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 Koonal Prasad and Legal/General Research and Editing by Miss Komal Prasad. Please note, we consent and give permission to the publication of this submission.
Organisation (if applicable)	N/A.
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 were drafted and enforced from a consultation committee of an era that does not accurately reflect the current social, economic, medical and political climate today. It is not representative of a modern society in 2022. As society moves forward, as must guidelines.

This includes the Medical Board of Australia's current Code of Conduct, which again does not reflect the modern practice of medicine. This profession has become restrictive, over governed and such guidelines and codes are suffocating for medical practitioners.

Current Practice

- The current guidelines are inadequate in regulating cosmetic medical and surgical practices.
- There is no accredited college to deliver these training pathways.
- The assumption that cosmetic surgical and medical practices do not treat known disease and therefore do not lie under the same scope of receiving college accreditation is short sighted, out of touch and simply inaccurate.
- Poor self image, physical deformities, scarring and even depression and anxiety have been shown to be appropriately addressed by addressing the cosmesis of an individual. Research articles on this can be provided.

Training

- There is no accredited college.
- Cosmetic medicine is an important path of healthcare for many Australians in a modern society and the medical guidelines need to move into this relevant period.
- It is very important to note that non-surgical college affiliated cosmetic practitioners as well as surgical college affiliated practitioners do not have exposure to cosmetic surgery/procedures in their traditional scope of training.

Important Considerations

- The debate here is, are non-surgical college affiliated practitioners safe practitioners of cosmetic surgery or should there be restrictions?
- Many cosmetic surgeons, who are not affiliated with surgical colleges, take relevant exposure, training and theatre time to understand the procedures before solo practice. The scope for training does not exist based on an outdated assumption on why a cosmetic training college cannot be accredited.
- It is also important to note that other surgical trainees from surgical colleges do not get exposure to cosmetic surgery/procedures either in their training (breast specific augmentation, Brazilian butt lifts, etc.). For example, plastics and reconstructive, ENT, general surgery etc.
- The actual cosmetic surgery/procedures are not always the issue. The actual issue is the aftercare of patients.
- Issues in post procedural care such as wound review and management, early detection of complications (all procedures have risk), pain management, mental health monitoring, cause adverse health events due to poor initial health assessments.

- If practising within one's scope and experience is the concern then consider that surgical college accredited practitioners are not equipped to undertake relevant health assessments and mental health assessments prior to cosmetic surgery/procedures and certainly do not have the scope of experience and training in managing analgesia management and weaning protocols especially of S8 medications and the physical, medical and mental health events which can occur post surgery.

- Cosmetic practitioners with a physician's college Fellowship (FRACGP, specialist physician etc.) do have the scope for appropriate pre-procedure medical and mental health assessments as well as the scope for monitoring of care, analgesia, medical and mental health support post procedure as necessary.

- There are pitfalls in all domains of medicine when addressing cosmetic surgery/procedures.

- However, it is clear that at least a Fellowship in a college has lead to enough exposure in general medicine and experience of health management to safely conduct a cosmetic surgery/procedure and manage the after care of the patient.

- Therefore, the gap in the market lies in an accredited college that trains capable practitioners in the safe art of cosmetic surgery/procedures while managing appropriate pre and post care aspects as discussed. A Cosmetic College Fellowship that is accredited is the answer and very necessary.

- The above considerations are very important if of course patient safety is at the forefront of this consultation.

- Ignoring the shortfall of practitioners from accredited surgical colleges as mentioned and only focusing on restricting practitioners who are not affiliated with an accredited college would create a monopolised level of inadequate pre-procedure assessments, mental health considerations, analgesia management and post procedure medical and mental health concerns as noted.

- No consideration in the shortfalls in care in cosmetic practice from all different practitioners means that unfortunately patient safety is no longer at the forefront, but the monopolisation of an industry is the main and only aim, and hence this would be for monetary gain for a collection of practitioners who are heavily aligned with the two prominent surgical colleges in Australia. That unfortunately is not how a free industry like Australia should function - please see the saga regarding the state government ban imposed on the greyhounds industry in New South Wales to realise what a knee jerk reaction to a small number of cases can cause.

