
# 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** | **Australasian College of Cosmetic Surgery and Medicine (ACCSM)** |
| **Organisation (if applicable)** | Australasian College of Cosmetic Surgery and Medicine (ACCSM) |
| **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?** |
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| They are reasonable but given the rapid changes that have occurred in the area of cosmetic surgical practice, could be improved in some key areas. See answer to Q2 below. |

| **2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?** |
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| The most critical changes to the Guidelines are required at **s8 (Training and experience)** and **s9 (Qualifications and titles)** to ensure two specific outcomes, namely that:<br><br>1) **ALL** medical practitioners undertaking cosmetic surgical procedures have **basic core surgical training and competence in addition to *specific* cosmetic surgical training and competence.**<br><br>2) Individual medical practitioners are **required to declare to patients** the training that they have had to demonstrate competence in the performance of **cosmetic surgical** procedures. This is because 'cosmetic surgeons' are not all the same. There is much overlap between 'specialist surgeons' and 'cosmetic surgeons.'<br><br>For example, some specialist surgeons refer to themselves as 'cosmetic "plastic" surgeons' and some 'cosmetic surgeons' are also registered as specialist surgeons.<br><br>There are in fact **three types** of medical practitioners who undertake cosmetic surgery in Australia. They are succinctly described in the video of the Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]<br><br>The **first group** are Fellows of the ACCSM. The College is the only medical college in Australia which provides education and training leading to Fellowship specifically in cosmetic medicine and surgery. That Fellowship requires **mandatory** postgraduate core surgical training and experience followed by two years of **mandatory** dedicated cosmetic surgical training, examinations and associated specific demonstrated competency following a traditional surgical apprenticeship model.<br><br>The ACCSM' surgical syllabus has been approved by CanMEDS, which is a physician competency framework developed by the Royal College of Physicians and Surgeons of Canada and is the most accepted and applied of its type worldwide. Importantly, this syllabus includes not only technical elements (the 'Doctor as an expert'), but also training in the other elements of professional development necessary to deliver to the public safe, quality care in cosmetic surgery. Deficiencies in delivery of these 'non-technical' skills are responsible for the majority of complaints against practitioners delivering cosmetic surgery (see below).<br><br>The **second group** are plastic surgical Fellows of the Royal Australasian College of Surgeons (RACS), including 'cosmetic' plastic surgeons, who have postgraduate training in plastic surgery accredited by the Australian Medical Council (AMC) and undertaken in public hospitals on Medicare-eligible caseload. Some cosmetic surgical topics are included in RACS' academic curriculum, but of course that does not necessarily equate to training or competence in cosmetic surgery. Such training may be associated with an **optional** six months dedicated cosmetic surgical training<br><br>The **third group** comprise GPs and specialists with skills in other fields – who may or may not have basic surgical training but have **zero** mandated cosmetic surgical training.<br><br>Each of the above groups have varied training backgrounds especially in respect of specific cosmetic surgical training. See video of invited Keynote Address detailed above. |

Comprehension of the above is important because of the obvious risk of harms and complications to patients undergoing cosmetic surgery. Evidence exists that this is caused from practitioners **both *with* and *without*** advanced surgical training and/or who are practising outside their scope of competence. Multiple examples across two decades comprise:

1) In 2011, a study of medical negligence claims and patient complaints identified that one in six disputes arose from cosmetic procedures. By medical speciality, the rate of complaints against plastic surgeons was significantly higher, at more than twice that against any other specialty or subspecialty group. Rate ratios indicated that this was true for claims as well.[2]
2) In 2012, a study by the Melbourne University School of Public Health in cooperation with Avant (the largest Australian MDO which indemnifies half of all Australian doctors) and the Victorian Health Services 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.[3]
3) In a 2013 study of healthcare complaints in Australia, compared with general practitioners, plastic surgeons were at twice the risk of being the subject of recurrent complaints.[4]
4) The only doctor who has been the subject of a finding of culpability in the death of a patient during a liposuction procedure in 2007 was a plastic surgeon.[5] The Coroner observed there was agreement that '*...irrespective of a medical practitioners' provenance or primary qualification, there was a need for specific training and experience in performing liposuction surgery.*' In 2015, the Victorian Civil and Administrative Tribunal required the plastic surgeon *'to complete further education.'*[6]
5) In October 2021, the current Senate Inquiry was presented with evidence in the form of data from the Australian Health Practitioner Regulation Agency (AHPRA) that in 3 years to June 2021, more than half of the practitioners – 52 percent (96/183) – who were the subject of notification (complaints) to AHPRA relating to cosmetic surgery were surgeons holding AMC-accredited specialist surgical registration. Of these, 71 percent (68/96) were specialist plastic surgeons.[7] See here

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

For overall perspective, please see attached relevant documents published in the international medical literature[8] here, print and online media[9-12] here along with submissions to the recent Senate Inquiry dated 28-29 June 2021[13] see submission here also see addendum here and 11 October 2021[14] see Answers to Questions on Notice at pdf file number 13 and additional information at pdf file number 3.

As per Q2 above, the application of codes and guidelines must be directed to ensuring **competency** in the practice of cosmetic surgery. This matter is comprehensively detailed in the video of the invited Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

By way of explanation, cosmetic surgery is typically dealt with at superficial level by the media and sometimes misrepresented by medical commentators. Amongst the most critical of flaws relevant to its practice are frequently made statements suggesting that training and competence of **accredited specialist surgeons, including plastic surgeons, in cosmetic surgery in Australia** may be assumed because they have been accredited as specialist surgeons.

However, the actual evidence regarding training or lack thereof of AMC-accredited specialist surgeons in Australia must be considered and is compelling. **In summary**, the AMC provides **no evidence** of cosmetic surgery training by RACS in 8 specialty training programmes outside plastic and reconstructive surgery. Within the ninth, plastic and reconstructive surgery, AMC reports since 2002 suggest **inadequate** cosmetic surgical training.

