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	Rodney Cooter AM MBBS MD FRACS(Plast)
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?
No, they allow under qualified doctors to perform invasive surgery, often with high risk Class 3 implantable devices like breast implants.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
The guidelines should only allow fully qualified specialist surgeons with an FRACS to perform invasive surgery. Face-to-face consultations are a must for cosmetic surgery and the cooling-off period must be tailored to the magnitude of the surgery eg 7 day period of reflection for all adult surgery NOT involving implants, and at least 10, preferably 14 days for any cosmetic surgery involving implants.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
Advertising of surgical procedures needs a complete overhaul and continual oversight to remove puffery and overstated abilities and outcomes.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
These august organisations should be offering more insightful truth information for patients to assess whether their surgeon has appropriate qualifications and/or practice limitations.
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.
It should be a more transparent process that defines outliers and their pathway of management rather than the opaque process that exists and is rather unilateral.

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
No. Many websites overstate qualifications and contain images that have a sexualised nature.
7. What should be improved and why and how?
Better oversight of all advertising and recognised penalty levels for any deviation from what is acceptable.
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?
No. Inducement adverts must be banned. Unrealistic post op images should be banned.
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?
All social media should follow the same guidelines as any other policy for adverts ie anything that commoditises cosmetic surgery should be banned.
10. Please provide any further relevant comment in relation to the regulation of advertising.
All doctors, solo or in group practice or in a business group, must state clearly their qualifications so there is no ambiguity about whether they are a specialist in the eyes of the unsuspecting public who have trust in the medical profession being honest.

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)?
It's not what it's called, it's what happens and who does it that should define this area of surgery. Only those specialist plastic surgeons with 5 years of specialist training at an AMC accredited institution should be licenced to perform invasive cosmetic surgery. Creating another pseudo-speciality simples confounds the public further.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
The only endorsement should be the most qualified surgeon being allowed to operate and that requires an FRACS post-nominal.
13. What programs of study (existing or new) would provide appropriate qualifications?
FRACS full qualification
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Currently, even limiting the title surgeon has not been effective in some states because non-surgeons can still legitimately claim to do surgery even though they can't say they are surgeons. It should NOT be about title protection but should be about scope of practice to protect patients who shouldn't have to decipher who can do what.

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?
There should be an international information flow with examples of countries who have had the courage to grasp this nettle eg France and also Puerto Rica where ist is simply illegal to do invasive surgery unless the operator is appropriately qualified.
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
Yes, there should be clear guidelines about roles and responsibilities.
18. Please provide any further relevant comment about cooperating with other regulators.
The TGA has embraced the Breast Device Registry which we run out of Monash University and further registry information should be sought about all cosmetic surgery as a mandated requirement because these procedures are offered direct to the public with no intervening regulator like Medicare or Private Health Insurers. Medico legal insurers could also help to control this opaque space by only insuring fully qualified practitioners.

In some ways Ahpra and the Medical Board are conflicted because they have all doctors as members.

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?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
Data collection in a registry setting could give much needed data but should be mandatory.
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?
Yes but compliance is the issue here.
24. If not, what improvements could be made?

Assess by a study that retrieves Patient Reported Outcomes, like we do with the Breast Device Registry.
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?
Yes

26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?
No
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
Simply list those specialist surgeons who are qualified to do this surgery.
28. Is the notification and complaints process understood by consumers?
Not fully
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
They should add riders to all patient information products given at the time of consultation
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.
Proper and full informed consent is the holy grail that we are pursuing.

From: Danyluk, Andrew (Health)
To: Cosmetic Surgery Review
Subject: Cosmetic surgery consultation
Date: Tuesday, 8 March 2022 5:19:42 PM

As an emergency registrar I am so offended by cosmetic medical doctors as presently constructed. Many of my friends are surgical registrars and fight tooth and nail to gain skills and talents both soft and technical that allow them to break skin. The absoulte [redacted] who frequent many cosmetic medical settings are simply worse.

My role of managing and stitching wounds and critical care procedures in my mind is the absolute maximum proxomity I should get to a cutting skin. And in that I have accredited training.

The thought of people with no surgical exam, surgical training program or intraining exam with meaningful anatomy content masquerading as surgical doctors is digusting and rewards mediocrity in my vocation.

The four corners report, what I gather from my readings, all suggest the same thing. A cosmetic surgeon should be a guarded term for those with an accredited training program in plastic surgery.