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

The current status quo should be maintained within the cosmetic surgery industry and extending the length of the current guidelines is unnecessary and will definitely create further confusion for medical practitioners and the use of arbitrary powers by AHPRA and the Medical Board of Australia.

Guidelines should be short and concise, with no inclusion of medico-legal jargon.

If a cosmetic surgery college is not recognised as an official medical college based on a superficial argument that cosmetic surgery is not addressing conventional medicine, then a legal conundrum is created as it cannot be governed by the same rules as every other college or medical body.

It is a thriving and generally safe industry like any other body modification industry. An industry itself cannot be outlawed or restricted into collapse. There is a freedom of trade and commerce, which is an exclusive power of the Commonwealth and such a right is contained in the Commonwealth of Australia Constitution Act 1900 (Cth) ss 51, 92. Like every other industry, including specialities of medicine, there are an equal number of good, bad and poorly trained practitioners.

But to say cosmetic surgery does not address conventional medicine is short-sighted, silly and insulting. Cosmetic surgery helps to avoid diseases of the mind and helps to improve diseases that have affected the body. Mental health and positive body image is a very real medical issue and uncontrolled, a very real disease.

Accredited Training College

- See above for the requirement for an accredited training college to exist.
- It is also not unreasonable to expect cosmetic practitioners to also hold at least a Fellowship from any medical college so they have exposure to general and surgical medicine and management.

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

The current guidelines are clear.

It is up to the regulatory bodies to properly uphold these guidelines. Guidelines should be clear, consistent, communicated to all medical practitioners and not be subject to constant and unnecessary policy reform by the COAG Health Council, AHPRA and the Medical Board of Australia.

AHPRA should not wait to receive constructive feedback from medical colleges on whether such guidelines and policy reforms are fair to the medical practitioner and abide by relevant state and Commonwealth legislation. AHPRA should take the initiative and indicate to the COAG Health Council that certain guidelines and policies will be detrimental to the medical practitioner, the practice of medicine and jeopardise patient safety.

Competency training is adequately available through the Australasian College of Cosmetic Surgery and Medicine for now. Furthermore, there are equally credible overseas pathways. The suggestion that only practitioners with fellowships with surgical colleges have the capacity and experience to perform certain cosmetic surgery/procedures is highly misleading and plainly wrong. There are certain standards and guidelines and training pathways.

It is important to remember, a plastics and reconstructive surgeon may not have the relevant training in the principles of a particular cosmetic surgery/procedure. For example, Brazilian butt lifts are not a regular training encounter for Registrars undergoing the surgical college pathway.

However, it is not unreasonable to expect both cosmetic and plastic surgeons to undergo additional training to minimise patient risk, prior to being able to engage in cosmetic surgery/procedures.

The input of legal firms, as stakeholders, is irrelevant to the practice of good medicine and medical guidelines. It leads to the unsafe medico-legal practice of medicine and deters from proper medicine. Law firms have a very minimal understanding of what hardships and obstacles medical practitioners faced before COVID-19, during COVID-19 and face after COVID-19. Furthermore, the agenda and biasness of law firms in this consultation must be noted and questioned by medical practitioners.

I have taken note on a wider scale of the variety of legal firms pushing consultations such as this and national reform. These are largely plaintiff firms. I can state with good authority and personal experience that medico-legal defence firms encourage safe practice of medicine, whereas plaintiff firms and their proposals when examined, do nothing for the safe practice of medicine. Plaintiff law firms are known to be labelled as 'ambulance chasers' and constantly on the lookout for a massive pay day, so to speak.

Within the legal profession and plaintiff law firms there is a discourse, an understanding and assumption that medical practitioners have 'deep pockets'. That is, medical practitioners are in possession of a substantial amount of financial resources that can finance an excess amount in damages, interest and costs for the plaintiff and law firm, if and only if the court enters a judgment and orders in favour of the plaintiff and thus the plaintiff is successful in their suit.

I find such unethical and overzealous aims to be in poor taste, and not in good spirit or approached with good faith and clean hands for the patient, for the medical practitioner or for the court system.

Law firms should note their duty to the court, to the administration of justice and ensure that case management principles are strictly adhered to.

