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	
Organisation (if applicable)	Urological Society of Australia and New Zealand (USANZ)
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

The responses below relate to urogenital cosmetic medical and surgical procedures an example of which includes penile enhancement/augmentation (both medical with injection of fillers and major surgical with dermal fat grafting/division of suspensory ligament of the penis etc.). These responses are from the USANZ, the peak surgical body for urogenital surgery in Australia and New Zealand.

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?
Overall the guidelines are satisfactory. Many questions remain about the detail and enforcement of the guidelines
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
1. Recommendation for referral to seek 2nd opinion from an interested FRACS (Urology) or FRACS (Plast). 2. Extend the cooling off period to allow a second opinion and/or review by sexual health psychologist. 3. Enforcement of review by sexual health psychologist/psychiatrist prior to treatment. 4. Qualifications. Determination by AHPRA what are acceptable qualifications and training required to undertake cosmetic medical or surgical procedures of the urogenital region. 5. Qualifications. Its accepted that satisfactory completion of Royal Australian College of Surgeons accredited specialist surgical training is the basis for ascertainment of competency of surgical practice in Australia. This should be applied to 'cosmetic surgeons' and all its equivalents. 6. Continuing medical education/audit. As part of any surgical practice, the basis of quality control is audit and review of outcomes of common conditions by a standardised process. Similar mechanisms should be applicable and mandatory to assess outcomes of medical practitioners who are not FRACS (Urology) or FRACS (Plast). 7. Stronger enforcement and penalties for breeching of advertising regulations. Many websites/social media accounts glamourise treatments, overplay outcomes providing unrealistic expectations, enhance practitioner experience and training, downplay the complexity of treatments and minimise risks/potential for revision surgery. The peak body representing surgeons of the urogenital region are FRACS (Urology)/USANZ. The peak bodies of aesthetic/cosmetic surgery are FRACS (Plast)/APAS/ASAPS. There is no peak body for other medical practitioners who perform cosmetic medical and surgical procedures in the urogenital region including those with FRACS outside of Urology and Plastic and Reconstructive Surgery. There must be a governing body guiding this group of medical practitioners who undertake cosmetic medical and surgical cosmetic surgery of the urogenital region to take into account the special characteristics of penile form and function, allow for training and audit outcomes against their peers.

There are few randomised control trials available in the area of penile enhancement treatments. The vast majority of published evidence is overall low quality with associated low level of evidence[1]. Many of the recruited patients in trials have a condition described as 'small penis syndrome' or other. This is a man with a normal penis size but has a body dysmorphic syndrome (a psychological condition) and believes his penis is small. Invasive treatments (medical and surgical) for a psychological condition with associated risks should have a second opinion by another qualified medical practitioner and a sexual health psychologist. The use of medical and surgical treatments to enlarge the penis remains highly controversial[2]. There is a lack of any standardization of all described procedures. Indications and outcome measures are poorly defined and often non-validated. The reported complications including include penile deformity, paradoxical penile shortening, disagreeable scarring, granuloma formation, migration of injected material and sexual dysfunction have all been reported frequently.

There is/are no defined qualification/s to acceptably practice cosmetic medical or surgical procedures on the urogenital region. There is no training for this type of practice in Australia or New Zealand known to members of USANZ. Many of the treatments are an extension of treatments elsewhere in the body e.g. Filler injections to the face now applied to the penis to increase penile girth or glans size not considering the specific form and function of the penis and associated risks.

References:

1. Manfredi et al. Penile girth enhancement procedures for aesthetic purposes. Int J Impot Res (2021)
2. Vardi et al. Eur Urol. 2009 Apr;55(4):1002. A critical analysis of penile enhancement procedures for patients with normal penile size: surgical techniques, success, and complications

In addition to published evidence, anecdotally, members of the USANZ have seen many patients who have undertaken cosmetic medical and surgical treatments of the urogenital region by non-members who are dissatisfied or have developed complications. These patients have been left out in the cold having been abandoned by their cosmetic surgeon/physician and left to seek help as best they can with few avenues for recourse. They are left physically, psychologically and financially harmed.

