in requests for Female Genital Cosmetic Surgery (FGCS). Our own enquiry in Australia following a similar trend (2015), resulted in a change in the item numbers and a diluted version of the same recommendations. We opted for a 'cooling off period' of 3 months and

mental health screening to be conducted by a psychologist, GP or psychiatrist who is not affiliated with the practitioner undertaking the procedure.

3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

The existing codes and guidelines should be effectively implemented, and patients should not be recommended by their surgeon to seek a medical referral from their general practitioner to qualify for a Medicare rebate.

To date there has been no register of cosmetic procedures being performed because many of these procedures do not attract a Medicare rebate. However, a register of these item numbers should be lodged and tracked for the purposes of measuring frequency of procedures undertaken, types of procedures, and tracking of patients if implants are used.

There is now a central register being created by the TGA for implants and it is imperative that for mesh and breast implants this is tracked and patients have knowledge of what has been inserted.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?

1. A register for all cosmetic procedures – procedures that occur outside of Medicare are still pertinent to the individual's wellbeing and self-image. As a logical progression from this, they need to be tracked and rates/ trends measured.

2. As with the example of Female Genital Cosmetic Surgery (FGCS), the unexpected rise in incidence of these procedures in 2010-2013 alerted many sectors of the health system around the need for psychological screening of women and adolescents. This has also exposed the disproportionate influence social media and advertising has on aesthetic norms, social attitudes and has highlighted the gendered inequity in the advertising industry. Measuring and collecting data has secondary societal benefits when such trends are identified which then allows for the root cause of problems to be further uncovered and then addressed. This has led to a review of Sexist Advertising through Women's Health Victoria (https://whv.org.au/our-focus/gender-equality-advertising)

3. APHRA and Medical Board Australia as well as the TGA (where implants are used) should be involved in addressing cosmetic surgery notifications. For this, we require data of Medicare rebated procedures and those that are not Medicare rebated. Hence the need for 2 registers.
   Procedures which result in complications and which end up in hospital and therefore attract a Medicare item number are the only items that can be measured to date. Quality data around satisfactory outcomes is lacking due to the inadequate data that measures procedures performed.
   This therefore makes advertising for certain procedures promising positive outcomes and benefits even more spurious because evidence-based data is lacking. The cosmetic industry as a result, does not conform to the professional standards and expectations we have in all other areas of surgery such as orthopaedics.

4. Additional monitoring that could be implemented may include de-identified but linked data extraction from primary care and hospitals to see if there is an uptake in revised procedures or presentations with adverse effects after cosmetic surgery.

5. A de-identified registry could monitor medical devices used and procedures done so that targeted recall is possible. For example, the TGA arthroplasty implant registries could be used as an exemplar.

5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.
When things go wrong, people go to their GP who might not even know that they have had this procedure done. General practitioners need to be given some advice as to how to address these issues for the most part, we recommend that patients see the surgeon who performed the procedure. Sometimes the procedure was undertaken overseas – so therein lies a problem. Sometimes the procedure has been performed by a nurse or beauty therapist especially with respect to laser burns and botox injections.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?

It is insufficient and clearly has not been adhered to. More emphasis needs to be made on sexist advertising and the gendered bias of the cosmetic industry. Our emphasis should not be to normalise the industry but to outline firstly that women and people in the community are now under more pressure than ever and that other options should be sought first.

https://whv.org.au/resources/whv-publications/advertising-inequality-impacts-sexist-advertising-women's-health-and

7. What should be improved and why and how?

Seek some input from Women's Health Victoria – their programme on the review of the National Framework for the advertising industry, is an Australian first and possibly a world first.

https://shequal.com.au/app/uploads/2020/11/Seeing-is-Believing.pdf

See link here: https://whv.org.au/resources/whv-publications/advertising-inequality-impacts-sexist-advertising-women's-health-and

8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?

As mentioned in Q 7 &6

Seek input from Women's Health Victoria – their programme on the review of the National Framework for the advertising industry, is an Australian first and possibly a world first.

https://shequal.com.au/app/uploads/2020/11/Seeing-is-Believing.pdf

See link here: https://whv.org.au/resources/whv-publications/advertising-inequality-impacts-sexist-advertising-women's-health-and

Promotion of cosmetic surgery via social media should be regulated as per the advertising guidelines so that health services can not:

• be false, misleading or deceptive, or likely to be misleading or deceptive

• offer a gift, discount or other inducement, unless the terms and conditions of the offer are also stated

• use testimonials or purported testimonials about the service or business

• create an unreasonable expectation of beneficial treatment

9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?

Yes, Seek some input from Women's Health Victoria – their programme on the review of the National Framework for the advertising industry, is an Australian first and possibly a world first.

https://shequal.com.au/app/uploads/2020/11/Seeing-is-Believing.pdf

See link here: https://whv.org.au/resources/whv-publications/advertising-inequality-impacts-sexist-advertising-women's-health-and

10. Please provide any further relevant comment in relation to the regulation of advertising.

We have a long way to go because women's bodies have been objectified for generations and in advertising – the modus operandi has been 'sex sells'. The cosmetic surgery industry is driven by pecuniary interests, popularised beauty ideals and not health – the emphasis on the appearance is normalised and justified by 'it improves people's self-esteem, so I am doing them a service' – needs to be revisited. These are not evidence-based statements and should not be used as justification. Plastic surgery is inordinately expensive for this reason, and preys on the vulnerability of the person who has low self-esteem with the promise that surgery fixes all. Which it does not. We have all been exposed to this normalisation of an industry for such a long time. In medical circles and no doubt in the public arena, this is a 'sexy' and lucrative area of medicine which holds the promise of high incomes for trainee doctors.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?

There is confusion around the use of the terms Cosmetic Surgeon (this could be a GP, a Dermatologist even a nurse practitioner) and a plastic surgeon (a college trained surgeon).

For the most part, the consumer is not aware of the differences and the significant difference in training and standards of practice that the practitioner is working under.

We classify cosmetic surgery as minor and major – however anything that affects the skin and the outward appearance has major implications when it goes wrong. Even minor cosmetic procedures can have major consequences for the consumer if things go wrong or if these are performed by an inexperienced practitioner or poorly trained beauty therapist.

Nurses and beauty therapists who perform 'minor procedures' should be properly trained – best practice requires that patient care continues after the procedure and should be managed by that same person with its complications also. If they are not trained to do so, they should not be performing these. That part of the 'minor cosmetic industry' needs better, tighter regulation.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?

The public sector cannot determine easily if the 'cosmetic surgeon' is a plastic surgeon, dermatologist or a general practitioner (more often than not).

[redacted]

Micro credentialling should be provided by the RACS.

13. What programs of study (existing or new) would provide appropriate qualifications?

Not in my scope

14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

The title 'cosmetic surgeon' is often used regardless of the particular training background. Some are fully qualified surgeons, having completed accredited surgical training programs, while others are not. The titles of those performing procedures need clearer clinical definitions. Titles should be sufficient for the consumer to have an understanding of the skill level of the provider e.g. whether they are a plastic surgeon FRACS / dermatologist FACD, GP or nurse.

New cosmetic procedures

Newer emerging cosmetic procedures such as female genital cosmetic surgery (FGCS) raises other concerns regarding regulation. FGCS is not medically indicated and aims to change aesthetic (or functional) aspects of a woman's genitalia. These procedures can be performed by anyone with a medical degree, including a cosmetic surgeon, gynaecologist, plastic surgeon, or urologist. No formal training is required and there are no evidence-based guidelines for these procedures at present.

