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	Hudaifa Obaidi
Organisation (if applicable)	
Email address	[redacted]

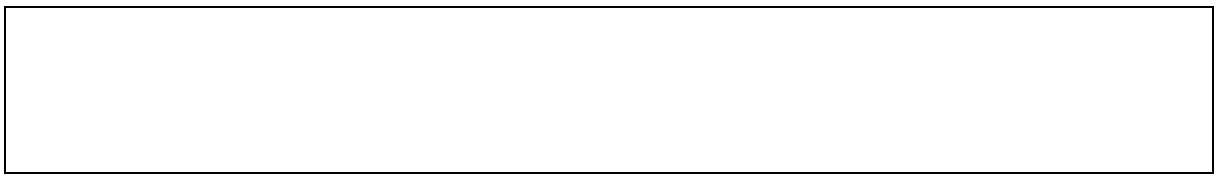
Your responses to the consultation questions

Codes and Guidelines

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

Management of notifications

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



Advertising restrictions

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

Title protection and endorsement for approved areas of practice

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

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

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

Cooperation with other regulators

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

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

24. If not, what improvements could be made?

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

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

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

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

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

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

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

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

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

Further comment or suggestions

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

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Submissions can be emailed to:

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

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

Your details

Name	Carley O'Connell
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, because they do not have an expected standard of training and experience. They are too broad and not protective of the profession and people's safety.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
It is essential patients know the qualifications of their 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?
Important to be followed up ethically.
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.
NA

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
Clearly not as unregistered people are causing harm.

7. What should be improved and why and how?
Clear expectations about standards of care.
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?
More specific regulatory response
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?
possibly
10. Please provide any further relevant comment in relation to the regulation of advertising.
This could be misleading, target vulnerable people and not reflect reality.

Title protection and endorsement for approved areas of practice

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

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

Cooperation with other regulators

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

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines **adequately explain the mandatory reporting obligations?**
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21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

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

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

Further comment or suggestions

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

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

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

Your details

Name	Dr Harpreet Singh Pannu
Organisation (if applicable)	Nedlands Medical Clinic
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

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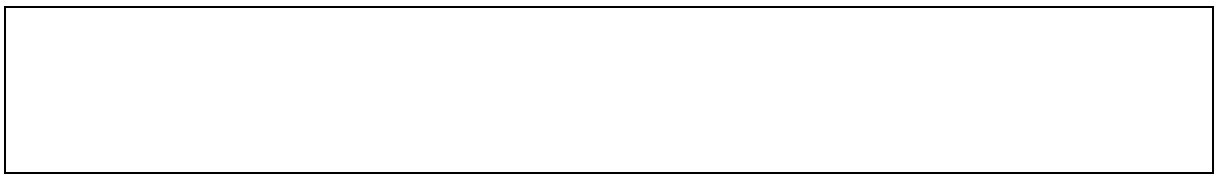
1. These could indeed be improved. Currently there is no recognised specialty of Cosmetic Surgery, nor can there be, without a change in the National Law. Therefore no training programme is recognised by the AMC for cosmetic surgery, and the title "cosmetic surgeon" may be used by any medical practitioner. 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.
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

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

Your details

Name	Samantha Peacock
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, because they do not have an expected standard of training and experience.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

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

Advertising restrictions

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

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

Title protection and endorsement for approved areas of practice

11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
As cosmetic surgery is performed by doctors from a wide range of medical and surgical backgrounds, I think it is essential if the public is to be protected. Cosmetic surgery is not a specialty and so there are no official specialists. Other than word of mouth and the doctor's own website and advertisements, the public has no way of knowing if he or she trained in cosmetic surgery or not. If doctors who are properly trained and competent are endorsed to practice cosmetic surgery by the authorities, the public would be able to choose an endorsed doctor. Whereas I understand that surgical groups with vested interests may not like the proposal that they, along with every other doctor performing cosmetic surgery, should be endorsed, why would Ahpra and the Medical Board NOT want to protect the public in this way?

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

Cooperation with other regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
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17. Do roles and responsibilities require clarification?
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23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?

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

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

Further comment or suggestions

31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.
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Assoc. Prof. David G Pennington FRCS(Ed),FRACS
ABN: 18990749711
Provider No: 0096357J
Medico-legal consultations for Plastic & Reconstructive Surgery

Royal Australasian College of Surgeons

Australian Society of Plastic Surgeons

All correspondence and enquiries to:
[redacted]
Phone: [redacted]
Email: [redacted]

March 14, 2022

Mr Andrew Brown,
The Independent Reviewer,
AHPRA and the Medical Board of Australia
Review of the regulation of health practitioners in cosmetic surgery,

Dear Mr Brown,

I am writing to give input into this review.