The problem of lack of cosmetic surgical training of plastic surgeons is fundamental and has always been the case because cosmetic surgery falls outside of plastic and reconstructive surgery in public hospitals where reconstructive plastic surgeons are trained and cosmetic surgical procedures are not performed.[8,15]

Documentary records going back at least two decades have consistently detailed the lack of cosmetic surgical training of plastic surgeons in Australia, including but not limited to the following, in chronological order:

The AMC first highlighted the problem in its **2002 Accreditation Report** of the education programmes of the RACS in which it stated that *'There are groups other than the RACS that provide training in areas such as cosmetic surgery…'* and estimated that only *'…20 to 30 per cent of positions currently have some time spent in a private consulting or theatre environment.'*[15]

Despite that 2002 Accreditation Report, the Australian Society of Plastic Surgeons (ASPS) informed patients (both in 1998) and 2008 that the post-nominals FRACS after a plastic surgeon's name was an assurance that the surgeon was *'**fully trained** in the field of Plastic and Reconstructive **and Cosmetic Surgery Procedures** by the Royal Australasian College of Surgeons (or its equivalent)* (emphasis added)'.[16]

Yet also in 2008, [redacted]

The **2017 AMC Accreditation Report** stated *'There is currently a deficit in the experience available to trainees with regard to aesthetic surgery which is a significant part of plastic and reconstructive surgery practice, but not often available in public hospitals. Currently the training sites have difficulty providing aesthetic surgery experience for their trainees, and so those graduating from the training program will have a gap in this area of practice.'*[18] [redacted]

Subsequently, RACS stated in its **2018 Progress report to the AMC** at page 12, under 'Standard 4: Teaching and learning approach and methods,' at Recommendations for improvement *'Consider options to mitigate the lack of training in some parts of Australia and New Zealand, such as in outpatient settings, endoscopy and aesthetic surgery. To mitigate the lack of access to outpatients, endoscopy and aesthetic surgery, Orthopaedic, General Surgery and Plastic and Reconstructive Surgery training boards are **considering utilising private consulting rooms and working with hospitals to ensure alternative arrangements are in place*** (emphasis added), *via training post accreditation criteria.'*[20]

It may be deduced from RACS' statement above that at the time of the 2018 Progress report, [redacted]

The following year, RACS then stated in its **2019 Progress report to the AMC** at page 16, (in relation to the same Standard 4) – '*RACS is working to try to mitigate the lack of training in some parts of Australia and New Zealand such as in outpatient settings, endoscopy and aesthetic surgery…The RACS Specialty Training Board (STB) in Plastic and Reconstructive Surgery Australia (P&RS Au) now requires hospital posts applying for re-accreditation to articulate the length of time trainees **may** rotate through a private setting, and to have exposure to curriculum topics including the **extent of aesthetic surgery training opportunities*** (emphasis added). *The RACS STB in P&RS Au reports that the **proportion of procedures** that are used to train surgical registrars on the **operative techniques used by plastic surgeons to maximise the 'cosmesis' (aesthetic impact) of a surgical procedure** has increased from 46% in 2009 to 77% - 79% in 2018/2019* (emphasis added).'[21]

[redacted]

The latest **2021 AMC Accreditation Report** (published in February 2022) is conspicuously silent about any robust dedicated cosmetic surgical training and experience for plastic surgical trainees.[22] It shows little has changed and [redacted] For example – 'surveying exposure to aesthetic procedures during rotations', in context that such rotations are undertaken in public hospital posts where cosmetic surgery is not performed and that 'Meetings and conferences' do not represent a traditional apprenticeship model of accepted surgical training.

The evidence detailed above forms the bases of **why** the necessary changes addressing Q2 are necessary in relation to the guidelines at **s8 (Training and experience)** and **s9 (Qualifications and titles)**.

In addition, the impact of two years of COVID-19 pandemic related interruption to the provision of cosmetic surgery in many parts of Australia will inevitably have had a significant impact on the

training of all practitioners in cosmetic surgical procedures. It will have particularly affected those RACS trainees who are only exposed to cosmetic surgery in private practice settings and then on intermittent bases.

## 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?**

It is important to appreciate that the risks of cosmetic surgery are not higher than other forms of surgery, just different. They are multifactorial and exacerbated by the young nature of the area of practice. They therefore require different training and skills which relate not only to risk avoidance but also for optimal management when complications occur (see video detailed below).

With this in mind, an expert panel could be set up to assist AHPRA and the MBA.

The panel would comprise appropriately trained, qualified and experienced clinicians who **actually undertake** relevant cosmetic surgery. Whilst all representative craft groups should be involved, care must be taken to avoid structural bias of expert panel formation that has caused failures in the past (see the video of the invited Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1])

The panel could advise AHPRA and the MBA on the **assessment** of cosmetic surgery notifications, whilst being independent from subsequent **management** of such notifications that should remain solely the independent remit of AHPRA and the MBA.

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

As detailed in the answer addressing Q2, there is much misunderstanding about risk in cosmetic surgery and as a consequence also about managing cosmetic surgery notifications, including the risk assessment process.

This is because the practice of cosmetic surgery is typically dealt with at superficial level by the media and sometimes misrepresented by medical commentators. Available, relevant objective evidence for the basis of risk in relation to the required training and skills for cosmetic surgery is revealing.

In 2011, a study of medical negligence claims and patient complaints identified that one in six disputes arose from cosmetic procedures. By medical speciality, the rate of complaints against plastic surgeons was significantly higher, at more than twice that against any other specialty or subspecialty group. Rate ratios indicated that this was true for claims as well.[2]

In 2012, a study by the Melbourne University School of Public Health in cooperation with Avant (the largest Australian MDO which indemnifies half of all Australian doctors) and the Victorian Health Services 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.[3]

In a 2013 study of healthcare complaints in Australia, compared with general practitioners, plastic surgeons were at twice the risk of being the subject of recurrent complaints.[4]

Most recent evidence published by AHPRA (the AHPRA data) to the 2021 Senate Inquiry detailed that in 3 years to June 2021, more than half of the practitioners – 52 percent (96/183) – who were the subject of notification (complaints) to AHPRA relating to cosmetic surgery were surgeons holding AMC-accredited specialist surgical registration. Of these, 71 percent (68/96) were specialist plastic surgeons.[7]

Following publication of the AHPRA data, Dr Anne Tonkin, Chair Medical Board of Australia said *'…the "cowboy" reputation of cosmetic surgeons was not reflected in AHPRA/board data'* and that *'…complaints around cosmetic procedures were spread evenly among cosmetic surgeons, plastic*

*surgeons and other specialities, so there was no simple dichotomy between "bad" cosmetic surgeons and "good" plastic surgeons."*[23]

Accordingly, in light of the above, the management of cosmetic surgery notifications about medical practitioners must be properly informed and carefully managed.