I want all medical practitioners to be aware that no matter what domain of medicine you practice, in the legal world, a guidebook has been compiled to demonstrate the common clinical pitfalls of medical practitioners and discussions on medical litigation (the guidebook is titled as: 'Why Patients

Sue Doctors: Lessons Learned from Medical Malpractice Cases' (2020)).

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 Considerations

The focus on cosmetic practices was heightened even further after [redacted] engaged in unsafe medical practice and the inappropriate use of the TikTok and other social media platforms. Currently, there are far more accredited surgeons, with college Fellowships, engaging in cosmetic practices that are displaying very questionable behaviours and interestingly their questionable behaviours are not being examined under a microscope by the COAG Health Council, the Medical Board of Australia or AHPRA.

It does not matter what domain of medicine you look at, there are some bad and a lot of very capable and good medical practitioners out there. A select amount of cases should not be used to demonise or restrict medical practitioners. This would be akin to the knee jerk reaction displayed through the greyhounds industry ban in New South Wales, which was recently back flipped on, leading to unnecessary law suits for compensation for loss of earnings (whether it be loss of past, current, future or ongoing income).

It is important to note that there are medical practitioners practising cosmetic surgery, who have had investigations, and proposed reprimands, but have reached agreements on these not being notated on AHPRA's public register. Maybe an additional category needs to exist to suggest that an agreement in confidence has been reached and this needs to be published on AHPRA's public register. Why is there a need for secrecy? If this consultation is about being open and honest with the public, then maybe AHPRA and the Medical Board of Australia need to stop engaging in back door deals with certain medical practitioners and state and Commonwealth governments.

However, AHPRA's register of practitioners is generally not a tool patient's use readily, especially if they do not have a health background.

Risk Assessment and Notifiable Actions

- Risk assessment processes need to balance the rights and wellbeing of the medical practitioner to being able to practice safely versus public safety.
- At no point should public safety outweigh the wellbeing of a practitioner if they are a safe practitioner. This would lead to institutional victimisation and create practitioners who practice medico-legal medicine out of fear.
- Practitioners who do not trust the regulatory bodies to handle matters fairly and justly on a case-by-case basis will be more reluctant to make mandatory notifications against other practitioners.
- Also, why does AHPRA and the Medical Board of Australia think it is necessary to form a separate mechanism to manage cosmetic surgery notifications? A notification is a notification and thus all notifications should be managed equally and fairly. Just because a notification relates to a cosmetic surgery, it does not give AHPRA and the Medical Board of Australia the right or authority to use their existing powers arbitrarily and be automatically inclined to assume that that the cosmetic surgery performed by the medical practitioner was performed poorly or not according to their standards or guidelines.
- Again, assess each notification in a reasonable timeframe and fairly and equally.

Changes Proposed

- Medicine does not follow the principles of "the consumer is always right" - the medical industry is NOT similar, at any point, to the retail and hospitality sector, therefore, it is best

not to use this concept in this regard and in medicine. The concept that because a notification is made against any practitioner that they must have engaged in unsafe practice is WRONG.

- Better triaging of complaints. Was this an expected and known risk of the procedure or an actual unsafe practice?
- Understanding of discussions of expectations versus achievable reality.
- Incorporation of more representation. That is, persons who are board members and on the investigation panels need to adequately understand this scope of medicine. Non-representative persons will not understand the practice and complexity of cosmetic surgery. A diverse panel would generally be a good approach and this is lacking at this point.

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

See above.

Advertising Restrictions

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

As a General Practitioner/Cosmetic Physician, I have noted a growing number of unscrupulous activities and advertising practices which I can give examples of. The plastic surgeons have not been named to preserve their confidentiality, for example:

- Dr "so and so's [redacted]" - multiple plastic and reconstructive surgeons.
- Done by "Dr's last name" across a top covering women's breasts.
- General practice of patients sending intimate photographs to a generic online database prior to consults - this is clearly predatory behaviour and there are no guarantees that the clinic can and will be able to keep such sensitive information safe from hacking and leaks.
- The need to book the actual surgical procedure (very expensive procedure) prior to consults.
- Manipulation of Google reviews. That is, patients are persuaded to give an overall positive review of the clinic or patients are persuaded to remove any negative comments about the clinic especially if they give a negative review of an individual plastic and reconstructive surgeon.