Kind regards, Dr Andrew Danyluk

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	Jacqueline Davies
Organisation (if applicable)	[redacted]
Email address	[redacted]

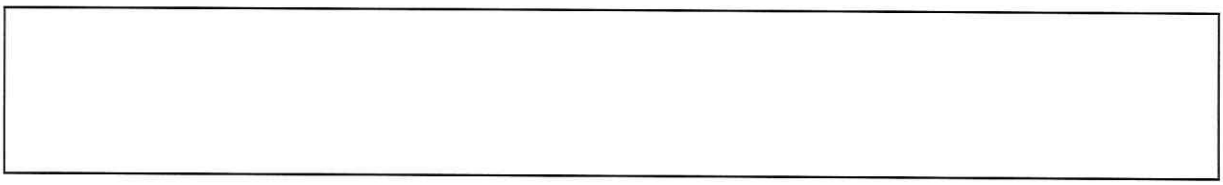
Your responses to the consultation questions

Codes and Guidelines

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

Management of notifications

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



Advertising restrictions

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

Title protection and endorsement for approved areas of practice

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

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

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

Cooperation with other regulators

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

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

24. If not, what improvements could be made?

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

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

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

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

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

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

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

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

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

Further comment or suggestions

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

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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	Simon Dawkins
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)?
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?**
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications

Information to consumers

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

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

Further comment or suggestions

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

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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 Caroline Do, MD
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?
Regarding training and qualifications, there is no official training/governing body for cosmetic doctors/physicians in Australia so points 8.1 and 8.2 are open to interpretation. Having worked as a cosmetic doctor previously I found it difficult to know which courses to undertake due to lack of regulation around training for doctors and lack of a training committee. I ended up training in Germany in 2020 in aesthetics due to their more rigorous standards compared to Australia whereby only medical doctors non Germany can inject and they do not have nurse injectors.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
Regarding 6.1 and 7.2, there are lots of nurse injectors who inject without a doctor on-site to supervise as they use the "Skype loophole". Unfortunately this is common practice in Australia and the doctors prescribing the injections also don't necessarily need to have appropriate cosmetic experience in order to be a prescribing doctor. [redacted] can attest to the lack of face to face doctor consultation so guidelines pertaining to 7.2 are not being adhered to.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
I make comments pertaining to cosmetic medicine (non invasive injectables) only as this was the field I worked in. I feel the industry is very nurse-dominated in SA where I live/practice. There is a lack of supervision by qualified on-site doctors despite this being outlined in the guidelines. Patient outcomes are at risk and this has unfortunately become standard and accepted practice within the industry and patients aren't aware of the risks these procedures carry.

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?
N/A
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?
Regulation of advertising yes, but due to social media developing at a faster rate than new guidelines can come out ie. recent Tik Tok scandals, there is indirect advertising taking place constantly on these platforms that traditional guidelines do not adequately cover. This is especially poses a risk to the adolescent population group as I found in my personal practice that there were many 18 year olds seeking procedures as soon as they could legally do so.
7. What should be improved and why and how?
- More regulations regarding training of cosmetic doctors/surgeons. The term can be used loosely by anyone who's undertaken a 3 day training course at present. - More restrictions on nurse injectors due to unregulated prescribing by doctors without cosmetic experience and closer monitoring of the consultation processes whereby doctors remotely consult using video conference and not being on-site to manage potential complications.
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?
See below.
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?
Please see response to #6. Furthermore, due to social media being a global platform, we are exposed to various practices in different countries that are potentially dangerous (eg. filler pens, certain lip injection techniques) due to unregulation in those countries but those practices are being adopted here. Therefore, Australia needs to have higher standards and better regulation of procedures for improved patient outcomes. These guidelines should be constantly updated for practitioners of cosmetic medicine due to the nature of social media. These guidelines need to reflect emerging peer-reviewed research as there is an increasing body of research around cosmetic medicine internationally.
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)?

An Ahpra endorsement would better address the issues I have raised regarding patient safety issues. This would also help with transparency around what these qualifications mean ie. cosmetic surgeon vs plastic surgeon.

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
See #14.
13. What programs of study (existing or new) would provide appropriate qualifications?
The Cosmetic Physician College of Australia has done a lot of work to advocate for higher standards of practice in cosmetic medicine. GPs working in cosmetic medicine also have done further training and these qualifications should be monitored/endorsed.
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Not just cosmetic surgery but also the terms “cosmetic medicine”, “cosmetic physician”, “aesthetic doctor” (used interchangeably) will also need the same title protection/endorsement/transparency. Cosmetic surgery =/= cosmetic doctor currently.