## Advertising restrictions

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

No.

Poor examples of advertising of cosmetic surgery services are easily found across **ALL** types of medical practitioners, including both cosmetic surgeons and plastic surgeons. Whilst perhaps more commonly attributed to cosmetic surgeons, plastic surgeons also often conduct themselves similarly.

For example, in relation to advertising and social media of plastic surgeons, psychology Professor Emeritus Nichola Rumsey delivered a *'stern rebuke'* to plastic surgeons of the Australasian Society of Aesthetic Plastic Surgeons (ASAPS) at their 2018 Symposium and said she was *'…"deeply uncomfortable" with the advertising and social media marketing plastic surgeons engaged in."*[24]

However, the evidence in fact goes back much further – in fact more than two decades. For example, despite the 2002 AMC Accreditation Report of the education programmes of the RACS, the Australian Society of Plastic Surgeons (ASPS) informed patients (both in 1998) and 2008 that the post-nominals FRACS after a plastic surgeon's name was an assurance that the surgeon was *'**fully trained** in the field of Plastic and Reconstructive **and Cosmetic Surgery Procedures** by the Royal Australasian College of Surgeons (or its equivalent)* (emphasis added)'.[16]

[redacted]

In other words, there is a systemic problem across **ALL** types of medical practitioners in relation to advertising in cosmetic surgery which is not adequately addressed by AHPRA and the Medical Board's current approach to regulation.

See answer to Q3 above for information to facilitate detailed comprehension of the issue.

**7. What should be improved and why and how?**

Improvement is needed in relation to the regulation of advertising of **ALL** medical practitioners who undertake cosmetic surgical procedures. The areas of particular relevance are found in the **'Guidelines for advertising a regulated health service'** at:

**s4.1 (False, misleading or deceptive advertising)**

and

**s4.1.4 (Titles and claims about registration, competence and qualifications)**

Relevant to this, please see the answer provided to Q2 and Q3 above in relation to **'Training and experience'** and **'Qualifications and titles'**. Specifically, these are the factors that must be made clear to patients. Any regulatory change in advertising must allow patients to be able to identify those doctors who are trained, competent and safe to perform cosmetic surgery from those who are not.

**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?**

The current Guidelines are reasonable in general terms, but the practice of cosmetic surgery is so unique and commercial in nature that it requires a correspondingly unique and specific regulatory approach in order to protect the public.

See the video of the invited Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

**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?**

The emergence of social media has facilitated the promulgation of many seductive claims about cosmetic surgery not only by medical practitioners, but also third-party commercial entities. The related advertising issues are not different in themselves, but AHPRA and the MBA are only able to regulate the actions of medical practitioners.

Additional separate legislation may therefore be required to address the actions of such third-party commercial entities that have an interest in promoting cosmetic surgery services.

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

AHPRA and the MBA ought be aware of advertising undertaken by surgical craft groups **coincident with the regulatory reform process** of recent years.

For example, in late 2020 the Australasian Society of Aesthetic Plastic Surgeons (ASAPS), commenced a public campaign with hashtag **'#Know the Difference'** that resulted in labelling other medical practitioners who are not their members in pejorative terms (eg fake) whilst simultaneously suggesting their engagement in 'misleading and deceptive conduct (eg using terms such as deception, unlawful, mislead, danger'.

ASAPS also suggested under s18 of Australian Consumer Law that those medical practitioners were engaged in misleading and deceptive conduct to cosmetic surgery consumers about their legality, alleged lack of qualifications and recognition.

ASAPS claimed that their campaign was *'…designed to educate consumers on the differences in registration status and AMC accredited surgical training between registered and non-registered Plastic Surgeons…'.*

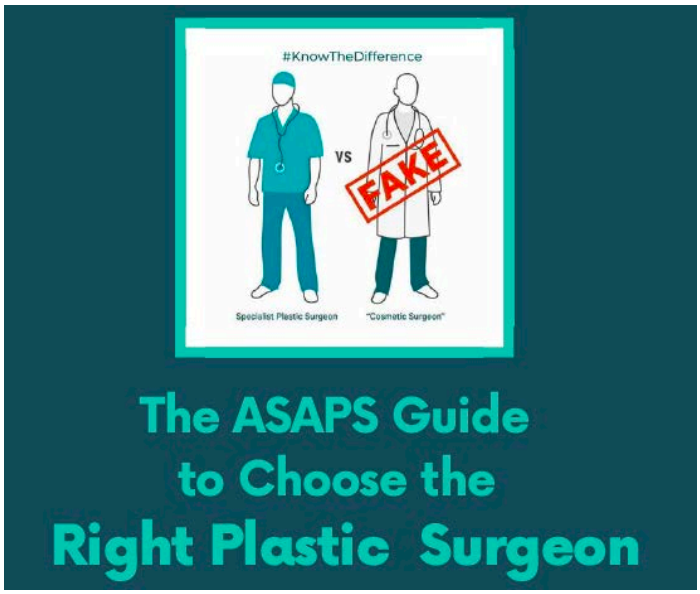
However, the flaws in ASAPS' campaign were summarised in a paper entitled **'#KnowTheDifference. Are plastic surgeons deceiving the public**' published on the ACCSM website in January 2021 see here.