The above are examples of conduct and behaviour displayed by multiple plastic and reconstructive specialists/surgeons. However, I am sure the Royal Australasian College of Plastic Surgeons and the Royal Australasian College of Surgeons is well aware of this, or ought to be and as is AHPRA and the Medical Board of Australia.

Apart from the very unprofessional use of TikTok and other social media platforms in the recent times, I am still searching for multiple cosmetic surgeons who also display similar unethical behaviours. It is indeed a difficult find.

The women used are impressionable young women who can and have faced much reputational and psychological harm by the above practices and conduct.

Poor surgical practice, poor ethical practice and a lack of compassion and care is not exclusive to cosmetic surgeons only (a common misconception and assumption). These accredited college surgeons are violating patient confidentiality, trust and safety through their questionable practices, yet we want to target non-surgically accredited cosmetic practitioners. One has to ask if patient

safety is being prioritised in this consultation or is there a more sinister motive/agenda.

The approach needs consistency as the current aims in even attempting to govern cosmetic practice and advertising is rife with double standards and inconsistencies.

For Example:

- The above practices mentioned continue and do so under the radar of the state and Commonwealth governments, AHPRA and the Medical Board of Australia.
- However, Cosmetic Physicians are not able to advertise particular branding of injectables and have to manage before and after photos within strict parameters. Again, why is there a double standard?
- Clearly, the unscrupulous actions mentioned above, by particular accredited and fellow affiliated surgeons, are far more harmful to the public.

7. What should be improved and why and how?

AHPRA's register of practitioners needs to improve. AHPRA's register is a well known entity.

I really would like to know why there are certain plastics and reconstructive surgeons, as well as cosmetic surgeon practitioners out there who have not had their reprimands properly notated. The Freedom of Information Act 1982 (Cth) and the interest of public safety dictates that these should be readily available if requested by a medical practitioner or member of the public that is a consumer of cosmetic surgery procedures.

It is important to note that the entire reason this consultation paper has been commissioned is due to [redacted] without a surgical Fellowship, who engaged in unfortunate, negligent and unsafe medicine, leading to patient harm. Their actions were deplorable.

Major Error of the Medical Regulators

However, it is also important to remember that [redacted] almost over 10 years ago, was found by the [redacted] Court of [redacted] to have engaged in negligent medical practice. I and many other general and surgical practitioners would very much like to know as to how this individual was allowed to continue practising, even though the patient informed the regulatory body (AHPRA) of the outcome of the legal proceedings and the judgment of the court - the Medical Board of Australia was aware of the judgement (see the [redacted]). Any ongoing bad practice from that instance by that practitioner could have been prevented, had the regulatory body (AHPRA) and the Medical Board of Australia abided by a court judgement. Patient harm occurred on a shared liability basis thereafter.

The national regulatory body (AHPRA) and the Medical Board of Australia ought to have known better. That ought to know argument is paramount to the regulators prosecutorial efforts. AHPRA and the Medical Board of Australia needed to have enforced that onto itself. At this point patient safety was not only compromised by an unsafe cosmetic practitioner, but the regulatory body (AHPRA) and the Medical Board of Australia as well, in not respecting a court judgement. In general principle, defying a court judgement lends the individual to face certain ramifications. This ought to have happened. The defiance of not adhering to the court's judgment leads to further public harm by this medical practitioner. The defiance of this judgement and allowing the practitioner to continue to practice without reprimands was a far greater risk to public safety.

Please NOTE: AHPRA and the Medical Board of Australia are bound by a court's judgment. These regulatory bodies are not above the law and the fact that these two bodies presumed that it was ok to ignore a court's judgment is profoundly disgusting and disrespectful to the successful plaintiff and the presiding judicial officer in the above case. Do not disrespect the sanctity and independence of the legal/court system.

AHPRA and the Medical Board of Australia presume that the law and court judgments do not apply to them. This attitude needs to be amended.

Imbalance in Duty of Care to Practitioners

AHPRA's recent efforts now to prioritise public safety, hinges on shifting the balance of care, where the public view and safety would be prioritised above the practitioner's wellbeing and health.