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?
N/A
16. If yes, what are the barriers, and what could be improved?
N/A
17. Do roles and responsibilities require clarification?
Absolutely.
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?
Not sure
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?
Patient advocacy
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?
No. As previously stated, doctors are video calling in to obtain a brief history and consent in certain practices.
24. If not, what improvements could be made?
Stricter regulations around nurse injectors.

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?
I have not read this.
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?
Please see number 9.
28. Is the notification and complaints process understood by consumers?
No.
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
Better regulation of the industry. Sub par practices are currently the norm in Australia and we can do better.
30. Please provide any further relevant comment about the provision of information to consumers.
Having more educated, qualified doctors in the field. This would entail an overhaul of the current training/regulations. More consumers are wanting these procedures (fuelled by social media) and the current Australian regulation of providers is substandard compared to some other countries eg. Germany as mentioned previously. There is no peer-reviewed evidence based guidelines for cosmetic procedures that practitioners can refer to. A formal committee should be appointed for this purpose.

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 feel that the majority of patients do not adequately understand the level of risk these procedures carry due to the lack of doctor input/supervision ie. getting injectables at a laser lounge by a nurse during lunch break vs a traditional face to face doctor consultation in doctors rooms. Injectables carry the risk of blindness, of vascular occlusion etc. In my experience, most patients who came to me having had multiple procedures done previously were not aware of these risks. Patients should not be considered consumers and there is a duty of care that AHRPA and the medical board needs to take more seriously in Australia so that we hold ourselves to a higher standard and keep up to date with not only social media but also the new technologies being developed. This is a rapidly growing field and Australia currently lacks the regulations and guidelines required to keep up with this, putting our patients at increased risk.

Do not hesitate to contact me for further information.

From:	Eleanor Eastoe
To:	Cosmetic Surgery Review
Subject:	Submission for independent review
Date:	Tuesday, 8 March 2022 8:36:49 PM

Dear Mr Brown,

As a doctor and [redacted] I believe that the training, assessments and qualifications for aesthetic practice are vague and not appropriate. I also feel that the title ‘aesthetic surgeon’ is entirely false and misleading to the general public.

Aesthetic medicine should have its own monitored training program like any other medical specialty including theory/necessary practical time and assessments. And those practicing aesthetic medicine should never be referred to as surgeons, they have no surgical training and it’s dangerous to do so.

Kind Regards,

Eleanor

From:	Robert Edwards
To:	Cosmetic Surgery Review
Subject:	Re: Public consultation now open – Independent review of the regulation of health practitioners in cosmetic surgery
Date:	Thursday, 10 March 2022 4:59:29 PM

All surgery should be done by properly trained and qualified practitioners This means the FRACS.

Sent from my iPhone

PRS Review

To the CS Review at APHRA. 12th April 2022

Sirs

After a career as Reconstructive Plastic Surgeon who also performed cosmetic surgery I feel qualified to comment in this review, and I have been thinking on the matter before making this reply, hence the delay in this submission.

I began training in plastic surgery with Dr L S Davies at the then Brisbane General Hospital in 1956, now the Royal Brisbane Hospital. I was the first surgical registrar in plastic surgery at the new South Brisbane Hospital now the Princess Alexandra Hospital, in 1958. Subsequently I knew Sir Benjamin Rank in Melbourne at the Royal Melbourne Hospital and John Hueston. In England in 1960 I worked with Rainsford Mowlem and met Sir Harold Gillies, working also with John Barron for two years in UK. Subsequently I was in Wellington New Zealand for 5 years as plastic Surgeon. Back in Brisbane from 1969 I worked for 25 years as plastic surgeon in public and private practice, doing a variety of surgical reconstructions.

I have done secondary repairs on many patients who had cosmetic surgery performed by doctors who were poorly trained or not skilled. Since then I have written books, and considered the subject now under review.

Among books I have written are *Autobiography of a Plastic Surgeon, Anecdotal History of Plastic Surgery, Plastic Surgeon to Sculptor,* and the story of my father's role as surgeon *North Queensland Country Surgeon.* We did a multi author book *Malignant Skin Tumours* from Brisbane which I edited with a colleague in 1980 and 2nd edition in 1991, with diagnosis and surgery, and many other modalities of treatment also, and pathology.

I lectured medical students for many years at the University of Queensland where I was made Clinical Professor of Surgery, discussing all aspects of plastic, reconstructive and cosmetic surgery.