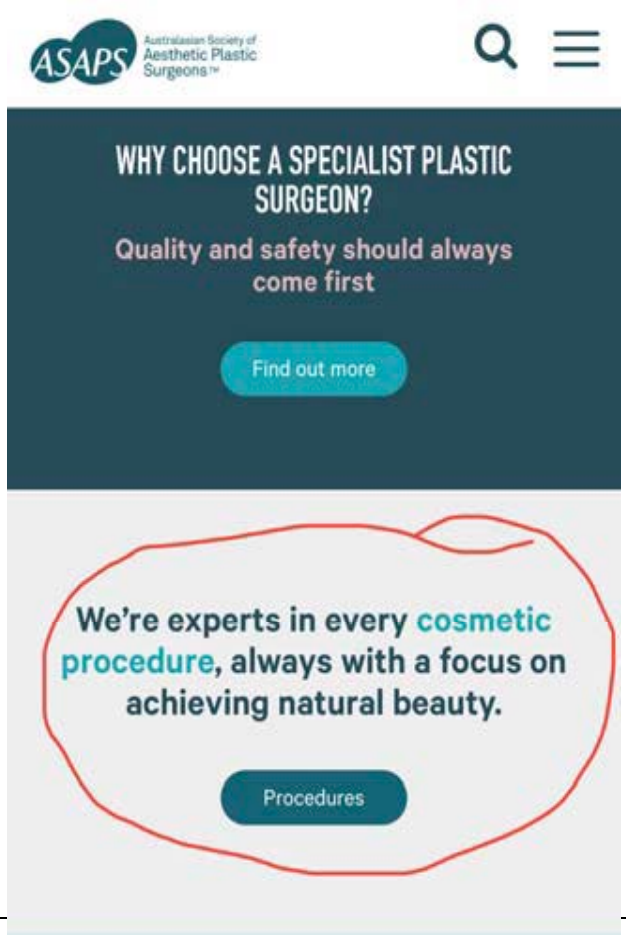
**In summary,** [redacted] (see images appended below and answers to Q3, Q5 and Q6 above.)

[redacted], thus demonstrating poor conduct of medical practitioners occurs at [redacted] aswell as on an individual basis. This also needs to be addressed by AHPRA and the MBA in any related regulatory change.

AHPRA and the MBA may wish to consider the timing of ASAPS' campaign in relation to the current regulatory reform process. See the video of the invited Keynote Address entitled 'Cosmetic Surgery

– myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]




## 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)?**

This is ***the* solution** that would be effective in protecting the public.

AHPRA's register of practitioners is **not** currently useful in relation to making informed decisions about choosing a medical practitioner to perform cosmetic surgery as it provides no relevant information about specific training in cosmetic surgery. This is the case in relation both to holders of 'General Registration' and AMC-accredited 'Specialist Registration'. See answer addressing Q3 above and referenced supporting documentation.

Regulatory change **must** allow patients to be able to **identify** those doctors who are trained, competent and safe to perform cosmetic surgery from those who are not. Recognition of cosmetic surgery as an independent medical specialty would be the optimum solution. Whilst sought in 2009 from the Australian Medical Council, that remains precluded under National Law which requires any new specialty to address a 'burden of disease'.[25] Cosmetic surgery does not.

Nevertheless, a solution is available under section 98 of National Law - **Endorsement for an Area of Practice** - created to accommodate new areas of practice not fitting the criteria of new medical specialties, yet still requiring protective regulatory restriction. This reflects precisely the situation regarding cosmetic surgery.

Critically, such **Endorsement** for the area of practice of Cosmetic Surgery must apply to **ALL** medical practitioners undertaking cosmetic surgery and would indicate having met and maintained an agreed **National Accreditation Standard comprising core surgical competence with additional training and competency specific to cosmetic surgery**, regardless of a practitioner's other competencies and providence.[26]

By this means, competent medical practitioners of cosmetic surgery would then be easily identifiable and its application would make AHPRA's register of practitioners useful. Accordingly, patients would be protected.

See 1-page **Endorsement** fact-sheet summary dated February 2022[26] here.

In summary, this **Endorsement** solution would comprise:

1. An independently set, National Accreditation Standard that mandates **ALL** doctors offering cosmeticsurgery to meet these CORE and SPECIFIC training and competency requirements.
2. Endorsement by AHPRA, under Section 98 of the current National Law, of doctors who meet andmaintain the Standard. AHPRA has suggested to the ACCSM that the Endorsement model would be a pragmatic and effective way to implement the National Accreditation Standard.
3. An AHPRA administered Cosmetic Surgery Register identifying doctors who are endorsed for cosmeticsurgery.
4. Restriction of the title "Cosmetic Surgeon" and "Cosmetic Plastic Surgeon" (in the case of specialistplastic surgeons) to doctors on the Register.

If adopted this solution would:

- Allow the public to identify easily doctors who are trained and competent in cosmetic surgery andvice versa.
- Provide protection for patients BEFORE something goes wrong thereby enhancing patient safetycompared with the reactive regulatory response available to AHPRA at present.
- Facilitate AHPRA taking action more readily against doctors who may be practising outside of theirscope of practice.
- By being competency-based and independently set and assessed, be fair to all practitioners as it willnot favour any particular group of doctors on the basis of their non-cosmetic surgical training and qualifications.
- The AHPRA register of Endorsed medical practitioners who practise cosmetic surgery may also be used by private hospitals, whose credentialing committees would be provided with greater clarity and objectivity when considering applications for operating privileges to perform cosmetic surgical procedures. Similarly, Medical Defence Organisations could use

this Register when assessing practitioners for indemnity insurance (see further detail in Q14 below).

Since no adequately trained and competent practitioner would have anything to fear from the Endorsement model (be they plastic or cosmetic surgeon, specialist in another discipline or not), AHPRA and the Medical Board should be aware that only two groups of practitioners might be anticipated to object to the implementation of such an Endorsement process and national Register of competent providers of cosmetic surgery:

**Firstly**, medical practitioners performing cosmetic surgical procedures who do not meet the required standard. This would for the most part be anticipated to comprise the third group of medical practitioners who *should* be eliminated (or effectively eliminated) from undertaking cosmetic surgery (See Q2 above and also video of the Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

**Secondly**, medical practitioners (or [redacted]) who seek to manipulate the regulatory reform process primarily to protect themselves rather than to protect patients, by eliminating competent alternative providers. AHPRA and the Medical Board may wish to consider the answer provided to Q10 above.

A less obvious but similarly tangible benefit of the Endorsement model is that if restriction of title prevents some medical practitioners from using the title 'surgeon', it would avoid the risk of them simply using other titles that imply they are expert providers of cosmetic surgical service.

This is because it would be a simple exercise to educate the public to seek medical practitioners Endorsed to practice cosmetic surgery by means of the AHPRA website. If any given medical practitioner had not been so Endorsed, then it would not matter what other title they called themselves as the public would know not to choose their services.

**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. See Q11 above.

As cosmetic surgery cannot be recognised as a speciality as it serves no 'burden of disease' and cosmetic surgeon is not a protected title yet so many medical practitioners (cosmetic surgeons and plastic surgeons alike) claim competence in cosmetic surgery they do not have, Endorsement of this area of practice by means of specific criteria (see Q13 below) would provide great clarity in regard to the specific skills, qualifications and experience of such Endorsed medical practitioners.