AHPRA should not just simply abide by and follow a policy direction put to them by the COAG Health Council. That is, in 2019 the COAG Health Council enforced a policy direction, a direction which must be followed by AHPRA and the National Boards where public protection is paramount and public protection must be prioritised when administering the National Scheme Policy Direction 2019-2020. Hence, the COAG Health Council endorses that public safety and protection is AHPRA and the National Boards' first duty and this outweighs any potential impacts that may affect the needs of the practitioner when considering sanctions.

It is important to note that this is a policy direction enforced by the COAG Health Council and it is just that a policy and it is not explicitly stated in law in the Health Practitioner Regulation National Law (NSW) s 3(3)(c). That is, just because this specific section does not give rise to the paramount requirement to enforce patient and community safety without even considering the wellbeing and health of the practitioner, the COAG Health Council has twisted this specific section in the legislation to suit the needs of their agenda driven crusade against health practitioners. It is very clear the COAG Health Council did a very poor job at interpreting this specific section in the National Law. All this policy directive has done is increase frivolous and vexatious claims at the detriment of the health and wellbeing of practitioners.

I urge that all medical practitioners examine this policy directive found on AHPRA's website and analyse the background of the Chair of the COAG Health Council and listed Chairs of each health board. It is blatantly obvious that a politician chairing this Council and the academic medical practitioners, who do not practise medicine within the field, cannot possibly understand the first-hand hardships and obstacles medical practitioners face when practising medicine to their best ability with their own health and wellbeing, the community and the patient being equally at the forefront.

Significant Implications

Firstly, an overzealous and misguided investigative body leads again to the practice of cautious medico-legal medicine, which hinders practitioners from practising proper medicine and instils a lack of trust amongst practitioners and against the regulatory body (AHPRA) and the Medical Board of Australia.

The entity which is the biggest risk to public safety, is one which does not harbour a safe working relationship with its medical practitioners, does not offer the support medical practitioners deserve. A safe and supported medical practitioner is a good public advocate for the practice of medicine.

It is important to note that medical practitioners pay the regulatory body (AHPRA) a substantial yearly registration fee. The body indirectly has a duty of care to these practitioners and ought to uphold its directorial duties, as dictated by ASICs guidelines and the Corporations Act 2001 (Cth) Part 2D.1 - Duties and Powers. AHPRA should essentially be advocating for medical practitioners, especially in terms of their best interests and health and wellbeing.

For example, the Law Society of NSW, during the height and initial phase of the COVID-19 pandemic, supported their members by issuing a message of support through the easing of financial constraints. That is, the Law Society of NSW acknowledged that the COVID-19 pandemic was having a critical impact on their members' livelihoods and health and wellbeing. To ensure that their members knew that they had the support of their regulatory body, the Law Society of NSW took affirmative actions and reduced the membership fees for practicing solicitors for the 2020-2021 practising year. A usual annual $410 Law Society membership fee was reduced to $10 (plus GST). The reason for this was that the Law Society of NSW believed that during a time where there was financial constraints on a member's personal budget, the $400 saving was best to be directed by the member in an area that is in more need within the member's personal life.

The leadership demonstrated by the Law Society of NSW and the support they provided to their members needs to be acknowledged and highly commended. This is the leadership and empathy that should be demonstrated by the Medical Board of Australia and AHPRA as a whole and by its CEO.

Medical practitioners are constantly reiterating the need for such leadership and advocacy for their industry.

Summation

Nevertheless, shifting the burden of proof in medical investigations while jeopardising medical practitioner health is bad for public safety, as it does not follow procedural fairness, it does not follow the rules of Administrative Law, it does not follow the rules of the court and it does not belong in a democratic society such as Australia.

AHPRA, the HCCC and the Medical Board of Australia need to closely ensure that during medical investigations of complaints lodged against medical practitioners, whether the complaint is frivolous/vexatious or legitimate concerns have been raised, due process is afforded to the medical practitioner, the objective standard of 'the practitioner ought to have know' be lowered in its threshold and application, that is, a subjective case-by-case approach should apply and mostly importantly a national guideline on the medical complaints handling process should be established - similar to the guideline developed by each state's Ombudsman in relation to how Australian tertiary institutions should and must handle complaints by staff and students.

There needs to be a clear definition of what constitutes a vexatious and/or frivolous complaint.

