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	Mayra Treacy
Organisation (if applicable)	[redacted]
Email address	[redacted]

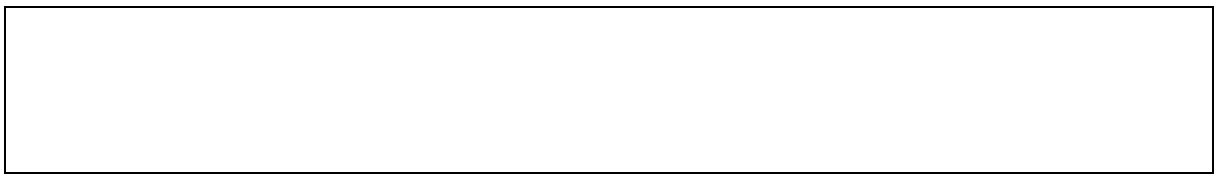
Your responses to the consultation questions

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" 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.

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Your details

Name	Dr Pedro Valente
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!

Within Australia, many Universities have been offering Tertiary Education Programs where candidates graduate with a Bachelor of Medicine, Bachelor of Surgery (MBBS). This is evident since 1856 for universities such as The University of Sydney and 1862 for Melbourne University.

We, as doctors graduate with an MBBS and therefore have the right to call ourselves a "surgeon" on the basis of part of our degree (Bachelor of Surgery) as recognised by the AMC. To remove this would be stripping Doctors of half of their medical degrees and opening the AMC, the respective Universities and other associated bodies to possible Class Action.

The title of "surgeon "is not only used by Medical Professionals but also by other professionals such as Dentists, Oral Maxillofacial Surgeons, Orthodontists, and even arborists who call themselves "tree surgeons".

The use of the descriptive term "surgeon" is not the issue at hand. It is the type of training / quality of training that ought to be questioned. I would expect a practitioner using the title 'Surgeon' to be competent in their area of speciality. That is, I would expect an ENT surgeon who is operating on sinuses to be trained in that area and I would expect a Cosmetic Surgeon to be trained in Cosmetic Surgery. I do not accept that a Gynaecologist can be doing abdominoplasties, or a General Surgeon to be doing breast aesthetic work or a Dentist to be doing non-surgical procedures if they have not had training in Cosmetic surgery.

Unfortunately, within Australia there is only one non-accredited College which does Postgraduate Cosmetic Fellowship Training. That is, The Australasian College of Cosmetic Surgery and Medicine (ACCSM). Unfortunately, [redacted] they have remained unsuccessful in obtaining recognitions with the AMC.

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

Cosmetic Surgery has not been able to be regulated in the same way as other surgery, because unfortunately cosmetic surgery is not a recognised AMC specialty.

There are two ways in which it could be regulated in the same way as other surgery, either to make Cosmetic Surgery a specialty (AMC recognised specialist), or use an endorsement model whereby the safety of this practice is regulated.

The Endorsement Model would allow patients to safely research these Practitioners and know that they have received the required training in Cosmetic Surgery & Medicine and that they meet strict Standards to remain on this Endorsement list.

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

Unfortunately current regulation allows anyone, including GPs, General Surgeons who primarily operate on cancers and Specialist Plastic Surgeons who primarily operate on trauma and reconstruction to call themselves cosmetic surgeons.

Specialties who have a FRCS such as Plastic & Reconstructive surgeons who undertake their accredited training programs for 5 years in Public Hospitals and never actually have a term in Aesthetic Surgery. They undertake subspecialties of general plastics, hand surgery, microsurgery, cranio-facial and burns in Public Hospitals. Unfortunately, Aesthetic Surgery is undertaken in Private Hospitals not the Public Sector. Therefore, Plastic Surgeon Trainee's may never have any aesthetic training during their training programs as provided by The Royal

College of Surgeons. It is not until after the completion and aware of FRACS may they consider further 6–12-month fellowships (mostly abroad) in Cosmetic Surgery. But how can a Specialist Plastic Surgeon who elects to undertake a fellowship in possibly hand surgery come back to Australia and also call themselves a Specialist Plastic, Hand & Cosmetic Surgeon?

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?

There should be a simple solution to a complex problem. Patients deserve to have a cosmetic surgical procedure performed by a practitioner who is trained and skilled in that particular procedure.

Therefore, failing the recognition of Cosmetic Surgery as a specialty, the next best thing for patient safety would be an endorsement model for *ALL* doctors/surgeons wishing to perform cosmetic surgery to ensure their safety and competence *specifically* in Cosmetic Surgery.