Given that AHPRA and the Medical Board only protect 'title' but do not restrict 'scope of practice'[27], the Endorsement model is the **only** pragmatic way to achieve safety for the public under current legislation. It would also work and would be an innovative solution to a problem that currently troubles western society.

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

The ACCSM is the only medical college in Australia which provides education and training leading to Fellowship specifically in cosmetic medicine and surgery. That Fellowship requires **mandatory** postgraduate core surgical training and experience followed by two years of **mandatory** dedicated cosmetic surgical training, examinations and associated specific demonstrated competency following a traditional surgical apprenticeship model.

The ACCSM' surgical syllabus has been approved by CanMEDS, which is a physician competency framework developed by the Royal College of Physicians and Surgeons of Canada and is the most accepted and applied of its type worldwide. Importantly, this syllabus includes not only technical elements (the 'Doctor as an expert'), but also training in the other elements of professional development necessary to deliver to the public safe, quality care in cosmetic surgery. Deficiencies

in delivery of these "non-technical" skills are responsible for the majority of complaints against practitioners delivering cosmetic surgery.

In this context, completion of the surgical training program leading to surgical Fellowship of ACCSM would be considered an appropriate qualification. In additional, other appropriate qualifications may include Fellowship from one of the Royal Colleges of Surgeons in conjunction with additional training specifically in cosmetic surgery. A points-based accreditation system is proposed here, in the ACCSM' Submission to Australian Governments - Health Practitioner Regulation National Law Reform dated 4 January 2021 to at P7-10 see here.[28]

More specifically, in relation to **appropriate qualification** under Section 98 of National Law, Endorsement of an Area of Practice, a practitioner is established as being *qualified* to practise in an approved area of practice, ONLY if the practitioner holds EITHER of the following qualifications to the endorsement:

**(i)** ***an approved qualification;***
**(ii)** ***another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification.***

These two categories effectively encompass all practitioners who wish to practise in cosmetic surgery and are described in detail below.

***(i) an approved qualification;***

In addition to a medical degree, attainment of an approved qualification in cosmetic surgery would be defined as successful completion of study in an accredited training program (which would be determined by the AMC against the accreditation standards). These would include training programs that exclusively focus on the practice of cosmetic surgery. Practitioners would then be considered as having met the criteria for endorsement for cosmetic surgery, according to Section 98 (1)(a) part (i) of National Law: '*Holds an approved qualification'*. Such training programs would include mandatory Continuing Professional Development (CPD) programs to ensure only skilled clinicians who meet the minimal standard are eligible to renew their registration with endorsement annually. An example of this would be the surgical training program provided by the ACCSM as it is focused solely on the practice of cosmetic surgery and medicine.

**(ii)** ***another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification.***

There is a cohort of established practitioners who practice cosmetic surgery who may have had training from institutes or colleges which do not focus exclusively on cosmetic surgery, therefore would not fall within the proposed list of accredited programs, such as fellowships in dermatology or those obtained overseas. These may include but are not limited to surgical fellowships in plastic surgery from the various Royal Colleges of Surgeons (England, Edinburgh, Glasgow, Ireland and Canada) and the USA. The ACCSM proposes that accreditation of practitioners who fall into this category be assessed by a points-based accreditation system, modified appropriately from a model for accreditation previously proposed by the ACCSM (see link above)

Plastic surgical Fellows of RACS would also fall into this category as the education programmes of RACS have virtually no exposure to cosmetic surgery (see Q3).

This group of practitioners would need to meet the endorsement criteria provided for in Section 98 (1)(a) part (ii) of National Law: '*holds another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification.'* To enable adequate assessment of these practitioners in this context, an objective, transparent, competency-based system such as the model proposed by ACCSM may be considered.

This model comprises a points-based accreditation system where practitioners are required to demonstrate both knowledge-based and practical competencies by acquisition of a threshold level of at least 100 points. The proposed points-based accreditation system might take the following form:

- Up to date Continuing Professional Development (CPD) 10 points

- Surgical Fellowship RACS-FRACS (Plastic) if it included optional 6-month cosmetic surgery training module — 90 points
- Surgical Fellowship RACS-FRACS (Plastic) if it excluded optional 6-month cosmetic surgery training module — 80 points
- 6-month cosmetic surgery training module post RACS-FRACS (Plastic) — 10 points
- Other Royal College Surgical Fellowship (England, Edinburgh, Glasgow, Ireland and Canada)-FRCS (Plastic) — 80 points
- Surgical Fellowship USA (Plastic) — 80 points
- 6-month cosmetic surgery training module post other Royal College Surgical Fellowship / Surgical Fellowship USA (Plastic) — 10 points
- Other surgical Fellowships (Australia and overseas) (Non-Plastic) — 50 points
- Cosmetic surgical practice experience (minimum 100 major cosmetic surgical procedures – logbook tabled) — 10 points
- ACCSM examination (successful completion of the American Board of Cosmetic Surgery written examination and viva voce) — 30 points

The value of such a points-based accreditation system is that it would be objective, transparent and competency-based and would exclude any medical practitioner with minimal formal surgical training and unassessed/unaudited practice-based experience.

It is important to appreciate that such an approach would capture inadequately trained practitioners who cause harm including for example recent high-profile cases that have resulted in class actions. Further, it would allow patients to identify such inadequately trained practitioners whilst also ensuring that any trained, competent practitioner who has not completed an accredited training program be allowed the opportunity to be considered for endorsement to practice in cosmetic surgery and medicine.

Illustrative examples might include:

1) A medical practitioner trained and qualified as a specialist plastic and reconstructive surgeon, who has **not** completed at least 6 months of cosmetic surgery specific training would acquire 80 points. A further 10 points would be acquired by up-to-date CPD, meaning that only a 6-month cosmetic surgery training module would then be required to achieve the 100-point threshold.

2) A medical practitioner trained and qualified as a specialist plastic and reconstructive surgeon, who **has** successfully completed at least 6 months cosmetic surgery specific training would acquire 90 points. A further 10 points would be acquired by up-to-date CPD, thus achieve the 100-point threshold and thus would be eligible for inclusion for endorsement.