The current definition of what constitutes professional misconduct, under the Health Practitioner Regulation National Law (NSW) s 139E, is very vague and convoluted. This definition needs to be clear and concise. Also, under the National Law (NSW) s 5 (Definitions) professional misconduct is not specifically defined and instead it just states 'this definition is not applicable to New South Wales'. However, what definition is being referred to is unknown. Please provide clarity.

- Professional misconduct defined in the National Law (NSW) s 139E and in the definitions section under the National Law (NSW) s 5 should contain the definition of professional misconduct and it should be the same and in uniformity. Why is there a discrepancy?
- This discrepancy means that the definition of professional misconduct in the National Law of each state and territory can be subject to abuse by AHPRA, the HCCC and the Medical Board of Australia during the complaints handling processes. This vagueness should be addressed.
- In addition, further clarification and guidance needs to be given on what is safe practice that medical practitioners are suppose to engage in at all times. But it is important to remember safe practice is subjective and should be assessed on a case-by-case basis.

Shall we not forget the sacrifices all medical practitioners made during the last 18-24 months during the COVID-19 pandemic. General practitioners, Physicians, Surgeons, Nurses, Ambulance Officers and other allied health staff inclusive. These heroes upheld the nation as COVID-19 ravaged the healthcare system and in return these heroes were handed a pay freeze by the NSW Government, which was supported by the Industrial Relations Commission, instead.

The regulatory body and the parliament ought to ensure that the health, safety and wellbeing of these medical practitioners is prioritised and that there is due processes, procedural fairness and care given in the event of complaints.

Of course, in light of bad, unsafe or unprofessional practice, the practitioner deserves to be reprimanded. However, it is imperative to understand that the patient or the public is not always right, not always honest and not always across the guidelines in medicine or specifics of a case.

Nonetheless, the following is a suggestion that can assist consumers and medical practitioners in deciding what the appropriate referrals to cosmetic surgeons could be by listing the following on AHPRA's register of practitioners:

- Job Title - aka Cosmetic Physician.
- Level of Surgical Training i.e. - RACS, RACPS or not associated with a College.
- Include level of cosmetic physician/surgery training experience aka. Diplomas.

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 already heavily regulate advertising of cosmetic surgery/procedures. But advertising is a right that any practitioner or service giver holds.

Again, this is a concept which is classed under the idea of free trade and commerce. Therefore, a specific regulatory response is NOT required. Leave the cosmetic industry as is - maintain the status quo.

Interference in trade and commerce will no doubt bring to the forefront the idea of compensation, with the recent overturning of the greyhounds industry ban in New South Wales being a perfect example.

Absolutely, the relationship between corporatisation is more common in cosmetic surgery versus other surgical fields. Personal appearance and body care is a multimillion dollar industry and involves topical skin care, lasers, photodynamic therapies and chemicals peels and abrasions which can pose serious risks just like any other surgical speciality including cosmetic surgery.

The cosmetic surgery industry is quite different to other surgical fields in that respect. If the Australasian College of Cosmetic Surgery and Medicine is not accepted as an accredited college and field of medicine purely because of the misconception that it does not treat medical disease, then it cannot be governed under the same principles of other surgical fields.

Hence, it falls under the governance of trade and consumer laws as with any other product and service driven industry. Therefore, for business viability and meeting client demands, advertising, marketing and business management all become core underpinnings.

If the medical regulators want governance over the cosmetic surgery industry, then rightfully accept the Australasian College of Cosmetic Surgery and Medicine as an accredited college treating self-esteem, mental health, body deformities and some forms of dysmorphia, which are very real diseases. Hence, then the industry can fall under appropriate marketing and social media regulations as any other domain of surgery.

9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?

The idea of advertising and risk needs to be addressed. Are the results promised and the before and after depictions accurate and original without manipulation is the question.

The risk borne via promotion and advertisement is the same for cosmetic surgery, as it is for other industries marketing skin rejuvenation and skin care options including special topical agents, laser, IPL, photodynamic therapies, peels, abrasions, etc.

Whether a cosmetic surgeon without a surgical college affiliation is involved, or whether an accredited surgical college surgeon is involved in cosmetic surgery, the risk from promotion and advertisement remains the same.