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

Codes and Guidelines for any 'surgeon' should follow standards set by what the public expects to be the highest. The RACS has established criteria for training and maintenance of standards.

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?

Formal review including by accredited surgeons in relevant specialty practice.

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

None further

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
No
7. What should be improved and why and how?
There needs to be an exhaustive list of advertising that will or will not breach the National Law. The vagueness of guidelines for advertising a regulated health service has led to large and growing 'grey' areas as the guidelines fail to keep up with technology. This may require a specialised unit at AHPRA to keep updated with technology and continually update a list when technology changes. There needs to be consideration of specific guidelines or regulation for cosmetic medical procedures and cosmetic surgical procedures Enforcement and penalties. Overall, even when the guidelines are updated, more needs to be done to enforce them and offer stricter penalties & licence restrictions if breached as a deterrent
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?
A more specific response is 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?
Yes. By its nature, social media driven by any individual medical practitioner minimises the complexity of cosmetic medical and surgical procedures undertaking straightforward cases, glamourising outcomes with no complications. As the user dictates the content within social media there is inherent bias towards the positive self-promotion.
10. Please provide any further relevant comment in relation to the regulation of advertising.
It needs to be honest and reflect accurate achievable results. Glamourisation with mis-leading preys on the vulnerable and those who may have psychological issues and/or lack of insight into the genesis of their body dysmorphia.

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)?
Endorsement is not peer review and a low bar for standards in surgery.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Endorsement needs to be via formal criteria with standards of practice.
13. What programs of study (existing or new) would provide appropriate qualifications?
Each would need to be assessed on merit. Programs of study used by the RACS would be a reasonable comparator.
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 community ar large rely on regulators to ensure that standards of practice are high. The current issue with cosmetic practitioners leaves much to be desired. The title of surgeon should not be diluted to the lowest common denominator.

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 can be difficult to clarify deviations from practice when minor compared to major. Patients who are dissatisfied may not in the main report issues for fear of repercussion or shame.
16. If yes, what are the barriers, and what could be improved?
Streamlined notification with clear guidelines for standards expected.
17. Do roles and responsibilities require clarification?
Clearly they do!

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?
Yes
20. Are there things that prevent health practitioners from making notifications? If so, what?
Yes, fear of being a dobber, being accused of professional jealousy. Not wanting to get involved in undue red tape. Pushback from legal muscle.
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
Make it without malice if undertaken with genuine concern for patient safety.
22. Please provide any further relevant comment about facilitating notifications
Make it easier to afford a warning for transgressions to try and correct poor clinical standards.

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?
No
24. If not, what improvements could be made?

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:

'Should' be replaced by 'must' also provide written information in plain language.

- the complaints process and how to access it.

The written information must include details of how make a complaint beyond the medical provider for example clear written information of how to make a complaint to AHPRA. Currently, the guidelines for complaints is vague with initial reporting to the medical practitioner then beyond that to regulatory body (generally not specifically). To obtain a good understanding of the specific volume and complexity of complaints consumers should be referred to a single regulatory body Australia wide

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

Yes

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

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

Monitor broadly. Waiting for a complaint will mean that harm has been caused to more than just the complainant. The Board should be proactive if it means to protect the public from practitioners who are not adhering to established standards.

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

No

Anecdotally members of USANZ see patients dissatisfied with cosmetic treatment and feel they have exhausted all avenues to improve their outcome. Few if any have made a notification of complaint through lack of understanding the process

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

Make it mandatory during the consent process that written information specifically how to make a notification to AHPRA must be provided by the medical practitioner providing any cosmetic medical or surgical procedure to the patient. Post procedure if the patient is dissatisfied this written information must again be provided
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.
The key change should be one where the Board is proactive in monitoring advertising, claims and endorsements. This means a presence on the web and social media platforms as they evolve. This is where the Board is deficient.