3) A medical practitioner trained and qualified as a surgeon with a non-plastic surgery Fellowship would acquire 50 points. A further 10 points would be acquired by up-to-date CPD and a further 10 points from 100 major cosmetic surgical procedures (log book tabled) of cosmetic surgical practice experience. This surgeon would therefore be required to acquire a further 30 points (perhaps by sitting the ACCSM examinations ***without*** necessarily the intention of joining the ACCSM).

Once agreed and established, it is proposed that points-based accreditation system is administered by the AMC as the Accreditation Authority for Endorsement for the practice of 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.**

**Specialist title protection** formed a key option of the Consultation Regulation Impact Statement – Medical practitioners' use of the title 'surgeon' (RIS) released on 13 December 2021 by the Victorian Department of Health (See also Q27). Identical considerations are pertinent for consideration by AHPRA and the Medical Board here also.

Relevantly, option 4.1 of the Consultation RIS was stated as *'Restricting use of the title to the 10 surgical specialty fields of practice approved by the Ministerial Council.'*

A striking equivalence was observed between that Option 4.1 and the proposal made the Royal Australasian College of Surgeons (RACS) to restrict use of the title 'surgeon' to *'medical practitioners who have completed AMC accredited specialist training in the medical specialty of surgery.'*[29]

In effect, that means almost exclusively RACS' own members, since RACS undertakes almost all such training. It would allow any RACS surgeon to promote themselves as a specialist surgeon when advertising cosmetic surgery services, regardless of whether or not they have any training, experience or competence in cosmetic surgery.

Concurrently, plastic surgical Fellows of RACS with membership of ASAPS seek to ban the title 'cosmetic surgeon', with the effect that non-RACS practitioners who *are* specifically trained, competent and safe in its practice, would be prevented from using both the titles 'surgeon' and 'cosmetic surgeon'.[30-32] See also Q10.

This proposal would [redacted] that would exclude many trained medical experts in cosmetic surgery.

How RACS' proposal would actually protect patients is unclear.

RACS and associated groups acknowledge that *'…cosmetic procedures need to be performed by a practitioner who is trained in the procedure…* [33] However, as earlier detailed in the answer addressing Q3 above, the ACCSM reiterates that the AMC provides no evidence of cosmetic surgery training by RACS in its eight specialty training programmes outside of plastic and reconstructive surgery.[18] Within the ninth, plastic and reconstructive surgery, **AMC reports since 2002** suggest inadequate cosmetic surgical training.

To reiterate, in its **2017 Report**, the AMC variously stated in relation to cosmetic surgery that plastic surgical trainees have a *'lack of training', a* '*deficit'* in experience available and qualify with *'a gap in this area of practice'*.[18]

In its latest **2021 Report** (published in February 2022) the AMC is conspicuously silent about any robust dedicated cosmetic surgical training and experience for plastic surgical trainees.[22]

The ACCSM also reiterates that, consistent with these AMC reports over two decades, in 2008, from [redacted]

Further, the current Senate Inquiry has recently reported evidence that in 3 years to June 2021, more than half of the practitioners – 52 percent (96/183) – who were the subject of notification (complaints) to AHPRA relating to cosmetic surgery were surgeons holding AMC-accredited specialist surgical registration. Of these, 71 percent (68/96) were specialist plastic surgeons.[7,34]

The common theme seems to be that RACS' AMC-accredited surgical training programs have provided, most commonly, no training in cosmetic surgery and at best, in plastic surgery, a *'deficit'* leading to a *'gap'* in that area of practice.[18]

The disadvantages of creating an effective regulated monopoly in cosmetic surgery at the behest of those who would benefit from it most would require exceptional evidence of commensurate public interest. That evidence clearly does not exist.

Furthermore, isolated title restriction as per option 4.1 of the RIS and also proposed by RACS, has a precedent of failure in Queensland from the early 2000s.[35] That attempt did not protect patients but instead reportedly tied up regulators through vexatious complaints relating to title restriction made by one practitioner against another.

Title restriction alone will **not** protect patients by allowing them to identify surgeons who ***are*** trained, competent and safe in cosmetic surgery. Worst of all, it may give false reassurance that because the doctor is allowed to use the restricted title 'surgeon', he or she is trained, competent and safe to perform cosmetic surgery when they may have no training whatsoever in this area of practice.

Tangibly, the only doctor who has been the subject of a finding of culpability in the death of a patient during a cosmetic (liposuction) procedure was a plastic surgeon. Following the death of Lauren James, the Victorian Coroner observed '…*there was a need for specific training and experience in performing liposuction surgery*' and in 2015, the Victorian Civil and Administrative Tribunal required the plastic surgeon *'to complete further education.* [6]

Put another way, adopting option 4.1 of the RIS, equivalent to the current proposal of RACS to restrict the title 'surgeon' to holders of specialist registration *without* linkage to accreditation specifically in cosmetic surgery, would not have saved Ms James' life.

Whilst many plastic surgeons in Australia *are* competent and safely perform cosmetic surgery, the evidence demonstrates that this is not merely *because* they have qualified as AMC-accredited specialist plastic surgeons, but likely from *subsequent additional training and/or experience*.

Regarding non-RACS cosmetic surgeons, unquestionably, inadequately trained or irresponsible cosmetic surgeons exist and are a danger.[36,37] This is exacerbated by such practitioners' ability to use the title 'cosmetic surgeon'. However, in the same way that Ms James' death does not mean all plastic surgeons performing liposuction are dangerous, it is incorrect to extrapolate that all cosmetic surgeons are inadequately trained or irresponsible.

Following publication of the AHPRA data, Dr Anne Tonkin, Chair Medical Board of Australia said *'…the "cowboy" reputation of cosmetic surgeons was not reflected in AHPRA/board data'* and that *'…complaints around cosmetic procedures were spread evenly among cosmetic surgeons, plastic surgeons and other specialities, so there was no simple dichotomy between "bad" cosmetic surgeons and "good" plastic surgeons.'*[23]

It is clear the evidence proves that adverse, avoidable outcomes, occur from *both* plastic surgeons and cosmetic surgeons who may have no training or inadequate training in cosmetic surgery.

That assessment supports the **Endorsement proposal** for a national competency-based accreditation Standard for **all** doctors performing cosmetic surgery, a Register of those who have met and maintain the standard and restriction of the title 'cosmetic surgeon' to those on the Register, administered by AHPRA. See answer to Q11 above.