A previous submission was made to the Medical Board of Australia's Public Consultation Paper and Regulation Impact Statement in March 2015 on registered medical practitioners who provide cosmetic medical and surgical procedures. It highlighted those cosmetic procedures, such as injectable Botox and collagen treatments, are often performed by a beautician or nurse. These are sometimes supervised by the treating doctor, but it is likely there are instances when this is not the case. As stated in item 8 of the Medical Board's draft guidelines, treatments should only be provided if the person performing the procedure has the appropriate training, expertise and experience in the particular cosmetic procedure being performed. The person performing the procedure should be able to deal with all routine aspects of care and any likely complications.

It would also be beneficial if the industry could agree on a delineation of services according to the complexity of the procedures.

A resource was published by the RACGP in 2015 to highlight this information to GPs and other health professionals: Female genital cosmetic surgery – A resource for general practitioners and other health professionals

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?

It appears that AHPRA is the first port of call for concerned consumers. There may be a back log of complaints and investigations. Often patients will see their GP who may not even know that they had the procedure in the first place, for an opinion and to lodge a complaint. With respect to TV nesh implants and breast implant leaks often it is the GP they patient will go to.

GPs should be supported with a flow chart to investigate a claim or assist a patient wanting to lodge a complaint. Oftentimes however, even when things go wrong, which they do, a break down in in communication or inaccessibility between the patient and the surgeon / cosmetic practitioner becomes the issue.

Little can be done to support people who have surgery /procedures overseas.

16. If yes, what are the barriers, and what could be improved?

1. First and foremost - patients should be able to assess what the training of the provider is and which college the provider is affiliated with

2. GPs should be provided with adequate information such as a flow sheet' when patients come to you with cosmetic surgery gone wrong' – next steps.

3. Item numbers and tracking of procedures – who knows what has been undertaken? When there is no item number and there is no Medicare cost associated with the procedure, what level of priority do these claims attract with MBA and AHPRA? Are these patients then left to languish as with TV Mesh?

17. Do roles and responsibilities require clarification?

Yes.

18. Please provide any further relevant comment about cooperating with other regulators.

As above.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**

Not for cosmetic procedures gone wrong.

This is mostly for medical practitioners who are not fit to practice.

A process is required for surgical / cosmetic procedures – that have caused harm or yielded an unfavourable outcome. However, for the most part, the legal agreement between the consumer and the practitioner prior to the procedure usually protects the practitioner against any claims for compensation based upon patient dissatisfaction. No one can promise 100% perfection.

20. Are there things that prevent health practitioners from making notifications? If so, what?

The lack of ease in accessing the appropriate site and it is not mandatory to report unsatisfactory outcomes. It is unclear if reporting should go to Australian Commission on Safety and Quality in Healthcare (ACSQH) of MBA, or TGA.

21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?

Plain English information levelled at consumers but written by MBA and RACS

To integrate the gendered aspects of this industry and the social media influence on peoples' expectations.

A previous submission was made to the Medical Board of Australia's Public Consultation Paper and Regulation Impact Statement in March 2015 by RACGP on registered medical practitioners who provide cosmetic medical and surgical procedures. It highlighted that cosmetic procedures, such as injectable Botox and collagen treatments, are often performed by a beautician or nurse. These are sometimes supervised by the treating doctor, but it is likely there are instances when this is not the case. As stated in item 8 of the Medical Board's draft guidelines, treatments should only be provided if the person performing the procedure has the appropriate training, expertise and experience in the particular cosmetic procedure being performed.

The person performing the procedure should be able to deal with all routine aspects of care and any likely complications.

22. Please provide any further relevant comment about facilitating notifications

As above

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?

It does, however informed consent is often under emphasised. Many people when asked what they have consented to cannot give you a clear description of what is being undertaken, what implant they are having and what the possible complications are.

A good test of adequate informed consent would be to have the consumer patient relay this in verbal or audio and confirm that they understand.

24. If not, what improvements could be made?

As above.

25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

Yes, especially given that there is an emotional element driving the desire to undertake any elective cosmetic procedure. It is all about feedback and accountablity - of both the consumer and the practitioner. A bit like a 'cooling off' period – it encourages reflection.

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?

It is not in plain English – and it is not translated for all CALD groups in language they understand.

27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?

Plain language statement

In multiple languages

Visual – perhaps as not everyone read and understands the written format as well.

28. Is the notification and complaints process understood by consumers?

No

It is not understood by doctors either all that well.

29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?

There should be a site – in simple language which outlines what can be done.

If in that step one is 'see your GP', my request is that you first provide GPs with adequate updates and involve them in the process of designing such a flow sheet.

30. Please provide any further relevant comment about the provision of information to consumers.

As above.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.

Thank you for the opportunity to comment.

Response template for submissions to the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*

You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

The consultation questions from the consultation paper are outlined below. Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

Submissions can be emailed to:

Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Professor Rodney Sinclair
Organisation (if applicable)	Australasian Hair and Wool Research Society
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
No
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
The unqualified inclusion of hair replacement therapy in Minor (non-surgical) cosmetic medical procedures is too broad. It could potentially encompass intralesional injection of corticosteroid as a treatment of alopecia areata or other TGA approved medical therapies for medical hair loss. Also of note, there are MBS item numbers for scar revision and hair transplantation surgery for cicatricial alopecies.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
What I believe the document aims to refer to could be more precisely described as 'hair restoration surgery for male pattern hair loss.'

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
13. What programs of study (existing or new) would provide appropriate qualifications?
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
28. Is the notification and complaints process understood by consumers?
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
30. Please provide any further relevant comment about the provision of information to consumers.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.

Response template for submissions to the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*

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Submissions can be emailed to:

Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Dr Arushi Singh
Organisation (if applicable)	
Email address	[redacted]

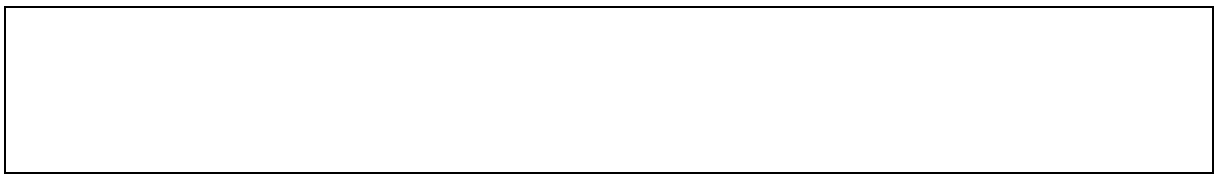
Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
1. These could indeed be improved. Currently there is no recognised specialty of Cosmetic Surgery, nor can there be, without a change in the National Law. Therefore no training programme is recognised by the AMC for cosmetic surgery, and the title "cosmetic surgeon" may be used by any medical practitioner. Patients are at risk, because they are unable to identify if the doctor offering cosmetic surgery has the relevant *specific* training and skill. Currently it is impossible to determine if a practitioner is operating within their scope of practice.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
1. The Endorsement model for practitioners performing cosmetic surgery should be adopted to protect the public. Those endorsed medical practitioners who have met a National Accreditation Standard should be on a public register.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
1. This standard would ensure that practitioners not only have a core surgical competence, but also that they have reached an acceptable level of competence and skill *specifically* in Cosmetic surgery. The practitioners would be required to be part of a recertification programme specific to cosmetic surgery. To ensure patient safety, this model would need to be applied to *all doctors* who perform cosmetic surgery irrespective of their prior backgrounds.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.



Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
. Establishing an endorsement model would essentially protect patients from adverse outcomes. Those practitioners, who are endorsed to practice cosmetic surgery, would have the appropriate training and experience in cosmetic surgery. This would be clear to patients, because there would be an AHPRA administered Cosmetic Surgery Register identifying doctors who are endorsed for cosmetic surgery. Patients could then be rest assured that they are being treated by doctors who are operating within their scope of practice. A title restriction should be linked to a competency-based accreditation Standard/Register as proposed by the

College (ACCSM) by means of the Endorsement pathway provided for in Section 98 of National Law.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Establishing an endorsement model would provide clarity to the consumer, about the specific skills and qualifications of practitioners holding the endorsement. It would identify those practitioners who have the core surgical training and competence, and *specific* cosmetic surgical training and competence as well as on-going professional education in cosmetic surgery.
13. What programs of study (existing or new) would provide appropriate qualifications?
13. The Australian College of Cosmetic Surgery and Medicine (ACCSM) is a well-recognised college, which has been established well over 30 years ago. This college is well equipped to provide appropriate qualifications for those practitioners to be endorsed in Cosmetic Surgery and Medicine.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Specialist title protection is reserved for medical specialists who have been recognised by the AMC. Until this point, Cosmetic surgery and Cosmetic Medicine have not been specialist pathways recognised by the AMC, because there is no burden of disease. Failing being recognised by the AMC as a medical specialty, the endorsement model would be an appropriate way in which to regulate the cosmetic surgical industry. The title 'Cosmetic Surgeon' should be protected for those practitioners who have had specific recognised training in Cosmetic surgery. It is clear that specialist surgeons as recognised by the AMC do not have specific training in Cosmetic Surgery and specialist plastic surgeons qualify with a 'gap' in the area.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?

18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?

The Medical Board's current codes and guidelines do not specifically outline a practitioners training in cosmetic surgery. Currently consumers are left in doubt as to whether their surgeon has had any *specific* training in cosmetic surgery, even if their surgeon is a specialist surgeon as recognised by the AMC.

24. If not, what improvements could be made?

If the endorsement model is adopted for cosmetic surgery, it would allow the public to identify doctors who are trained and competent in cosmetic surgery, provide protection for patients before something goes wrong, facilitate AHPRA taking action more readily against doctors who may be practicing outside of their scope of practice, and by being competency- based and independently set and assessed, be fair to all practitioners and not favour any particular group of doctors on the basis of their non-cosmetic surgical training and qualifications

25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?

The AHPRA website, and public register of practitioners does not provide adequate information to consumers to safely choose their cosmetic surgeon. There should be a list of endorsed practitioners available for consumers to readily identify those practitioners who are adequately trained in cosmetic surgery.

27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?

AHPRA could provide a register of identified practitioners who have the necessary training in cosmetic surgery to perform such procedures safely

28. Is the notification and complaints process understood by consumers?

29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?

30. Please provide any further relevant comment about the provision of information to consumers.
It should be clear to consumers which doctor is trained *specifically* in cosmetic surgery, irrespective of their other previous training.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
It is vital that consumers are made aware of the *specific* experience and qualifications of their cosmetic surgeon, in order for them to make informed choices regarding their surgery and choice of surgeon. I support the proposal for a national competency-based accreditation Standard for *all* doctors performing cosmetic surgery. There should be a register of Endorsement of those who have met, and maintain the national standard. Restriction of the title 'Cosmetic Surgeon' should be applied to those medical practitioners who appear on the Register, administered by AHPRA. Since the Australasian College of Cosmetic Surgery and Medicine is the *only* training body in Australia specifically focused on training practitioners in Cosmetic Medicine and Surgery, this college would be best equipped to train practitioners and enable them to maintain their level of competence and skill.

Response template for submissions to the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*

You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

The consultation questions from the consultation paper are outlined below. Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

Submissions can be emailed to:

Mr Andrew Brown, Independent Reviewer
marked '*Submission to the independent review on cosmetic surgery*' at CSReview@ahpra.gov.au.

The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Kevin Skeen
Organisation (if applicable)	
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
No- as there currently is not a recognised specialty of Cosmetic Surgery. As a result, no training programme is recognised by the AMC for cosmetic surgery and the title "cosmetic surgeon" may be used by any medical practitioner. They do not have an expected standard of training and experience.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?

7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
I think it is essential if the public is to be protected. Cosmetic surgery is not a specialty and so there are no official specialists. Other than word of mouth and the practitioner's own website and marketing, the public has no way of knowing ifthey are trained in cosmetic surgery or not. If doctors who are properly trained and competent are endorsed to practice cosmetic surgery by the authorities, the public would be able to choose an endorsed doctor. Why would Ahpra and the Medical Board NOT want to protect the public in this way?

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Yes
13. What programs of study (existing or new) would provide appropriate qualifications?
I do not know but obviously, it must be specifically about cosmetic surgery.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Only doctors or specialists who are endorsed in cosmetic surgery should be allowed to call themselves cosmetic surgeons.

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
.
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?
No. As explained earlier, with no specialty and no endorsement for cosmetic surgery yet, the public register provides no relevant information about a practitioner's cosmetic surgery expertise or otherwise.
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
Introduce an endorsement for doctors who have met a competency standard in cosmetic surgery and show this on the public register.
28. Is the notification and complaints process understood by consumers?
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
30. Please provide any further relevant comment about the provision of information to consumers.

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
It seems obvious that endorsement should be introduced. It will protect the public from untrained and unsafe practitioners. It is hard to think of any reason the public or anyone without a vested interest would not welcome it.

From: Admin Complaints
To: Cosmetic Surgery Review
Subject: Submission to the independent review on cosmetic surgery
Date: Thursday, 10 March 2022 4:00:18 PM

Forwarding on behalf of below

Simon
Regulatory Coordinator, Complaints

Email | complaints@ahpra.gov.au
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | MELBOURNE VIC 3001 | www.ahpra.gov.au

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Please consider the environment before printing.

From: Mark Sowden [redacted]
Sent: Wednesday, 9 March 2022 12:33 PM
To: Complaints <complaints@ahpra.gov.au>
Subject: Re: Feedback for Ahpra

Dear Simon

Thank you for your email. Please find attached correspondence for AHPRA's consideration, could you please also on-send this to the relevant medical boards for their consideration in the current independent review:

Dear Hon Greg Hunt MP (Federal Minister for Health and Aged Care), The Hon Mark Butler MP (Shadow Federal Minister for Health), The Hon Yvette D'Ath MP (Queensland Minister for Health),

I have also cc'd into this email The Hon Terri Butler MP (my Local Federal MP), The Hon Joseph Kelly (my Local State MP), The Office of the Health Ombudsman QLD.

I did try to cc in The Australia Health Practitioner Regulation Agency (AHPRA) & National Boards; however, I could not find an email on their website, and I could not get through to a person after 98 minutes on hold over the phone (if you do have a contact email for AHPRA, could please on-send this to them for their consideration).