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

I have plenty of evidence of harms and complications resulting from cosmetic surgical procedures performed [redacted]

I see these patients on a daily basis for revisions. Sadly, these surgeons are operating outside of their scope of practice and patients are falsely led into thinking that because they are specialist surgeons recognised by the AMC, they must be competent in cosmetic surgery. Sadly, they are not.

In fact, in 2021 a survey of ACCSM surgical fellows found that 94% had been consulted by patients to address operative problems following cosmetic surgery undertaken by Australian qualified specialist plastic surgeons holding FRACS (Plast) and that 87% had undertaken revisional surgery on patients to address operative problems following cosmetic surgery undertaken by such Australian qualified specialist plastic surgeons.

Furthermore in 2012 a study by the Melbourne University School of Public Health, in co - operation with AVANT and the Victorian Health Commissioner reviewed 481 informed consent disputes resolved between 2002-2008. 77 involved cosmetic procedures, in nearly two thirds of which the practitioner against whom the allegation was made was a 'plastic surgeon'.

Again, in October 2021 the current senate enquiry was presented with evidence in the form of data from AHPRA that in 3 years to June 2021 more than half of the practitioners (52 %) who were the subjects of notifications (i.e., AHPRA complaints) relating to Cosmetic Surgery were in fact surgeons holding the AMC accredited specialist surgical registration. Of these 71% were specialist plastic surgeons.'

I also have plenty of evidence of harms and complications resulting from GPs, dermatologists and other registered medical practitioners who self-proclaims as cosmetic surgeons.

The ONLY way to protect the public and prevent, or at least reduce the harms inflicted on these innocent patients would be a national accreditation scheme or a register of 'Safe Cosmetic Surgeons' these surgeons should be primarily practicing cosmetic surgery, not just be dabbling in this arena and should have formalised specialist training in Cosmetic Surgery.

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?
I do think that strengthening existing mechanisms would be helpful, especially when it comes to social media and advertising guidelines.
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 above
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?
No
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 do not support restricting the title 'Surgeon'. Most medical practitioners qualified with a degree, which is a Bachelor of Medicine and Bachelor of Surgery (MBBS). I do not think that is either wise, not productive to strip doctors of a title already earned. I think that the title 'Cosmetic Surgeon' should be restricted to all those practitioners who have successfully completed specific training in cosmetic surgery. In this case, I do not mean RACS graduates only (since they are not trained in Cosmetic Surgery), but they should be allowed to freely use this title, if they have had post-RACS training in Cosmetic Surgery.

The title restriction in this form will make absolutely no change to who promotes themselves as cosmetic surgeons, performing cosmetic surgical procedures. Queensland as an example, where this was instituted with not much effect

Therefore, although the title ‘Surgeon’ not be restricted. ‘Specialist Cosmetic Surgeon’ Should be restricted to all those with significant training in COSMETIC SURGERY.

Honestly restricting the title ‘Surgeon’ is not really an option. There are dental surgeons, podiatry specialists who call themselves surgeons; there are dermatologists who call themselves surgeons. Notwithstanding the fact that many medical graduates already have Surgeon in their degree i.e. MBBS

Yes. There should be an endorsement model. All practitioners who have had specific training in Cosmetic Surgery should have to meet a minimum requirement and level of competence. Then these practitioners would need to have ongoing CPD requirements, research and development and would be able to use the title “Cosmetic Surgeon’.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Absolutely
13. What programs of study (existing or new) would provide appropriate qualifications?
Ideally the specialty "Cosmetic Surgery' should become recognised by the AMC, and the ACCSM the body of training in Cosmetic Medicine and Surgery. Failing this, there are certainly some improvements that can be made, for example a register of practitioners clearly visible on AHPRA who have met a reasonable standard in Cosmetic Surgery (that is, an Endorsement Model).
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
If the title 'Surgeon' is restricted to AMC specialist surgeons, some patients will only go to RACS trained surgeons for their surgery. Sadly, this will not change the pattern or number of complications suffered, as we have seen by the data 71% of complaints to AHPRA are the result of work performed by specialist plastic surgeons. [redacted] would have won a battle, but I think that it would be deleterious to patients. Furthermore, there are many well-trained Cosmetic Surgeons who would be the fall out of this change. There would of course continue to be the network of self-proclaimed doctors performing cosmetic surgical procedures under a different title, so in the end perhaps little will actually change?

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?

I am concerned that restricting the title "cosmetic Surgeon' to RACS trained surgeons will in effect defeat the purpose of the RIS. RACS surgeons are NOT trained in cosmetic surgery and so should NOT be allowed to use the term.