Plastic Surgery as such was named initially by Eduard Zeis in 1838 whose book *Zeis' Manual of Plastic Surgery* (translated to English by T J S Patterson in 1988) described the work of J F Dieffenbach, reconstructing injuries and deformities, many from the Napoleonic wars. Dieffenbach was the first plastic surgeon, also Professor of Surgery in Berlin, long before modern plastics were invented in the 1920s. The first cosmetic surgery of the modern era was done by Joseph with rhinoplasty and facelift in early 1900s; I have his book (in German). Sir Harold Gillies worked on WWI casualties, from 1915 on treating severe facial injuries in young men, and founded Plastic Surgery in England, writing books and also doing cosmetic surgery in the 1920-1960s. I met him in 1960, with Rainsford Mowlem and John Barron.

The place of cosmetic surgery in modern society where appearance is so important varies with the different procedures, and there are several aspects to discuss.

The psychology and appropriateness of each patient for the operation requested requires careful analysis, in each case, for results to be good, and adequate explanation is needed. When seeing

patients with failed surgery it is the psyche which must be treated first, usually by simple explanations.

With any one patient, and procedure requested, the technique to be used should be clearly described, the predictable results, and possible complications. A one to one confidence is important for a good outcome, and the interpretation of possibilities. Each person has different skin type, different scar formation, different deformity, or perceived deformity.

Sometimes the problem is a poor self-image in the patients mind, and that needs correction rather than surgery.

Some patients are better not to have the surgery requested and clear explanations why are essential. For some the risks outweigh possible advantages. Some will not take no for an answer and they will seek others willing to do the work; it is a free society.

Now we come to the many procedures considered as cosmetic surgery. Certainly correction of extensive facial injury has results which are undoubtedly considered cosmetic, and may involve more than one operation, and time for scars of skin, muscle, and bone, to mature. The body heals by forming fibrous tissue called scar and the way tissues are put together in layers determines much of that, and there are time schedules for it all. People's expectations need consideration as part of surgical technique.

Correction of ear deformity with reshaping is often of priority while at school, and there are many methods, depending on how severe the problem is, sometimes born with simply an ear remnant.

Rhinoplasty can be to correct injury caused deformity, or familial character undesired by the individual, or simply to improve appearance

Facelift operations have varied a lot from being originally a lift of skin and fat, to being a muscle lift, perhaps subcutaneous, to develop different facial expression and smile, perhaps for TV announcers. There are now many types of facelift and risk to the facial nerve is common to them all.

Some techniques such as dermabrasion for helping improve surface contour of facial skin can have complications which far outweigh possible benefits.

Injection of preserved collagen to fill furrows, scars or fill out lips, is often done by nurses or untrained practitioners, difficult to supervise. The results are temporary as the immune system reacts and resorbs, so some have the procedure frequently redone. Personally I never used that modality. In the early 1900s there was once injection of paraffin to fill facial contours which had long term problems difficult to correct.

Injection of 'Botox' a derivative of Clostridium Botulinum Toxin, the cause of botulism the highly toxic food poisoning, is used to paralyse selected muscles in face especially forehead, to get rid of overlying skin wrinkles. I never used this myself but it appears common, and is used by a variety of practitioners.

Breast augmentation and breast reduction and reshaping are all common and should only be done by trained surgeons.

Abdominoplasty is a larger operation to tighten abdominal muscles and remove excess skin and fat, frequently following pregnancies, a larger procedure in many cases.

Liposuction using specific suction cannulas and a high pressure suction machine, has many complications, especially in the hands of the unskilled.

Fat injection is used for supplementing contour and size, but is subject to unpredictable resorption, which needs to be understood by prospective patients.

Craniofacial surgery altering skull shape to overcome deformity is done by a team with plastic surgeon, neurosurgeon and perhaps oral surgeon in some cases, and other specialists. I started that in Brisbane with a neurosurgeon, orthodontist, speech pathologist, and the work continues to this day with new people. It could be regarded as an extended form of cosmetic surgery.

Repair of cleft lip and palate in young children is about function as well as appearance and I did that for many years, following the children through growth to age 18 years or longer. Older people repaired by earlier techniques would come for a revision of the repair, either to improve speech or to enhance appearance. The nose is affected and often in older people can be improved.

How to regulate who does cosmetic surgery and what training and practical experience they should have, is difficult to outline in a rigid way. So many factors are involved, but all need to be trained in surgical techniques.

Personality, being able to talk to patients, and be understood, is important. The ability to generate confidence and the ability to follow that through

Manual dexterity will vary with different surgeons.

An eye for line and form is needed, and experience, appropriate surgical training, are all important.