I would like to start by thanking all your office's staff for their time on the phone today discussing my concern. I would like to raise what I believe would be a reasonable and common-sense change to the current AHPRA guidelines, specifically a change to AHPRA guidelines for Registered Nurses providing cosmetic injectable treatments (prescription only schedule 4 medicines) and Medical Practitioners providing consultations, prescriptions, supervision for Registered Nurses providing prescription only cosmetic injectables.

Please find attached the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (1st June 2016), the AHPRA Fact sheet for cosmetic injectables providing a list of risks, the Medical Board of Australia (MBA) Guidelines for Registered Medical Practitioners who Perform Cosmetic Medical and Surgical Procedures (1st October 2016). Since the guidelines for both Registered Nurses and Medical Practitioners were updated in 2016 the industry of cosmetic injectables has changed dramatically. I have firsthand knowledge of the cosmetic injectable industry and have been involved in the industry since 2016 and have witnessed the changes. However, I must say that the changes I have witnessed have not been for the benefit of patient safety. I believe that patient safety should be the priority when setting guidelines, but the current guidelines have allowed both Registered Nurses and Medical Practitioners to put money ahead of patient safety.

Currently, under the Medical Board of Australia "Guidelines For Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures" clause 2. Patient Assessment and clause 7. Prescribing and Administering schedule 4 (prescription only) cosmetic injectables; Medical Practitioners can prescribe Botulinum toxin type A and Dermal fillers, both of which are prescription only schedule 4 medicines (cosmetic injectables), to patient's after a video call (facetime) consult with them and can then provide approval for a Registered Nurse to administer the prescription only medicine to the patient.

To put the above into layman's terms with an example:

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find out whats wrong. Unforunately, the Nurse can not get in contact with the Doctor. For this example, we'll say the Doctor is a plastic surgeon and has gone into surgery. The Nurse then contacts 000 and thankfully in this case the paramedic's realise the patient has an occluded blood vessle providing blood to the brain, and the paramedics provide another prescription only medication called Hyalase, which dissolves the dermal filler and restores bloodflow to the brain. Unfortunetly, that process took too long, and as a result the patient is now severely mentally impaired.

Unfortuantely, the above example is one of a multitude of well known risks, such as: death, atrophy, blindness, severe allergic reaction causing anaphalaxis, etc; the list goes on and on. The risks are real and they are serious and they happen in Australia. Unfortuantely, many Registered Nurses do not take cosmetic injectables seriously and treat it more like a hobby than a serious medical treatment. People have died, lost their nose, become brain dead, lost their lips, gone blind, etc. These risks will always exist; but the risk factor could be mitigated very easily and with a vary minor change to the guidelines. I propose simply changing the AHPRA guidelines (specifically for cosmetic injectables) to:

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And why would a Doctor not want to be phycially present? Simple, a Doctor could provide these cosulting services to 30 different cosmetic clinics, earning money from all the clinics while sitting at home and spending 2 miutes on the phone via facetime for each patient.

Who is the only loser from the current guidelines? Patient's. Patient safety is at risk, and the rise in complications needs to be addressed.

Although I could provide many numerous real life examples, I would like to provide one more example to put this issue into real life context. Last year, I personally know of and witnessed a plastic surgeon who was (and still is) providing consultation services via facetime to clinics. I witnessed this plastic surgeon answer a video call from a Registered Nurse (located in a different city to the doctor) during the middle of a plastic surgery (the plastic surgeon's patient was literally on the table with incisions) operation. I was stunned to say the least; however, I am aware of this plastic surgeon providing clinics with the same service at present. And unfortuantly, this is not an isolated case. Why? Although I believe it is negligent and a disaster waiting to happen if it hasn't already for both the plastic surgery patient and cosmetic injectable patient, the clinics and plastic surgeons only see the dollar signs.

Kind Regards

Mark Sowden

[redacted]

Kind Regards
Mark Sowden

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From: Complaints <complaints@ahpra.gov.au>
Sent: Wednesday, 9 March 2022 11:22 AM
To: [redacted]
Subject: RE: Feedback for Ahpra

Dear Mr Sowden,

The public consultation opened recently for the Independent review of the regulation of health practitioners in cosmetic surgery commissioned by Ahpra and the Medical Board of Australia.

The review was announced in November 2021 and is being led by former Queensland Health Ombudsman Andrew Brown, supported by an expert panel.

The review is particularly interested in understanding whether there are any barriers to consumers, practitioners or their employees raising concerns about unsafe practice or unsatisfactory outcomes. It is also examining how best Ahpra and the Medical Board of Australia should manage concerns when they are raised, and what information consumers should be given that may inform their decision-making.

There is a survey for consumers to easily share their experiences. Further information about how practitioners and other organisations can contribute is available on the review webpage.

The consultation ends on 14 April 2022. The Review expects to report his findings by mid-2022.

I trust this information is of assistance.

Simon
Regulatory Coordinator, Complaints

Email | complaints@ahpra.gov.au
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | MELBOURNE VIC 3001 | www.ahpra.gov.au

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Please consider the environment before printing.

From: Do Not Reply <donotreply@ahpra.gov.au>
Sent: Tuesday, 8 March 2022 12:59 PM
To: Complaints <complaints@ahpra.gov.au>
Subject: Feedback for Ahpra

Hi Team,

A web enquiry was submitted with the following feedback.

Full Name - Mark Sowden
Email - [redacted]
Phone - [redacted]
Phone Type - [Deprecated]
Address -
Comments - Comments - [Registration Number: Not Supplied] [Date of Birth: Not Supplied] I would like provide suggestions regarding the guidance issued by the NMBA and MBA on matters of cosmetic services to each board.
The MBA and the NMBA are responsible for the regulation of the medical and nursing professions in Australia. Both the MBA and the NMBA are supported in their roles by Ahpra. Each of these bodies is established independently of government.
I have raised my suggestions with Hon Greg Hunt MP (Federal Minister for Health and Aged Care), The Hon Mark Butler MP (Shadow Federal Minister for Health), The Hon Yvette D'Ath MP (Queensland Minister for Health), The Hon Terri Butler MP (my Local Federal MP), The Hon Joseph Kelly (my Local State MP) and The Office of the Health Ombudsman QLD.
Unfortunately, I could not find an email for AHPRA so I could not include APRAH in the correspondence and this enquiry is limited to 1000 characters, preventing me from making my sub. I would like the opportunity to email AHPRA my submission for AHPRA and the Board's consideration
Web Enquiry attached to Service Request

From:	Mark Sowden
To:	Cosmetic Surgery Review
Subject:	Proposed amendment to AHPRA and Board guidelines for Medical Practitioners and Registered Nurses
Date:	Tuesday, 15 March 2022 11:46:43 AM
Attachments:	Nursing-and-Midwifery-Board---Standard---Registered-nurse-standards-for-practice---1-June-2016 (4).PDF Ahpra---Fact-sheet---Supporting-a-safe-choice-about-cosmetic-injectables.PDF Medical-Board---Guidelines---Guidelines-for-registered-medical-practitioners-who-perform-cosmetic-medical-and-surgical-procedures (2).PDF

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

To whom it may concern,

I would like to raise what I believe would be a reasonable and common-sense change to the current AHPRA guidelines, specifically a change to AHPRA guidelines for Registered Nurses providing cosmetic injectable treatments (prescription only schedule 4 medicines) and Medical Practitioners providing consultations, prescriptions, supervision for Registered Nurses providing prescription only cosmetic injectables.