However, it is the competition driven market from corporatisation which also helps to minimise harms for patients, as the variety of choices available can aid the consumer in deciding what best suits them, and gives them the opportunity to avoid a variety of clinically, professionally or ethically poor practitioners.

Limiting the scope of practice for cosmetic practitioners, would prevent competition, choice and the consumer's ability to have the right to appropriate alternatives to suit their budget and circumstance. Lack of competition is the core driver for patients travelling overseas for poor levels of cosmetic surgical procedures from my experience.

If the sole purpose of limiting the scope of practice for cosmetic practitioners is purely for patient safety, then the loss of competition should be accompanied by consumer protections, guarantees and additional consumer rights in cosmetic surgery/procedures like any other industry such as a returns and refund policy and a predatory pricing guideline. That is of course, if patient safety and care is the only motive here.

Otherwise, limiting the title, hence limiting the competition does more harm than good not only for consumers, but to the industry and to very capable medical practitioners. AHPRA, the Medical Board of Australia and governments have a duty to and ought to take care of hard working medical

practitioners, their wellbeing and livelihoods matter as well. That is what the public expects from my research. Anything else is simply out of touch from public expectations.

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

N/A.

Title Protection and Endorsement for Approved Areas of Practice

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

This is a good idea in essence, however, more information needs to be available about who gives the endorsement.

It is important to remember that cosmetic surgery/procedures need appropriate pre-procedure medical and mental health assessments as well as appropriate after care considerations, monitoring of health, mental health and analgesia control.

Currently, general practitioners do not play a role in the monitoring process or referrals processes, unless the cosmetic practitioner is a Fellow of the RACGP. The involvement of a general practitioner might be an added consideration for the safety of the public.

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, see above.

Skills and college affiliations of the practitioner should be highlighted in the AHPRA's register of practitioner's database. We already have a platform, there is no excuse to not to use it to supply such information as I have discussed previously. For example:

- Title of practitioner (aka plastic surgeon, cosmetic physic, cosmetic surgeon).
- College affiliation.
- Cosmetic surgery experience/training.

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

See above.

Address the requirement for an accredited college that delivers training and a Fellowship in cosmetic surgery/procedures only.

The Australian College of Cosmetic Surgery and Medicine already exists and has the scope to deliver a program.

The only barrier has been narrow minded and outdated thinking about what constitutes real disease and treatment, A cosmetic college has not been accredited because the thought has been that cosmetic surgery/procedures do not treat diseases. This is not a way of thinking that has a place in society today. Cosmetic surgery/procedure treat low self-esteem, mood disorders, some forms of body dysmorphia and very real physical deformities, which are all very real diseases that are assessed on a daily basis by general practitioners.

14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

The idea of protecting titles is ludicrous and makes a lot of medical practitioners wonder if the drive to restrict cosmetic practice is actually driven by public safety as a core motivator, or is it driven solely by the ideas of title protection and profitability. This idea of title protection has been already discussed in another consultation paper and submission process titled 'use of the title surgeon by medical practitioners', which was commissioned by the Victorian Department of Health.

But let's discuss reports and notifications of potential harm. In a recent submission to the Senate - Community Affairs References Committee regarding the proposal for national regulatory change for medical practitioners in the cosmetic industry, AHPRA has admitted that of the notifications for poor standards of practice and outcome from cosmetic surgery/procedures, 52 percent of those complained against were accredited college based surgeons (Senate - Community Affairs References Committee Report (April 2022), p 26, paragraph 2.79 and AHPRA answers to questions on notice, 22 September 2021, pp.5-6).

In the Senate - Community Affairs References Committee Report (April 2022), p 26, paragraph 2.79, it was specifically stated that: "over a three year period (1 July 2018 to 30 June 2021), AHPRA received 16,226 notifications about medical practitioners, of which AHPRA identified 313 notifications relating to 183 practitioners that concerned 'botched surgeries' or a surgical outcome with a complication or resulting in injury. Of those notifications that specifically concerned cosmetic surgery/procedures, 52 percent related to medical practitioners who are registered in a surgical specialty (mostly specialist plastic surgeons)" - AHPRA answers to questions on notice, 22 September 2021, pp.5-6.