Firstly, I need to introduce myself and my credentials to comment.

I am a senior Plastic Surgeon, with an Australasian College of Surgeons Fellowship in Plastic Surgery. I was Department Head of Plastic & Reconstructive Surgery at Royal Prince Alfred Hospital, Sydney, for twenty years, between 1987 and 2007. From 2010 to 2015 I was Associate Professor of Plastic Surgery at Macquarie University Hospital. I have been in the past an expert consultant in Plastic Surgery to the NSW Health Care Complaints Commission (HCCC), where I was involved in investigation of complaints against practitioners claiming to be plastic surgeons. I am a member of the Australian Society of Plastic Surgeons and a former member of the Australian Society of Aesthetic Plastic Surgery. I am now in private medico-legal practice, and as such, have had exposure to a significant number of legal cases against practitioners holding themselves out to be "Cosmetic Surgeons".

For decades, the Australian Society of Plastic Surgeons (ASPS) has warned government and regulatory authorities at state and national level of the unregulated activities of a number of practitioners (not all of them doctors, not all of them nurses, some not even having any qualifications), who have caused a great deal of harm to a significant number of citizens, by the inept performance of surgical procedures, for which they were not qualified [1] . As a result of many complaints to the NSW HCCC, and substantial press coverage of "botched surgery", in 1998, Ms Merrilyn Walton was commissioned to investigate the situation. In 1999 she produced a report to the NSW Health Minister, Craig Knowles, outlining the problem, with recommendations for action [2] . Most of those recommendations were not implemented. One of the principal findings of Ms Walton and her Committee was the lack of adequate surgical training for many of those who were practicing as "cosmetic surgeons". One of her recommendations concerned surgical qualifications, where she recommended, I quote…

"6. Medical practitioners performing invasive cosmetic surgical procedures should have adequate surgical training, being that required for Fellows of the Royal Australasian College of Surgeons, or equivalent. (majority view)"

The term "*majority view*" is telling, as there was substantial lobbying by one particular group against that.

Under the heading “General quality and safety”, in her report, Ms Walton stated this fact,

“Any medical practitioner can practice cosmetic surgery in Australia”

That has not changed in over thirty years. It is a sad reflection on governments’ reluctance to act ethically and in the best interest of patient safety. There is a great deal of money made in this industry, and it is not without the bounds of possibility that political influence has been wielded via the dollar, to keep regulatory standards at a weak level.

During the course of the inquiry, a “society” of “cosmetic doctors”, many of whom had no surgical qualifications, decided that they should form a “college” in an attempt to appear to have a legitimate “training program” for cosmetic surgery. That “college” is now known as the *Australasian College of Cosmetic Surgery and Medicine (ACCSM*) [3]. During the inquiry, the *Australian Society of Plastic Surgeons (ASPS)* vigorously submitted the invalidity of a training program that was not based on the same principles and practice as are required of all specialty surgeons in Australia, that of a Fellowship of the *Royal Australasian College of Surgeons (FRACS)*, or recognized overseas equivalent. That program, as it applies to Plastic Surgeons, usually encompasses five hard years of closely-supervised training at Hospital Registrar level.

The fact that *ACCSM* has flourished since then, is evidence that the recommendations of Ms Walton re surgical training were ignored by the NSW government. Their “training program” is [redacted]

Since that time, there has been an explosion in cosmetic procedures, both surgical and “non-surgical”. The latter largely consists of injectable treatments, mainly facial, using ingredients that should require them to be administered by a doctor. However, there are numerous and growing incidences, where they are being administered by nurses and even by people with no formal nursing or medical training.

It is my contention that the current inquiry should be expanded to include these kinds of practices, as they constitute a significant number of adverse outcomes reported to health care complaints bodies around Australia.

The second pressing need is the control of advertising. This has long been recognized as a problem. There are numerous instances of online advertising which, if properly policed, would see many websites closed down on the basis of false advertising.

As a senior plastic surgeon, I have to say that some of my colleagues, trained plastic surgeons, no doubt feeling the competitive pressure of less scrupulous operators, have succumbed to the commercial advantages of fancy websites and their implied “perfect” results from surgery. They well know that this is often a fantasy.