Please find attached the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (1st June 2016), the AHPRA Fact sheet for cosmetic injectables providing a list of risks, the Medical Board of Australia (MBA) Guidelines for Registered Medical Practitioners who Perform Cosmetic Medical and Surgical Procedures (1st October 2016). Since the guidelines for both Registered Nurses and Medical Practitioners were updated in 2016 the industry of cosmetic injectables has changed dramatically. I have firsthand knowledge of the cosmetic injectable industry and have been involved in the industry since 2016 and have witnessed the changes. However, I must say that the changes I have witnessed have not been for the benefit of patient safety. I believe that patient safety should be the priority when setting guidelines, but the current guidelines have allowed both Registered Nurses and Medical Practitioners to put money ahead of patient safety.

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Kind Regards
Mark Sowden
[redacted]

Fact sheet

Supporting a safe choice about cosmetic injectables

You are entitled to safe cosmetic services. This factsheet includes information about cosmetic injectables, also known as anti-wrinkle injections and dermal fillers. It can help you understand some of the potential risks and what to look out for if you are considering a cosmetic procedure and where to go if something goes wrong.

All cosmetic procedures involve risks, but you can minimise preventable risks to your health and safety.

Before going ahead think about:

- **the people involved in the procedure**
- **the product they are using, and**
- **where the procedure is taking place.**

Cosmetic injectables and how they work

The two main types of injectable substances used are:

- botulinum toxin type A (sometimes known as 'Botox'), which temporarily paralyses the facial muscles that cause wrinkles, and
- dermal fillers, which plump out wrinkles or other parts of the face.

These types of injectables are **prescription only** medicines (schedule 4 medicines). This means that only authorised registered health practitioners can prescribe them.

Questions to ask

Prescribing the medicines and the initial consultation

First, make sure you consult a registered health practitioner who is authorised to prescribe injectables. Usually, this is a medical practitioner, dentist or nurse practitioner[1]. Before the procedure can go ahead, they must consult with you, take your full history and ensure the procedure is safe for you. They must also explain the possible risks and seek your informed consent. Make sure you discuss your expectations. The practitioner should have processes in place in case of complications or medical emergencies. Before going ahead, ask yourself if the procedure is right for you.

Questions you can ask include:

- Will the prescriber consult with me before going ahead?
- Will they take my full history and explain any potential risks?
- Are they registered and authorised to prescribe the medicines used in the procedure?
- What are the short and long-term risks and how will these be managed?
- Are there any long-term effects?
- How much time will I have to consider whether to go ahead?
- Is there any other information about this procedure?
- I have allergies. Is this injectable safe for me?
- Is it safe to drive after this procedure?

If you have concerns about any of the above, you can contact Ahpra to make a notification.

1 Medical practitioners, dentist and nurse practitioners are authorised prescribers. You can confirm that the nurse is a **Nurse practitioner** by checking the national online register of practitioners.

How do I know if the person carrying out the procedure is registered, qualified, skilled and experienced?

After prescribing the medicines, the authorised registered health practitioner might administer the injection themselves. They can also prescribe the injectable for another person to carry out the procedure. However, the prescriber must make sure that the person carrying out the cosmetic procedure is authorised to administer the injectable under the relevant state and territory drugs and poisons legislation and has appropriate qualifications, skills and experience. This is usually a registered nurse or an enrolled nurse under the supervision of a registered nurse.

Anyone claiming to be a doctor, dentist or nurse must be registered to practice in Australia. Check the national online register of practitioners on the Australian Health Practitioner Regulation Agency (Ahpra) website at www.ahpra.gov.au. This is where you can make sure the practitioners involved in your procedure are registered in Australia.

Remember:

- It is illegal to call yourself a medical doctor, dentist, nurse practitioner, registered nurse or an enrolled nurse if you are not registered.
- If you can't find the practitioner you are looking for on the national online Register of practitioners, or if you have any concerns about their practice, do not continue with the procedure and let us know.

However, registration may not be enough to ensure the person carrying out the procedure is qualified, skilled and experienced to carry out the procedure.

Ask questions such as:

- Are you registered to practise in Australia?
- What training have you had? Where did you train?
- How many times have you done this procedure before?
- How long have you been working in the area of cosmetics?
- Have you ever had a bad outcome? What happened and why?
- What are the likely results of this procedure and what can go wrong?
- What happens if something goes wrong? Which emergency procedures are in place?

What medicines or health products will be used as part of the procedure?

It's very important that any medicine or health product used in the procedure has been assessed by the Therapeutic Goods Administration (TGA) for safety, quality and efficacy. Counterfeit products imported from overseas are illegal and dangerous. They can also be difficult to identify.

Cosmetic injections use potentially dangerous medicines that are regulated and must be approved for supply in Australia by the TGA. State and territory health departments regulate the supply, storage, prescription and administration of these medicines.

Make sure the injectable used for your procedure is a legally sourced product that is prescribed by an authorised registered health practitioner in Australia. You can check by asking the prescriber about this. The brand and substance of cosmetic injectables cannot be advertised, so make sure you ask the prescriber for this information.

If you have the brand name of the injectable you can search for the product on the Australian Register of Therapeutic Goods (ARTG) on the Therapeutic Goods Administration (TGA) website. This will tell you whether that product has been approved for use in Australia.

Ask questions such as:

- What is the brand of the injectable that will be used? What substance does it contain?
- Is it labelled in English?
- Is it approved for use by the TGA?

You may want to ask to see the vial before the procedure to make sure the product matches with the information you have been given.

If you have concerns about the product used, you can contact Ahpra or the TGA.

Where should the procedure take place?

The place where you are having your procedure must, at a minimum, meet infection control standards. Unsafe premises can increase the risk of you getting an infection from the procedure.

Ask yourself:

- Is the premises clean and hygienic, does it have a waste disposal bin, a hand basin with a clean supply of water and have liquid soap and single use towels or a hand dryer for drying hands?
- Does the person carrying out the procedure wear protective equipment, including new gloves and a clean gown or apron?
- Are the needles taken from a sealed packet and disposed of safely?
- Is there a dedicated space for the procedure? Be careful about having the procedure in a place that looks more like an apartment than a clinic – it may be a sign that things are not legitimate, and you may be putting yourself in danger.

The person prescribing the medicines must be familiar with and ensure compliance with relevant legislation, regulations and standards. They are responsible for the condition of the premises and should ensure that the premises are appropriately staffed and equipped to manage possible complications and emergencies.

If you see that some of the infection control or safety precautions are not in place, you should reconsider where you have the procedure and contact Ahpra.

What are the other risks?

Remember that all procedures carry risks; nothing is completely risk-free. We want to help you understand the risks so you are aware of them before having a procedure.

Make sure you that you know what to expect before, during and after the procedure. This includes knowing that a registered health practitioner will provide you with appropriate after care, especially if you experience any side effects or complications.

There are many possible side effects and complications associated with cosmetic procedures that involve an injectable substance.

Ask questions such as:

- What are the common side-effects of this injectable?
- How can I recognise a complication that requires a practitioner's attention?
- What are the expected side effects?

This table includes some of the possible side effects or complications for the two most commonly used products. More information is available in the consumer medicines information leaflet.