Similarly GPs, or other Doctors who are NOT trained in cosmetic surgery should not be allowed to use the term. Therefore, restricting a title for someone not trained in that specialty will give the public a false sense of security and patients will be deceived into getting procedures believing that their surgeon is trained, when in fact they are not.

Furthermore, I fear that [redacted] and to monopolise this industry. If they really were concerned regarding patient safety they would wholeheartedly agree on the endorsement model, where a surgeon could be recognised as a 'cosmetic surgeon' if they have the training and skill. ASAPS calls the title 'Cosmetic Surgeon' a 'Fabricated title' it is only fabricated if no one is trained in Cosmetic Surgery. If A particular surgeon is trained in Cosmetic Surgery and uses the title, then is not fabricated.

There should be a simple solution to a complex problem. Patients deserve to have a cosmetic surgical procedure performed by a practitioner who is trained and skilled in that particular procedure.

Therefore, failing the recognition of Cosmetic Surgery as a specialty, the next best thing for patient safety would be an endorsement model for *ALL* doctors/surgeons wishing to perform cosmetic surgery to ensure their safety and competence *specifically* in Cosmetic Surgery.

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?
ACCSM Fellow's do.
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
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
Establish an Endorsement Model for Doctors training in Cosmetic Surgery.
28. Is the notification and complaints process understood by consumers?
No
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?

Major public information campaigns, but those not made by [redacted] These should be government campaigns, which should not be biased.

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.

Within Australia, many Universities have been offering Tertiary Education Programs where candidates graduate with a Bachelor of Medicine, Bachelor of Surgery (MBBS). This is evident since 1856 for universities such as The University of Sydney and 1862 for Melbourne University.

We, as doctors graduate with an MBBS and therefore have the right to call ourselves a "surgeon" on the basis of part of our degree (Bachelor of Surgery) as recognised by the AMC. To remove this would be stripping Doctors of half of their medical degrees and opening the AMC, the respective Universities and other associated bodies to possible Class Action.

The title of "surgeon "is not only used by Medical Professionals but also by other professionals such as Dentists, Oral Maxillofacial Surgeons, Orthodontists, and even arborists who call themselves "tree surgeons".

The use of the descriptive term "surgeon" is not the issue at hand. It is the type of training / quality of training that ought to be questioned. I would expect a practitioner using the title 'Surgeon' to be competent in their area of speciality. That is, I would expect an ENT surgeon who is operating on sinuses to be trained in that area and I would expect a Cosmetic Surgeon to be trained in Cosmetic Surgery. I do not accept that a Gynaecologist can be doing abdominoplasties, or a General Surgeon to be doing breast aesthetic work or a Dentist to be doing non-surgical procedures if they have not had training in Cosmetic surgery.

Unfortunately, within Australia there is only one non-accredited College which does Postgraduate Cosmetic Fellowship Training. That is, The Australasian College of Cosmetic Surgery and Medicine (ACCSM). Unfortunately, due to the [redacted] they have remained unsuccessful in obtaining recognitions with the AMC.

A surgeon who is Endorsed by the AMC and APHRA. It would be irrelevant if they were RACS trained or not. Plastic surgeons are not trained in Cosmetic Surgery, and thus should only be practicing in this arena if they have had further appropriate training. As far back as 2007 a survey of public opinion was performed by Galaxy research, which revealed that 97% of Australians believed that doctors should have to pass an exam and get a 'licence' in cosmetic surgery before being allowed to practice it. Further 98% believed that patients have the right to know if the doctor performing their cosmetic surgery procedure is trained SPECIFICALLY in cosmetic surgery.

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Your details

Name	Dr Sanjay Verma
Organisation (if applicable)	[redacted]
Email address	[redacted]

Your responses to the consultation questions

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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.
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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.

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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

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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.

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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?

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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.

From:	Peter Vickers
To:	Cosmetic Surgery Review
Subject:	Submissions Independent Review Cosmetic Surgery
Date:	Wednesday, 16 March 2022 6:02:33 PM
Attachments:	Appendix 30 - Letter of support from Dr Peter Vickers.pdf ATT00001.txt

Dear Sir/Madam

Please find below a submission I did (undated) to the Australian Medical Council application by The Australian College of Cosmetic Surgery circa 2008 for establishment of cosmetic surgery as a recognised college.

For my own observations I am a specialist Oral and Maxillofacial Surgeon.

In my field of practice I operate patients with facial deformity and patients requesting cosmetic improvement. I practice exclusively in my field and have exactly the same medical degree as plastic surgeons.

I have taught junior plastic surgeons how to operate simple and difficult cases pertaining to facial surgery. Similarly my Ear, Nose and Throat Surgery colleagues are experts in cosmetic changes to their relevant field of practice. I am aware General Surgery colleagues are experts on breasts and the abdomen.