Photographic records are a protection for both patient and surgeon

There should be some form of registration with selection based on the above, but it is difficult, that's why it is still in the realm of controversy

I hope the above gives some help in your considerations.

Yours Sincerely

Anthony J Emmett

MB BS FRCS FRACS

[redacted]

[redacted]

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	Samantha Endell
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 and feel safe. 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?
.
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.

Facilitating mandatory and voluntary notifications

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

Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?

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

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

Further comment or suggestions

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

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The 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.

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Mr Andrew Brown, Independent Reviewer
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The closing date for submissions is 5.00pm AEST 14 April 2022.

Your details

Name	Vivek Eranki
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?
AHPRA and Medical Board need to prioritise complaints on the basis on verified patient harm and likelihood of patient harm. Stakeholders in the space of Cosmetic/Plastic Surgery often raise alarm bells however these go unnoticed for tended periods of time whilst patient harm continues. I agree the reporting culture needs to be strengthened however, at the same time, AHPRA/MBA needs to become cognisant of such reports
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?
AHPRA and MBA have appropriately defined the advertising guidelines
7. What should be improved and why and how?
Enforcement of AHPRA/MBA's own advertising guidelines. AHPRA/MBA have a habit of releasing guidelines however there are multiple examples where they fail to be policed
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
They adequately address the risk
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?
AHPRA and MBA have appropriately defined social media advertising in their guidelines
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?
Yes
20. Are there things that prevent health practitioners from making notifications? If so, what?
Please refer to my comment earlier
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
Please refer to my comment earlier
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.

From: gabrielle Fairfield
To: Cosmetic Surgery Review
Subject: cosmetic nurse injectors working in [redacted]
Date: Tuesday, 15 March 2022 5:09:44 PM

Hi My name is Gabrielle Fairfield Boshuis.

I work in Emergency as a [redacted] in [redacted]

I have been aware that cosmetic nurse injectors work by locally hiring a room .

It seems that the prescriber is a GP somewhere interstate who is incharge of prescribing.

It also appears that the more nurses they hire the more lucrative it is for the GP.

There should be strict regulation and guidelines that the nurses should not inject without the supervision of the specialist.

In [redacted] this practice runs under the umbrella of beauticians

My concerns are that these nurses and medical practitioners should get registration with AHPRA to practise under strict guidelines..

Kind regards

Gabrielle

Gabrielle

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Your details

Name	Ronald Feiner MBBS (unsw)
Organisation (if applicable)	
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 and cosmetic medicine, nor can there be, without a change in the National Law. Therefore, no training programme is recognised by the AMC for cosmetic surgery or cosmetic medicine, and the title "cosmetic surgeon" and cosmetic physician may be used by any medical practitioner. Patients are at risk, because they are unable to identify if the doctor offering cosmetic surgery and cosmetic medicine 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 & cosmetic medicine 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 & medical competence, but also that they have reached an acceptable level of competence and skill *specifically* in cosmetic surgery & cosmetic medicine. The practitioners would be required to be part of a recertification programme specific to cosmetic surgery and cosmetic medicine. To ensure patient safety, this model would need to be applied to *all doctors* who perform cosmetic surgery and cosmetic medicine 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.

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Title protection and endorsement for approved areas of practice

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. Establishing an endorsement model would essentially protect patients from adverse outcomes. Those practitioners, who are endorsed to practice cosmetic surgery and cosmetic medicine, would have the appropriate training and experience in cosmetic surgery and cosmetic medicine. This would be clear to patients, because there would be an AHPRA administered cosmetic Surgery and cosmetic medicine 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 and /or medical training and competence, and *specific* cosmetic surgical and /medicine training and competence as well as on-going professional education in cosmetic surgery and/or cosmetic medicine..
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' and/or "Cosmetic Physician" should be protected for those practitioners who have had specific recognised training in Cosmetic surgery &/or cosmetic medicine. 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

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Information to consumers

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The Medical Board's current codes and guidelines do not specifically outline a practitioners training in cosmetic surgery &/or cosmetic medicine. 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 (and /or cosmetic medicine).

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 and /or cosmetic medmcine 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 and or cosmetic medicine, 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 and/or cosmetic medicine, in order for them to make informed choices regarding their surgery/procedures and choice of surgeon and/or cosmetic physician. I support the proposal for a national competency-based accreditation Standard for *all* doctors performing cosmetic surgery and /or cosmetic medicine. There should be a register of Endorsement of those who have met, and maintain the national standard. Restriction of the title 'Cosmetic Surgeon' (and/or cosmetic physician) 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.