Botulinum toxin type A	Dermal fillers
• redness • swelling at the injection site • bruising • skin tightness • drooping of the eyelids • headache • face pain • muscle weakness • numbness or a feeling of pins and needles • nausea, and • blurred vision.	• bruising • swelling and redness at the site where you were injected • itching • skin discolouration • vascular occlusion (blocked blood vessel which causes skin tissue death) • permanent blindness • double vision • stroke • bleeding • infection (bacterial or viral) • ulceration of the skin where you were injected • lumps (nodules) forming under the skin • allergic reaction • inflammatory reactions • haematoma (a collection of blood under the skin or in the deeper tissues) • permanent disfigurement and scarring as a result of one of the above, and • weakness of the muscles of the face, head and neck, which can cause difficulty swallowing or speaking.

For more information see the Cosmetic procedures resources section of the Ahpra website or contact us.

Medical Board of Australia

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

1 October 2016

MBA1608 03

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

Introduction

These guidelines have been developed by the Medical Board of Australia (the Board) under section 39 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law).

The guidelines aim to inform registered medical practitioners and the community about the Board's expectations of medical practitioners who perform cosmetic medical and surgical procedures in Australia. These guidelines complement *Good medical practice: A code of conduct for doctors in Australia (Good medical practice)* and provide specific guidance for medical practitioners who perform cosmetic medical and surgical procedures. They should be read in conjunction with *Good medical practice*.

Who do these guidelines apply to?

These guidelines apply to medical practitioners registered under the National Law who provide cosmetic medical and surgical procedures.

Definitions

Cosmetic medical and surgical procedures are operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.[1]

Major cosmetic medical and surgical procedures ('cosmetic surgery') involve cutting beneath the skin. Examples include: breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.

Minor (non-surgical) cosmetic medical procedures do not involve cutting beneath the skin, but may involve piercing the skin. Examples include: non-surgical cosmetic varicose vein treatment, laser skin treatments, use of CO_2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.[2]

Surgery or a procedure may be medically justified if it involves the restoration, correction or improvement in the shape and appearance of body structures that are defective or damaged at birth or by injury, disease, growth or development for either functional or psychological reasons.[3] Surgery and procedures that have a medical justification and which may also lead to improvement in appearance are excluded from the definition.

The medical specialty of **plastic surgery** includes both **cosmetic surgery** and **reconstructive surgery**. **Reconstructive surgery** differs from **cosmetic surgery** as, while it incorporates aesthetic techniques, it restores form and function as well as normality of appearance. These guidelines apply to plastic surgery when it is performed only for cosmetic reasons. They do not apply to reconstructive surgery.

How will the Board use these guidelines?

Section 41 of the National Law states that an approved registration standard or a code or guideline approved by the Board is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the profession.

These guidelines can be used to assist the Board in its role of protecting the public, by setting and maintaining standards of medical practice. If a medical practitioner's professional conduct varies significantly from these guidelines, the practitioner should be prepared to explain and justify their decisions and actions.

Serious or repeated failure to meet these guidelines may have consequences for a medical practitioner's registration.

1 Definition adapted from the Medical Council of New Zealand's *Statement on cosmetic procedures* (2011) and the Australian Health Ministers' Conference *Cosmetic Medical and Surgical Procedures – A National Framework* (2011).

2 Definitions adapted from the Medical Council of New Zealand's *Statement on cosmetic procedures* (2011).

3 Definition from *Cosmetic surgery guidelines* (Medical Council of New South Wales, 2008).

GUIDELINES FOR REGISTERED MEDICAL PRACTITIONERS WHO PERFORM COSMETIC MEDICAL AND SURGICAL PROCEDURES

Providing cosmetic medical or surgical procedures

1. Recognising potential conflicts of interest

1.1 Medical practitioners must recognise that conflicts of interest can arise when providing cosmetic medical and surgical procedures and must ensure that the care and wellbeing of their patient is their primary consideration.

2. Patient assessment

2.1 The patient's first consultation should be with the medical practitioner who will perform the procedure or another registered health practitioner who works with the medical practitioner who will perform the procedure. It is not appropriate for the first consultation to be with someone who is not a registered health practitioner – for example, a patient advisor or an agent.

2.2 If the first consultation is with another registered health practitioner, the patient should have a consultation with the medical practitioner who will perform the procedure, before scheduling the procedure.

2.3 The medical practitioner who will perform the procedure should discuss and assess the patient's reasons and motivation for requesting the procedure including external reasons (e.g. a perceived need to please others) and internal reasons (e.g. strong feelings about appearance). The patient's expectations of the procedure should be discussed to ensure they are realistic.

2.4 The patient should be referred for evaluation to a psychologist, psychiatrist or general practitioner[4], who works independently of the medical practitioner who will perform the procedure, if there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

2.5 Other than for minor procedures that do not involve cutting beneath the skin, there should be a cooling off period of at least seven days between the patient giving informed consent and the procedure. The duration of the cooling off period should take into consideration the nature of the procedure and the associated risks.

2.6 The medical practitioner who will perform the procedure should discuss other options with the patient, including medical procedures or treatment offered by other health practitioners and the option of not having the procedure.

2.7 A medical practitioner should decline to perform a cosmetic procedure if they believe that it is not in the best interests of the patient.

3. Additional responsibilities when providing cosmetic medical and surgical procedures for patients under the age of 18

3.1 The Board expects that medical practitioners are familiar with relevant legislation of the jurisdiction in relation to restrictions on cosmetic surgery for patients under the age of 18.

3.2 The medical practitioner must assess and be satisfied by the patient's capacity to consent to the procedure.

3.3 The medical practitioner should, to the extent that it is practicable, have regard for the views of a parent of the patient under 18, including whether the parent supports the procedure being performed.

3.4 Before any major procedure, all patients under the age of 18 must be referred for evaluation to a psychologist, psychiatrist or general practitioner[5], who works independently of the medical practitioner who will perform the

4 Referral to a general practitioner excludes referral to general practitioners who provide cosmetic procedures.

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procedure, to identify any significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

3.5 For minor procedures, referral for evaluation by a psychologist, psychiatrist or general practitioner[6], who works independently of the medical practitioner providing the procedure, is not required for patients under the age of 18, unless there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

3.6 For the patient under the age of 18, there must be a cooling off period between the informed consent and the procedure being performed:

- for minor procedures, the cooling off period must be a minimum of seven days
- for major procedures, the cooling off period must be a minimum of three months.

3.7 The patient should be encouraged to discuss why they want to have the procedure with their general practitioner during the cooling off period.

4. Consent

4.1 The medical practitioner who will perform the procedure must provide the patient with enough information for them to make an informed decision about whether to have the procedure. The practitioner should also provide written information in plain language. The information must include:

- what the procedure involves
- whether the procedure is new or experimental
- the range of possible outcomes of the procedure
- the risks and possible complications associated with the procedure
- the possibility of the need for revision surgery or further treatment in the short term (e.g. rejection of implants) or the long term (e.g. replacement of implants after expiry date)
- recovery times and specific requirements during the recovery period
- the medical practitioner's qualifications and experience
- total cost including details of deposits required and payment dates, refund of deposits, payments for follow-up care and possible further costs for revision surgery or additional treatment, and
- the complaints process and how to access it.

4.2 Informed consent must be obtained by the medical practitioner who will perform the procedure.

4.3 Other than for minor procedures, informed consent should be obtained in a pre-procedure consultation at least seven days before the day of the procedure and reconfirmed on the day of the procedure and documented appropriately.