Anyone that has a surgical fellowship should have the right to encompass cosmetic surgery in their practice. The descriptor " cosmetic surgeon" does not belong to a specific group, eg plastic surgeons.

Yours sincerely

Peter Vickers

http://www.cosmeticmedicalpracticesubmission.info/appendices/Appendix%2030%20-%20Letter%20of%20support%20from%20Dr%20Peter%20Vickers.pdf

M.O.F.S
CONSULTING ROOMS
Maxillo and Oral-Facial Surgeons

- Dr Peter Vickers
  Oral & Maxillofacial Surgeon
- Dr Michael Cooper
  Oral & Maxillofacial Surgeon
- Dr Paul G Hammans
  Oral & Maxillofacial Surgeon
- Dr Barry Gaudry
  Oral & Maxillofacial Surgeon
- Dr Peter D Cannon
  Oral & Maxillofacial Surgeon
- Dr John McHugh
  Oral & Maxillofacial Surgeon

Dr John Flynn,
CEO,
The Australasian College of Cosmetic Surgery,
PO Box 36,
Parramatta, NSW, 2124

Dear Dr Flynn,

Re: AMC accreditation in the discipline/specialty of Cosmetic Medical Practice

I lend my total support in respect of your College seeking accreditation by the AMC. As a registered Oral and Maxillofacial Surgeon and immediate past President of The Australasian Society of Maxillofacial Surgeons I hereby state that there is an entity within the scope of our specialty that is described as 'Maxillofacial Aesthetic Surgery'. While not describing myself as a Cosmetic Surgeon it is accepted that patients may seek treatment from myself or other Oral and Maxillofacial colleagues for either functional or cosmetic reasons. Since the specialty of Oral and Maxillofacial Surgery encompasses surgery of the face, jaws and neck it is routine that patients desire to use our specialty skills.

The descriptor, 'Maxillofacial Aesthetic Surgery' is a component of the definition of the scope of Oral and Maxillofacial Surgery as defined by The International Association of Oral and Maxillofacial Surgery. Cosmetic procedures that may be taught in surgical training or as a Fellowship include but not limited to:

- Corrective Jaw Surgery
- Chin and Cheekbone Surgery
- Facial Implants
- Liposuction to the neck
- Cervico-facial rhytidectomy

I do not believe that any one group has the sole right to trade exclusively on the premise that they 'own' aesthetic surgery. I say this because over 25 years I have trained all manner and types of surgeons, including Plastic, ENT, General and Cosmetic Surgeons. I do not possess an FRACS because Oral and Maxillofacial Surgery has its association with The Royal Australasian College of Dental Surgeons.

I personally get referred many patients from other disciplines who seek my expertise since the skill-set required to treat the patient is outside of their comfort zone. If there is opposition to AMC accreditation of Cosmetic Medical Practice it will inevitably come from other Colleges or Professional societies who seek monopoly control. This will not help patients and be anti-competitive.

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In summary I am totally supportive of The Australian College of Cosmetic Surgery seeking AMC accreditation for recognition of the specialty of Cosmetic Medical Practice. By creating a framework where doctors from all disciplines (including FRACS holders) can submit their credentials will raise the bar in respect of training standards and lead to better patient outcomes. I enclose my CV and would be happy to support this letter with a personal representation to the AMC accreditation board.

Yours sincerely

[redacted]

Peter G. Vickers, MBBS, BDS, FRCS (Edin), FRCS (Eng), FRACDS

Commonwealth and State registered specialist in Oral and Maxillofacial Surgery

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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 Shaun Walsh
Organisation (if applicable)	Dee Why Skin Cancer and Cosmetic Clinic
Email address	[redacted]

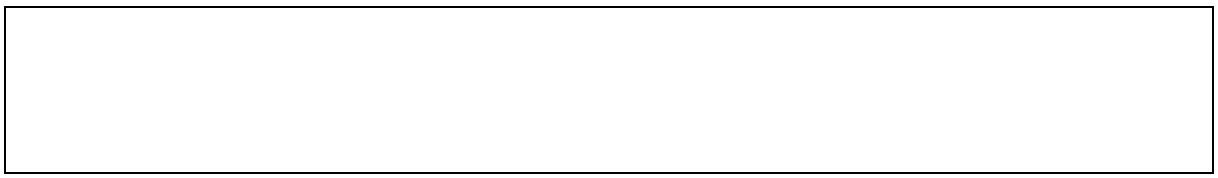
Your responses to the consultation questions

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.