Recently AHPRA has been lobbied by the *Royal Australasian College of Surgeons*, and supported by *ASPS*, to regulate the use of the title “surgeon”, and restrict it to those who have genuine surgical qualifications. I submit that that should be extended to make the use of the terms “cosmetic surgeon”, “practitioner in cosmetic surgery”, “cosmetic surgery practitioner” and all possible variations of those titles, to be restricted to doctors with an FRACS or overseas recognized equivalent.

Ms Walton in her 1999 report recommended the establishment of a NSW Cosmetic Surgery Council, as per point 1a, under **Cosmetic Surgery Credentialling**, p. i, of her report…

"1a. A Cosmetic Surgery Credentialling Council (CSCC) be established for all registered providers of cosmetic surgery procedures to provide independent and accountable verification of qualifications and training. "

It seems to me that this is a national problem, and requires a national solution. Such a Council should be part of AHPRA, should be incorporated into standards already expected of bodies like the RACS, and should have representatives of the RACS and ASPS on it.

Disciplinary action at present is recommended by AHPRA to the state offices of the Medical Board. The standards required in the cosmetic surgery industry must be established firmly and become law, in my opinion. The law requires their performance be acceptable to a "wide body of peers". Unfortunately, for many cosmetic surgery practitioners, who have no more than the basic medical qualification, they can be held to only that standard of their "peers", that of general practitioners, not surgeons. That needs to change, in my opinion.

In the aviation industry, a pilot with the basic flying skills of a single-engine, propellor-driven plane, is not given the controls of an A380 or an FA-18. Why should we not expect the same level of standards to apply to the cosmetic surgery industry?

Committees, commissions and reviews have a sad history in Australia of having their recommendations ignored, watered down, disregarded and not implemented. My sincere hope is that this problem will be dealt with ethically and your Review recommendations will be in the best interests of consumers and patients, not in the best interests of the "industry".

Sincerely,

[redacted]

(Assoc Prof) David G Pennington
FRCS(Ed),FRACS

[redacted]

[2] Downloadable at https://search.informit.org/doi/abs/10.3316/agispt.20001008
[3] https://www.accsm.org.au

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 Shawn Perera
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
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
I feel that minor cosmetic such as injectable fillers and botox should have checks and balances At least, special training in these procedures should be undertaken , and a practitioner should be specifically accredited by Ahpra to perform them. A further accountability suggested would be that after a certain amount of procedures given by one practitioner, a peer- review of the safety and suitability should be mandatory- preferably not by a member of the treating practitioner's financial group, and not with a view to have the review practitioner take over further treatments. Ie much like the reviews required for ongoing opioid prescritions.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

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

Advertising restrictions

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

Title protection and endorsement for approved areas of practice

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

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Yes, I totally object to the use of the title Surgeon being used by practitioners who did not undertake and attain FRACS qualifications
13. What programs of study (existing or new) would provide appropriate qualifications?
An accredited Certificate in Cosmetic Surgical Procedures at the very least- possibly run by RACS or another Board approved provider.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Non FRACS trained doctors should not call themselves Skin surgeons or Cosmetic Surgeons. They should go under the banner of " Special interest in : Cosmetic Surgery (and/or cosmetic injectables) – Accredited by **********)

Cooperation with other regulators

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

Further comment or suggestions

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

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

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 Toni Pikoos, PhD (Clinical Psychology)
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?

The current guidelines provide a good start, but I believe that they do not provide sufficient guidance to safeguard the psychological wellbeing of clients seeking cosmetic procedures. For example, psychological factors such as body dysmorphic disorder (BDD), anxiety, depression, obsessive-compulsive disorder and personality disorders are known to increase the risk of poor cosmetic treatment outcomes and may potentially worsen psychological functioning for these patients. While the current guidelines recommend referral to a mental health professional if these issues are identified, many practitioners who provide cosmetic procedures may not have had sufficient training to assess for these issues. I am one of very few BDD experts in Australia, and in conversation with my colleagues, each of us have only received a handful of referrals directly from cosmetic practitioners for psychological evaluations prior to cosmetic surgery. This is surprising, given the current estimates for BDD prevalence in individuals undergoing cosmetic surgery is around 13.2% (Veale et al., 2016) and in recent research in non-surgical cosmetic settings can be up to 25% (Pikoos et al., 2021). This may suggest that cosmetic practitioners are either not detecting psychological risk factors during their consultation process, or are choosing to treat anyway.