5. Patient management

5.1 The medical practitioner who will perform the procedure is responsible for the management of the patient, including ensuring the patient receives appropriate post-procedure care.

5.2 If the medical practitioner who performed the procedure is not personally available to provide post-procedure care, they must have formal alternative arrangements in place. These arrangements should be made in advance where possible, and made known to the patient, other treating practitioners and the relevant facility or hospital.

5.3 When a patient may need sedation, anaesthesia and/or analgesia for a procedure, the medical practitioner who is performing the procedure must ensure that there are trained staff, facilities and equipment to deal with any

6 Referral to a general practitioner excludes referral to general practitioners who provide cosmetic procedures.

emergencies, including resuscitation of the patient.

5.4 There should be protocols in place for managing complications and emergencies that may arise during the procedure or in the immediate post-procedure phase.

5.5 Written instructions must be given to the patient on discharge including:

- the contact details for the medical practitioner who performed the procedure
- alternative contact details in case the medical practitioner is not available
- the usual range of post-procedure symptoms
- instructions for the patient if they experience unusual pain or symptoms
- instructions for medication and self-care, and
- dates and details of follow-up visits.

6. Provision of patient care by other health practitioners

6.1 The medical practitioner is responsible for ensuring that any other person participating in the patient's care has appropriate qualifications, training and experience, and is adequately supervised as required.

6.2 When a medical practitioner is assisted by another registered health practitioner or assigns an aspect of a procedure or patient care to another registered health practitioner, the medical practitioner retains overall responsibility for the patient. This does not apply when the medical practitioner has formally referred the patient to another registered health practitioner.

7. Prescribing and administering schedule 4 (prescription only) cosmetic injectables

7.1 Medical practitioners must know and comply with the requirements of their state or territory drugs and poisons (or equivalent) legislation for schedule 4 (prescription only) cosmetic injectables. For example, requirements relating to permits, supply, storage and transport.

7.2 Medical practitioners must not prescribe schedule 4 (prescription only) cosmetic injectables unless they have had a consultation with the patient, either in person or by video. Remote prescribing of cosmetic injectables by phone or email (or equivalent) is not appropriate.

7.3 If the 'prescription only' cosmetic injectable is administered by another registered health practitioner who is not an authorised prescriber, the prescribing medical practitioner must be contactable and able to respond if required.

8. Training and experience

8.1 Procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure and deal with all routine aspects of care and any likely complications.

8.2 A medical practitioner who is changing their scope of practice to include cosmetic medical and surgical procedures is expected to undertake the necessary training before providing cosmetic medical and surgical procedures.

9. Qualifications and titles

9.1 A medical practitioner must not make claims about their qualifications, experience or expertise that could mislead patients by implying the practitioner is more skilled or more experienced than is the case. To do so is a breach of the National Law (sections 117 – 119).

10. Advertising and marketing

10.1 Advertising material, including practice and practitioner websites, must comply with the Board's *Guidelines for advertising of regulated health services*, the current *Therapeutic Goods Advertising (TGA) Code*, any TGA guidance

on advertising cosmetic injections and the advertising requirements of section 133 of the National Law.

10.2 Advertising content and patient information material should not glamorise procedures, minimise the complexity of a procedure, overstate results or imply patients can achieve outcomes that are not realistic.

11. Facilities

11.1 The Board expects that medical practitioners are familiar with relevant legislation, regulations and standards of the jurisdiction in relation to facilities where the procedure will be performed.

11.2 Procedures should be performed in a facility that is appropriate for the level of risk involved in the procedure. Facilities should be appropriately staffed and equipped to manage possible complications and emergencies.

12. Financial arrangements

12.1 The patient must be provided with information in writing about the cost of the procedure, which should include:

- total cost
- details of deposits required and payment dates
- refund of deposits
- payments for follow-up care
- possible further costs for revision surgery or additional treatment, and
- advising the patient that most cosmetic procedures are not covered by Medicare.

12.2 No deposit should be payable until after the cooling off period.

12.3 The medical practitioner should not provide or offer to provide financial inducements (e.g. a commission) to agents for recruitment of patients.

12.4 The medical practitioner should not offer financing schemes to patients (other than credit card facilities), either directly or through a third party, such as loans or commercial payment plans, as part of the cosmetic medical or surgical services.

12.5 Medical practitioners should not offer patients additional products or services that could act as an incentive to treatment (e.g. free or discounted flights or accommodation).

12.6 Medical practitioners should ensure that they do not have a financial conflict of interest that may influence the advice that they provide to their patients.

Acknowledgements

The Board acknowledges the following organisations' codes and guidelines, which informed the development of the Board's guidelines:

- Australian Health Ministers' Advisory Council's Clinical, Technical and Ethical Principal Committee Inter-jurisdictional Cosmetic Surgery Working Group (2011) *Supplementary guidelines for cosmetic medical and surgical procedures*
- Australian Society of Plastic Surgeons (2015) *Code of practice*
- Medical Council of New South Wales (2008) *Cosmetic surgery guidelines*
- Medical Council of New Zealand (2011) *Statement on cosmetic procedures*.

Review

Date of issue: 1 October 2016

The Board will review these guidelines at least every three years.

Nursing and Midwifery Board Ahpra

Nursing and Midwifery Board of Australia

REGISTERED NURSE STANDARDS FOR PRACTICE

1 June 2016

NMP00011

REGISTERED NURSE STANDARDS FOR PRACTICE

Orienting statements

Registered nurse (RN) practice is person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals, as well as with families, groups and communities. These people may be healthy and with a range of abilities, or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental and/or intellectual disabilities.

The Australian community has a rich mixture of cultural and linguistic diversity, and the *Registered nurse standards for practice* are to be read in this context. RNs recognise the importance of history and culture to health and wellbeing. This practice reflects particular understanding of the impact of colonisation on the cultural, social and spiritual lives of Aboriginal and Torres Strait Islander peoples, which has contributed to significant health inequity in Australia.

As regulated health professionals, RNs are responsible and accountable to the Nursing and Midwifery Board of Australia. These are the national *Registered nurse standards for practice* for all RNs. Together with the Nursing and Midwifery Board of Australia standards, codes and guidelines, these *Registered nurse standards for practice* should be evident in current practice, and inform the development of the scopes of practice and aspirations of RNs.

RN practice, as a professional endeavour, requires continuous thinking and analysis in the context of thoughtful development and maintenance of constructive relationships. To engage in this work, RNs need to continue to develop professionally and maintain their capability for professional practice. RNs determine, coordinate and provide safe, quality nursing. This practice includes comprehensive assessment, development of a plan, implementation and evaluation of outcomes. As part of practice, RNs are responsible and accountable for supervision and the delegation of nursing activity to enrolled nurses (ENs) and others.

Practice is not restricted to the provision of direct clinical care. Nursing practice extends to any paid or unpaid role where the nurse uses their nursing skills and knowledge. This practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills. RNs are responsible for autonomous practice within dynamic systems, and in relationships with other health care professionals.