By restricting the title 'cosmetic surgeon' (or use of the title 'surgeon' in the context of cosmetic surgery) only to doctors on the Register, patients will be protected by allowing identification of practitioners who are trained, competent and safe. International precedent exists – for example, Oklahoma and Texas allow American Board of Cosmetic Surgery diplomates to advertise their certification and state that they are 'Board Certified Cosmetic Surgeons.'[14]

Whilst public protection will be enhanced by the Endorsement of the area of practice of cosmetic surgery, no competent practitioner will be disadvantaged and no effective regulated commercial monopoly in the provision of cosmetic surgery services will be delivered to AMC accredited specialist surgeons who, with respect to cosmetic surgery, either have no training or inadequate training. By avoidance of monopoly creation, the public will benefit from competition between safe practitioners based on competence, price and service.

There are two further benefits of the Endorsement model proposal. **Firstly**, use of the Register would facilitate objective credentialing of cosmetic surgeons by accredited operating facilities including private hospitals and day surgeries. This would effectively restrict operating privileges to only those surgeons who appear on the Register and who have therefore been accredited as competent and safe to perform cosmetic surgery. **Secondly**, the Register could be used by Medical Defence Organisations (MDO) to identify practitioners appropriately trained in cosmetic surgery and thus appropriately restrict indemnity policies accordingly. Currently Medical Registration Standards require all medical practitioners to obtain annual Medical Indemnity insurance from an MDO to cover their scope of practice in order to renew their medical registration. If a medical practitioner were **not** on the Register and therefore appropriately denied indemnity insurance to practice

Cosmetic Surgery yet continued to do so, that individual would automatically be liable to appropriate regulatory action by AHPRA for operating outside the scope of practice for which they were indemnified. The effect would be fewer overall complications with associated reduction in pressure exerted upon the public healthcare system.

**In summary**, it is indisputable that regulation of cosmetic surgery is urgently needed,[8,11,12] but isolated title restriction that has a precedent of failure will neither fix the problem nor save life or limb.[11,12] In contrast, the proposed solution of an accreditation Standard/Register has been welcomed by commentators without a vested interest (listen here on ABC RN, Channel 7 Sunrise here and 6PR PerthRadio here). Nevertheless, plastic surgical groups are opposed to it [38,39] and have declined the opportunity to specify or openly debate their reasons. Until they submit the basis and evidence for their objections to public scrutiny, the perception that protection of patients runs second to protection of surgeons' interests in this multi-billion dollar cosmetic surgery industry will remain.

In addition, see video of the Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

## 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?** |
|---|
| The ACCSM is not aware of any such barriers. |
| **16. If yes, what are the barriers, and what could be improved?** |
| See Q15. |
| **17. Do roles and responsibilities require clarification?** |
| See Q15. |
| **18. Please provide any further relevant comment about cooperating with other regulators.** |

See Q15.

## 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?**

Unknown.

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

Unknown.

**22. Please provide any further relevant comment about facilitating notifications**

AHPRA and the MBA should be mindful of the commercial nature of cosmetic surgical practice in relation to vexatious notifications made by medical practitioners against each other.

A pertinent example of this relating directly to the practice of cosmetic surgery followed isolated title restriction in Qld in the early 2000s. Whilst that action did not protect patients, it instead reportedly tied up regulators through vexatious complaints relating to title restriction made by one practitioner against another.

Whilst the practice of cosmetic surgery is under current consideration of regulatory reform, safeguards should be put in place to guard against such actions, including by means of significant penalties against medical practitioners undertaking such action for their own commercial advantage.

See the video of the invited Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

## 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?**

Yes, but they could be improved in some key areas.

**24. If not, what improvements could be made?**

Regulatory change must allow patients to be able to identify those doctors who are trained, competent and safe to perform cosmetic surgery from those who are not. See answers to Q2 and Q3.

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

No.

Adequate information already exists and is easily available in the public domain.

Introducing such an additional requirement as suggested by this question risks derailing the Doctor-patient relationship before it has even begun.

Further, for commercial reasons in the environment of cosmetic surgical practice, it may precipitate an avalanche of inappropriate complaints, after the fact, from those who would not ordinarily have complained.

**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?**

AHPRA's website and public register of practitioners does **not** currently provide sufficient information about medical practitioners to inform consumer choices in the context of cosmetic surgery.

This is because it provides no relevant information about specific training in cosmetic surgery in relation to holders of either 'General Registration' or Australian Medical Council-accredited 'Specialist Registration'.

See answer to Q3 above and referenced supporting documentation.

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

To make AHPRA's register of practitioners useful, it should include '**Endorsement'** of medical practitioners to practice in the area of cosmetic surgery as provided under s98 of the National Law.

Such **Endorsement** must apply to **ALL** medical practitioners undertaking cosmetic surgery and would indicate having met and maintained an agreed National Accreditation Standard comprising **core** surgical competence with **additional** training and competency specific to cosmetic surgery, regardless of a practitioner's other competencies and providence.

By this means, competent medical practitioners of cosmetic surgery would then be easily identifiable and patients would thereby be protected. See 1-page **Endorsement** fact-sheet summary dated February 2022[26] here.

In this context, please see letter dated 15 February 2022, to the Office of Best Practice Regulation (OBPR) in the Department of Prime Minister and Cabinet[40] here detailing relevant flaws of the current Consultation Regulation Impact Statement – Medical practitioners' use of the title 'surgeon' (RIS) released on 13 December 2021 by the Victorian Department of Health.

Numerous statements are made throughout the RIS which suggest that training and competence of **accredited specialist surgeons, including plastic surgeons, in cosmetic surgery in Australia**

may be assumed because they have been accredited as specialist surgeons. The evidentiary reality is very different. See answer addressing Q3.

It is pertinent to communicate to AHPRA and the Medical Board that the **'fifth option (policy for greatest net benefit)** omitted from the RIS is well documented. It comprises the Endorsement model solution described above that would be effective in protecting patients undergoing cosmetic surgery. The model would restrict title 'cosmetic surgeon' and 'surgeon' (in the context of cosmetic surgery) to those on an independent public Register administered by AHPRA. It would provide certainty to patients seeking cosmetic surgery that those practitioners who had been Endorsed to be entered onto the Register had met and maintained the national accreditation standard required to be Endorsed in this area of practice under section 98 of the National Law.