In my conversations with cosmetic practitioners, many have expressed concerns that while they are able to detect obvious or serious risk factors during their consultation, clients who present with more subtle psychological risk factors (for example, mild BDD, lesser known mental health issues, relational reasons for obtaining treatment) may be harder to detect. I have also seen several patients with quite severe BDD who have been able to access cosmetic surgeries and have reported that they wished somebody had advised them against obtaining the procedure beforehand but it was never discussed. Research has demonstrated that 84% of a sample of plastic surgeons have operated on someone with BDD unknowingly and only found out post-operatively (Sweis et al., 2017). Further, a 2017 study showed that plastic surgeons only identified 4.7% of patients with BDD using their clinical intuition alone, compared to the use of an established screening tool (Joseph et al., 2017). This suggests that the current guidelines, while well-intentioned, may not provide sufficient guidance to practitioners in how to detect and screen for mental health issues and potential contraindications for treatment, such as BDD. This should be included as a mandatory component of training to become a cosmetic or plastic surgeon, and additional guidance should be given to practitioners regarding the use of questionnaires and surveys to help screen for psychological contraindications for treatment which are often considered more accurate and sensitive, compared to clinical intuition alone (Joseph et al., 2017). These measures could be used to indicate which clients may require further psychological evaluation from a mental health professional, and have been recommended by several experts in the field.

Joseph, A. W., Ishii, L., Joseph, S. S., Smith, J. I., Su, P., Bater, K., ... & Ishii, M. (2017). Prevalence of body dysmorphic disorder and surgeon diagnostic accuracy in facial plastic and oculoplastic surgery clinics. *JAMA facial plastic surgery*, *19*(4), 269-274.
Veale, D., Gledhill, L. J., Christodoulou, P., & Hodsoll, J. (2016). Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence. *Body Image*, *18*, 168-186.
Pikoos, T. D., Rossell, S. L., Tzimas, N., & Buzwell, S. (2021). Is the needle as risky as the knife? The prevalence and risks of body dysmorphic disorder in women undertaking minor cosmetic procedures. *Australian & New Zealand Journal of Psychiatry*, *55*(12), 1191-1201.
Sweis, I. E., Spitz, J., Barry, D. R., & Cohen, M. (2017). A review of body dysmorphic disorder in aesthetic surgery patients and the legal implications. *Aesthetic plastic surgery*, *41*(4), 949-954.

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

1) **Training**. An understanding of mental health issues and psychological contraindications for cosmetic treatment should be a mandatory component of training for cosmetic practitioners.

2) **Patient Screening**. The use of established screening questionnaires and surveys for mental health concerns (such as BDD, anxiety and depression) should be recommended in the guidelines, as these are often more sensitive and accurate than relying on clinical intuition alone. This will prevent individuals from 'falling through the cracks' and receiving treatment when they may be unsuitable candidates. The use of established screening measures may also assist cosmetic practitioners to identify clients who require further psychological evaluation in a time-efficient manner.

3) **Informed consent**. Information about the procedure should be provided verbally and in written format. Many clients may gloss over written information without fully comprehending it, and time and care should be given to explaining the procedure carefully with time for clients to ask clarifying questions. Further, informed consent should involve providing clients with information about both the physical *and* psychological benefits and risks of the procedure. For example, this can include greater risk of depression during the post-operative period, it is unlikely to have a significant impact on extrinsic factors such as one's social functioning or job performance, and clients with BDD may experience their appearance concerns worsening or shifting to a new area (Tignol et al., 2007). More recent research is also evidencing the potential for minor cosmetic procedures to become addictive, with clients requesting a greater amount of product and potentially going to greater lengths to finance their procedures (Shah et al., 2021). It is important that clients are informed about these possible risks prior to providing consent.

4) **Post-operative care.** Many clients experience poorer psychological wellbeing during the post-operative period, but this may not be discussed prior to undergoing surgery. A recent qualitative study reported on women's experience of cosmetic surgery in Australia, noting that many felt severe depression and isolation in the days following their surgery (Bonell et al., 2022). Women who were warned by their surgeons beforehand about the post-operative blues felt more prepared for these experiences. As such, post-operative care could also involve referrals to mental health professionals to help them adjust after surgery.

5) **Advertising**. More clear guidelines should be given regarding advertising cosmetic procedures. For example, the use of filters or photo editing should be prohibited on before and after shots. Further, individuals posting these images/videos should be required to note the risks involved in the procedure along with the post. Posts relating to cosmetic surgery should be age-restricted.