How to use these standards for practice

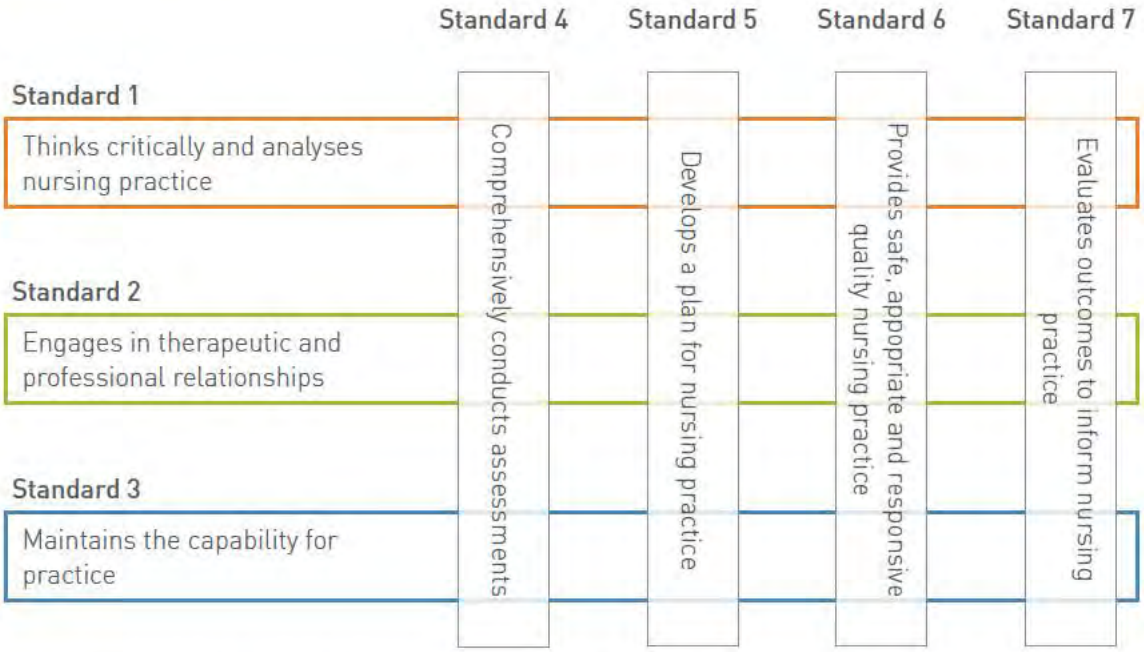
The *Registered nurse standards for practice* consist of the following seven standards:

1. Thinks critically and analyses nursing practice.
2. Engages in therapeutic and professional relationships.
3. Maintains the capability for practice.
4. Comprehensively conducts assessments.
5. Develops a plan for nursing practice.
6. Provides safe, appropriate and responsive quality nursing practice.
7. Evaluates outcomes to inform nursing practice.

The above standards are all interconnected (see Figure 1). Standards one, two and three relate to each other, as well as to each dimension of practice in standards four, five, six and seven.

REGISTERED NURSE STANDARDS FOR PRACTICE

Figure 1: RN standards



Each standard has criteria that specify how that standard is demonstrated. The criteria are to be interpreted in the context of each RN's practice. For example, all RNs will, at various times, work in partnerships and delegate responsibilities, however, not every RN will delegate clinical practice to enrolled nurses. The criteria are not exhaustive and enable rather than limit the development of individual RN scopes of practice.

The *Registered nurse standards for practice* are for all RNs across all areas of practice. They are to be read in conjunction with the applicable NMBA companion documents such as the standards, codes and guidelines, including the *Code of conduct for nurses*, *National framework for the development of decision-making tools for nursing and midwifery practice*, *Supervision guidelines for nursing and midwifery*, and *Guidelines for mandatory notifications*. The glossary is also important for understanding how key terms are used in these standards.

RN standards for practice

Standard 1: Thinks critically and analyses nursing practice

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.

The RN:

1.1 accesses, analyses, and uses the best available evidence, that includes research findings for safe quality practice

1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice

1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal

and Torres Strait Islander peoples and people of other cultures

1.4 complies with legislation, common law, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions

1.5 uses ethical frameworks when making decisions

1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations, and

1.7 contributes to quality improvement and relevant research.

Standard 2: Engages in therapeutic and professional relationships

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.

The RN:

2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships

2.2 communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights

2.3 recognises that people are the experts in the experience of their life

2.4 provides support and directs people to resources to optimise health related decisions

2.5 advocates on behalf of people in a manner that respects the person's autonomy and legal capacity

2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes

2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care

2.8 participates in and/or leads collaborative practice, and

2.9 reports notifiable conduct of health professionals, health workers and others.

Standard 3: Maintains the capability for practice

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe, and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals' capability for practice. RNs are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.

The RN:

3.1 considers and responds in a timely manner to the health and well being of self and others in relation to the capability for practice

3.2 provides the information and education required to enhance people's control over health

3.3 uses a lifelong learning approach for continuing professional development of self and others

3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities

3.5 seeks and responds to practice review and feedback

3.6 actively engages with the profession, and

3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

REGISTERED NURSE STANDARDS FOR PRACTICE

Standard 4: Comprehensively conducts assessments

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice.

The RN:

4.1 conducts assessments that are holistic as well as culturally appropriate

4.2 uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice

4.3 works in partnership to determine factors that affect, or potentially affect, the health and well being of people and populations to determine priorities for action and/or for referral, and

4.4 assesses the resources available to inform planning.

Standard 5: Develops a plan for nursing practice

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated.

The RN:

5.1 uses assessment data and best available evidence to develop a plan

5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons

5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes

5.4 plans and negotiates how practice will be evaluated and the time frame of engagement, and

5.5 coordinates resources effectively and efficiently for planned actions.

Standard 6: Provides safe, appropriate and responsive quality nursing practice

RNs provide and may delegate, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned and agreed outcomes.

The RN:

6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people

6.2 practises within their scope of practice

6.3 appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse's scope of practice or others' clinical or non-clinical roles

6.4 provides effective timely direction and supervision to ensure that delegated practice is safe and correct

6.5 practises in accordance with relevant nursing and health guidelines, standards, regulations and legislation, and

6.6 uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards.

Standard 7: Evaluates outcomes to inform nursing practice

RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.

The RN:

7.1 evaluates and monitors progress towards the expected goals and outcomes

7.2 revises the plan based on the evaluation, and

7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.

Glossary

These definitions relate to the use of terms in the *Registered nurse standards for practice*.

Accountability means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The RN who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated (Nursing and Midwifery Board of Australia 2013). See below for the related definition of Delegation.

Criteria in this document means the actions and behaviours of the RN that demonstrate these Standards for practice.

Delegation is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse. Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment. For further details see the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice (2013).

Enrolled nurse is a person who provides nursing care under the direct or indirect supervision of a RN. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a RN for the delegated care.

Evidence-based practice is accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice.

Person or people is used in these Standards to refer to those individuals who have entered into a therapeutic and/or professional relationship with a RN. These individuals will sometimes be health care consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities that are within the RN scope and context of practice. The RN has professional relationships in health care related teams.

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Registered nurse is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a RN in Australia.

Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

Standards for practice in this document are the expectations of RN practice. They inform the education standards for RNs; the regulation of nurses and determination of the nurse's capability for practice; and guide consumers, employers and other stakeholders on what to reasonably expect from a RN regardless of the

area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the registered nurse* (2010).

Supervision includes managerial supervision, professional supervision and clinically focused supervision. For further details see the NMBA's Supervision guidelines for nursing and midwifery.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA's Code of conduct for nurses.

References

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