**Critically**, as detailed above, this accreditation/Endorsement model was not included in the RIS, the public and most organisations have not been able to consider or comment on it. If this is not recognised when the submission responses are aggregated, a misleading conclusion is likely to be drawn.

Had the RIS asked "Do you think that all doctors performing cosmetic surgery and using the title cosmetic surgeon should have to meet an independently assessed cosmetic surgery training and competency standard", it is unarguable that the vast majority of submissions would have responded in the affirmative.
Neither of the current Consultation RIS options 4.1 or 4.2, relying as they do on a benchmark of specialisation in another area of practice, would do this.
The accreditation/Endorsement model **will** ensure an independently assessed cosmetic surgery training and competency standard and would therefore protect patients from unsafe practitioners.

See video of the Keynote Address entitled 'Cosmetic Surgery – myths, reality and the solution' presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

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

It is not possible to comment upon this question which needs to be addressed to consumers directly in order to obtain accurate perspective.

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

See Q28.

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

N/A.

## 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 important for AHPRA and the Medical Board to be aware of the scale of corporate influence upon cosmetic surgery in Australia.

In 2018 the International Society of Aesthetic Plastic Surgery (ISAPS) published a report in which it estimated Australians spend about $1billion on cosmetic procedures every year and that Australia ranked 9th globally for the number of cosmetic procedures. It indicated that there were approximately 200000 cosmetic procedures in Australia of which approximately 100000 were surgical procedures and approximately 100000 were non-surgical procedures. Approximately 4% of the population each underwent either a surgical, or non-surgical cosmetic procedure; the most common consumer was between the ages of 35-50, of which approximately 90% were women.[41]

Upon the background of such enormous commercial influence, it is hardly surprising that revelations about the cosmetic surgery industry now being considered by AHPRA and the Medical Board are common and almost inevitably greater than other surgical fields. However, they are not new.[42]

Following the 1999 Walton Cosmetic Surgery Inquiry, the NSW Cosmetic Surgery Credentialing Council (CSCC) failed due to an impasse created by [redacted].[43]

What has changed since 1999 is exponential increase in demand, access to cosmetic surgery, seductive social media claims and intense scrutiny.[36] The elephant in the room is lucrative financial incentives to medical practitioners, presenting two dangers to the public. **Firstly**, individual surgeons may recommend elective operations not necessarily in patients' best interests. **Secondly**, potential rewards of influencing regulatory reform to cause a commercial monopoly for a specific group of surgeons may distort representations made by surgical stakeholders. [redacted] are as active today as two decades ago.

It must be appreciated that the evidence now available proves that adverse, avoidable outcomes, occur from *both* plastic surgeons and cosmetic surgeons who may have no training or inadequate training in cosmetic surgery. This is the very reason why Endorsement of this area of practice using existing provisions within the National Law is the pragmatic solution to the problem in 2022.

For an overview of cosmetic surgery, how it fits within medical practice in Australia, its problems, related myths and the solution, please see video of the invited Keynote Address entitled **'Cosmetic Surgery – myths, reality and the solution'** presented to the 31st Annual Medico Legal Congress in Sydney on 16 March 2022 by Mr Patrick Tansley, President ACCSM see keynote address here.[1]

Because of deficiencies in the Consultation RIS (see Q14 and Q27), in particular the lack of consultation about the Endorsement model or any other model that would link title restriction to training, competence and safety in cosmetic surgery, the outcome of the public consultation process has been already compromised.

There is a very real risk that patients will be harmed if title restriction is not linked to training, safety and competence in cosmetic surgery (also see Q14 and Q27 above).

The ACCSM submits that AHPRA and the Medical Board have an obligation to ensure, to the best of their ability, that the regulatory changes to be made do not expose the public to these avoidable risks.

AHPRA and the Medical Board can achieve this by:

1. Supporting the Endorsement of medical practitioners who can demonstrate adequate training, safety and competence in cosmetic surgery by meeting an independently assessed accreditation standard.

2. Creating a Register of medical practitioners so endorsed in cosmetic surgery so the public can readily identify those medical practitioners who have, and continue to meet, the endorsement standard.

3. Recommending that title restriction be linked to Endorsed practitioners who are on the current Register.

Such regulatory reform will manifestly protect cosmetic surgery patients from practitioners inadequately trained in this area of practice.

When considering whether to recommend such measures, we respectfully suggest that AHPRA and the Medical Board consider, in the absence of a recognised specialty of cosmetic surgery what, if any, genuine and evidence-based objections exist to the Endorsement model for reform.

**ADDENDUM SUBMISSION 16 AUGUST 2022**

The Australasian College of Cosmetic Surgery and Medicine (ACCSM) makes the following **Addendum Submission** to its primary submission of 13 April 2022.

The ACCSM wishes to draw the attention of the reader to a newly published, peer-reviewed, open-access paper in the American Journal of Cosmetic Surgery, entitled **'Cosmetic Surgery Regulation in Australia: Who is to be protected – Surgeons or Patients?'**.[44] It is available online at https://doi.org/10.1177/07488068221105360

The paper urges regulators to implement changes to Australian law that would require **all** doctors performing cosmetic surgery to be accredited by introducing an independent, objective, competency based National Accreditation Standard in association with Endorsement of medical practitioners in the area of practice of cosmetic surgery. It warns against the other option currently under consideration – isolated 'title' restriction based on existing surgical specialties with no requirement for training and competence in cosmetic surgery. The paper is supported by extensive published material.[1,7-12,18,34,45-53]

In addition, the ACCSM also wishes to draw the attention of the reader to two relevant contemporary statements made by plastic surgeons internationally, in relation to identical considerations of patient safety in cosmetic surgery as those in Australia – *'We need validated evidence of hands-on competency in aesthetic surgery to keep patients safe* [54] and *'In summary: qualifications per se are pretty meaningless. A qualification which comes with a guarantee of competence is something else.* [55]

In relation to the articles in which these statements were published, the President of the ACCSM was invited to make comment. Accordingly, Mr Patrick Tansley MD FRCS (Plast) did so which was also then published in the PMFA (Plastics, Maxillofacial and Aesthetic) Journal as a peer-reviewed, open-access entitled **'Response – Who should decide the qualification to do cosmetic surgery?'**[56] and is available online at https://www.thepmfajournal.com/features/features/post/response-who-should-decide-the-qualification-to-do-cosmetic-surgery

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