Bonell, S., Austen, E., & Griffiths, S. (2022). Australian women's motivations for, and experiences of, cosmetic surgery: A qualitative investigation. *Body Image*, *41*, 128-139.
Shah, P., Rangel, L. K., Geronemus, R. G., & Rieder, E. A. (2021). Cosmetic procedure use as a type of substance-related disorder. *Journal of the American Academy of Dermatology*, *84*(1), 86-91.
Tignol, J., Biraben-Gotzamanis, L., Martin-Guehl, C., Grabot, D., & Aouizerate, B. (2007). Body dysmorphic disorder and cosmetic surgery: evolution of 24 subjects with a minimal defect in appearance 5 years after their request for cosmetic surgery. *European Psychiatry*, *22*(8), 520-524.

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

These guidelines should extend to all practitioners (including non-medical professionals) providing both surgical and non-surgical procedures. While non-surgical procedures have good safety profiles and are generally considered lower risk than major surgeries, many of the psychological issues associated with cosmetic surgery extend to minor procedures (see Pikoos et al., 2021) and therefore they too require a thorough consultation, screening and consent process.

Pikoos, T. D., Rossell, S. L., Tzimas, N., & Buzwell, S. (2021). Is the needle as risky as the knife? The prevalence and risks of body dysmorphic disorder in women undertaking minor cosmetic procedures. *Australian & New Zealand Journal of Psychiatry*, *55*(12), 1191-1201.

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?
Cosmetic practitioners should be required to document their assessment of the client's suitability for treatment (e.g., no significant psychological issues identified, reasonable expectations and motivations) and reasons why client was/wasn't referred for further psychological evaluation. If a notification has been made where a client was not adequately assessed/informed, practitioners should be expected to demonstrate how they completed this process.
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.
N/A

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
The current guidelines are already quite detailed, but could include additional information specifically for newer technologies such as Instagram and Tiktok.
7. What should be improved and why and how?
More specific guidelines could be given in relation to new technologies available through Instagram and Tiktok where cosmetic surgeries are now being advertised. For example, the use of filters, emojis and other forms of photo or video editing should be restricted on posts relating to cosmetic surgery, as this trivialises the procedures, minimises the risks, and exaggerates the benefits. Advertisers should be required to document the risks of the procedure on the post. A trigger warning prior to being shown the post could be useful on Tiktok or Instagram. For example, something along the lines of "This post involves an advertisement of a cosmetic surgery or procedure. All surgeries have risks and the following images may not accurately depict the complete surgical experience. Do you wish to proceed?" The use of before and after photos should be banned or heavily regulated as these often exaggerate the benefits or are subject to other external factors which may contribute to the difference in the photos, beyond the surgery or treatment being advertised. The posts should be age restricted to prevent young people being exposed to this content.
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 could be sufficient with some amendments (such 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?
More recently, advertisements for 'preventative' cosmetic surgeries and procedures are becoming increasingly popular suggesting that procedures may prevent signs of ageing later in life and are leading to trends such as the 'baby Botox' craze of younger people starting to get cosmetic procedures. The preventative benefits of cosmetic procedures are very difficult to substantiate with good scientific evidence, so this may be an area that could be further regulated.
10. Please provide any further relevant comment in relation to the regulation of advertising.
Cosmetic surgeons/practitioners should not be allowed to 'upsell' cosmetic procedures by offering additional treatments or surgeries, beyond those which are specifically requested by the patient or if the patient has specifically asked for their recommendations. Many clients attend these consultations when feeling vulnerable or experiencing lowered self-esteem and are more susceptible to being convinced into procedures which may not be necessary for them at the time.

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 would help to a large extent as regulatory bodies could then mandate the minimum level of training that is required to deliver cosmetic procedures and receive endorsement. Developing a standardised training approach and expected competencies would provide further standards for AHPRA to evaluate the practice of cosmetic practitioners against, and protect consumers.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
Yes
13. What programs of study (existing or new) would provide appropriate qualifications?
I cannot comment on the surgical aspects of training, but I do feel that part of this training needs to involve counselling micro-skills and at least an introductory level training into mental health issues which may present in a cosmetic context. This is prudent given many clients seek cosmetic procedures for psychological reasons, such as increasing self-esteem. Further, cosmetic surgeons have the potential to do harm even during their consultation process by confirming or denying the presence of appearance flaws in individuals with Body Dysmorphic Disorder and may need specific training to navigate this area sensitively.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Regulating the specialist title will ensure that all practitioners delivering cosmetic procedures have received a minimum level of training and education to practice safely.

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?
Unsure about the specific barriers, however, efforts should be made to establish nationwide regulation and standards. Currently, patients who may be refused treatment by one practitioner or in one state can travel elsewhere or find another practitioner to deliver the treatment. As such, regulation needs to be consistent across these bodies.
16. If yes, what are the barriers, and what could be improved?
Unable to comment
17. Do roles and responsibilities require clarification?
Unable to comment
18. Please provide any further relevant comment about cooperating with other regulators.
Unable to comment

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?
Unable to comment
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
Unable to comment
22. Please provide any further relevant comment about facilitating notifications
N/A

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 current guidelines are adequate regarding physical risks of the procedure, but do not provide recommendations about information regarding psychological outcomes and risks.
24. If not, what improvements could be made?
While clients do report improvements in self-esteem and body image, improvements in social, relationship and job functioning are often much rarer and minimal following cosmetic surgery. This should be explained to clients when these are their primary motivations for treatment. In addition, for clients with BDD, there is risk of a worsening of their appearance concerns, concerns shifting to another area of their face or body, or a lack of perceived change following the treatment. Further, evidence is beginning to emerge regarding the addictive nature of cosmetic procedures, with these treatments triggering neurobiological reward pathways by boosting mood, confidence, or self-esteem (Newell, 2011; Shah et al., 2021). As such, clients may desire more extensive surgeries in the future which could come at a physical, mental and financial cost. Clients with BDD may be

particularly susceptible to cosmetic treatment addiction, as they often display impulsivity, compulsivity, and the heightened presence of other addictive behaviours (e.g., substance and alcohol abuse; Grant et al., 2019; Jefferies-Sewell et al., 2017)

Further, individuals with BDD may not have the capacity to critically evaluate the decision to seek cosmetic treatment. BDD patients often display poor insight into the psychological nature of their appearance concerns (Hartmann et al., 2013; Phillips et al., 2014). They may also experience aberrations in executive function and interpretive biases (Johnson et al., 2018; Labuschagne et al., 2013) which could affect their decision-making abilities. Further, the high degree of distress that is often associated with BDD may create desperation and poor judgement, where individuals are willing to try anything to alleviate their distress, without fully comprehending the risks or consequences. Evidence of this has been reported when individuals with BDD attempt DIY-surgeries (such as cutting the fat from their legs or the cartilage in their nose; Veale, 2018) in frantic attempts to improve their appearance. Patients with BDD may have difficulty declining a procedure even if they change their mind or decide it is not within their best interests. As BDD is often associated with heightened fears of negative evaluation (Toh et al., 2017) and reduced assertiveness (Didie et al., 2012), they may have difficulty saying 'no', if a cosmetic practitioner is emphasising the benefits of a procedure or trying to upsell another treatment. Given these concerns, BDD is a clear contraindication for treatment but be these concerns could be provided as reasons to explain to the patient why a treatment may be refused.

Further, a patient should be informed about:

- Psychological benefits and risks of the procedure
- The availability of psychological treatments to improve body image and self-esteem as alternatives or adjunct to cosmetic surgery (particularly in clients with BDD or very low self-esteem/confidence that may not shift significantly with cosmetic surgery).
- The risk of post-surgical 'blues' or depression
- The potential risk of 'addictive' relationships with cosmetic surgery or procedures to develop.

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

Yes

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

Good information about protecting physical wellbeing in making the decision, but limited information about making an informed decision with psychological wellbeing in mind.

For example, the Medical Guidelines suggest informing clients about other treatments that are available, but I feel that this is typically interpreted as alternative cosmetic treatments (or no treatment at all). Psychological treatments are available to improve self-esteem and body image, such as Cognitive Behavioural Therapy, which should be suggested to clients as alternatives to undergoing surgery.

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

AHPRA/Medical Board could provide more information about psychological benefits and risks of these procedures.

28. Is the notification and complaints process understood by consumers?
No – I have seen many clients for psychological treatment who have had bad experiences of past treatments and have gone to see the practitioner who administered the procedure, have been told that there is nothing wrong with the outcome or the treatment administered or nothing can be done, and have been sent away. They are usually unaware of further complaint processes that are available.
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
Could mandate that practitioners provide information about the complaints process in any post-operative correspondence that is sent to the patients. It may also be beneficial to advertise these complaint details through online forums, such as Tiktok and Instagram, where cosmetic procedures are often advertised.
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.
I would be happy to assist in further consultation regarding how to ensure that the current regulations safeguard clients' physical *and* mental wellbeing.