Therefore, the stakeholders pushing for limits to the use of the title of cosmetic surgeon based on patient safety reasoning need to have a close look at the report given to the Senate - Community Affairs References Committee by AHPRA. Actual accredited specialist surgeons make up for the majority of practitioners complained against by patients.

<u>Please Note</u>

A title of surgeon or Doctor is not exclusive and used by many other professions. It is not a protected titled and nor should it be due to the vast amounts of professionals that rely on the use such terminology for professional practice.

Hence, it is an order of legality, intellectual property and not a simple matter.

Associate Professor Dr Michael Eburn (ANU College of Law) states that the term Doctor is honorific and the title is governed by convention alone (https://australianemergencylaw.com/2018/02/14/is-doctor-a-protected-title/). Therefore, in a manner of legal terms, it is an open title. The surgeon or Doctor title is granted by an institution

Now this point is important: You cannot restrict the use of the surgeons title from someone who completed a Bachelor of Medicine/Bachelor of Surgery (MBBS) medical program. By the very definition, that title is educationally earned and protected. Just as the title of Doctor is earned and protected whether it be a Doctor of Medicine or through a PhD in other areas of study.

Again, the surgeon title is not exclusive to trained surgeons. It is educationally achieved through the MBBS program and a descriptor of one's job activities/role.

Surgical colleges have no claim to the title surgeon similar to medical professionals not having a claim to the title of Doctor. Yes there may be slight misconceptions in what the titles entail, but the individual with the title ought to explain the differences in both titles. But there is no jurisdictional grounds to limit their use as limiting the use of one means the potential to limiting the use of the other.

There is no educational, professional or social dominion over the Doctor or surgeon title.

Cooperation with Other Regulators

15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?

The biggest barrier that myself and my colleagues have noted, and as unfortunate as it is, the board members of AHPRA obtained under the Freedom of Information Act 1982 (Cth), and the board members of the Medical Board of Australia, COAG Health Council show a distinct lack of diversity and experience within the cosmetic surgery/procedure industry.

This distinct lack of diversity has lead to these bodies not being in touch with current expectations of the public or of medical practitioners.

Medical practitioners have been calling out for a fair balanced system that also protects their health and wellbeing, along with weeding out unsafe practitioners not just in cosmetic surgery, but in all scopes of medicine.

16. If yes, what are the barriers, and what could be improved?

<u>Barriers</u>

- Academic non-practising medical professionals on the COAG Health Council, the Medical Board of Australia and AHPRA.
- Non-medical individuals/public servants who could not possible understand the difficulties of what happens in actual practice.
- An inherent lack of a cultural diversity on these boards.

Therefore, the decisions are not in line and not in touch with modern day Australia. The COAG Health Council and AHPRA, along with the Medical Board of Australia have just as much responsibility in protecting good practitioners as they do in protecting the public.

Let us not forgot what all medical practitioners did for us during the COVID-19 pandemic period and the hours worked and sacrifices made. The duty to protect practitioners from frivolous, inaccurate, vexatious and overzealous proceedings ought to exist, especially when a body collects a substantial yearly subscription fee/registration fee from its practitioners. This is what the public expects from the research I have conducted and that is what the body ought to do.

It is highly recommended that a more inclusive and diverse board be incorporated in these bodies mentioned above in order to reach a more accurate and fairer outcome for all. It is what the public and medical practitioners expect and deserve.

17. Do roles and responsibilities require clarification?

Of course, the roles and responsibilities need clarification.

AHPRA is bound and limited by the National law in each respective state and territory, and their duties ought to be to protect medical practitioners just as much as it is to protect the public and reprimand harmful practitioners.

The complaints handling roles and responsibilities of the HCCC, AHPRA and the Medical Board of Australia needs further clarification.

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

N/A.

Facilitating Mandatory and Voluntary Notifications

19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?

Absolutely.

The guidelines for mandatory reporting are perfectly clear and in my opinion is quite reasonable.

However, the issue is that these guidelines are often used vindictively by members of the public and other medical practitioners, for no other reasons than to cause harm and distress to another practitioner.

Of course there are obvious cases more often than not, which are accurately reported to the medical authorities to reprimand or de-register harmful practitioners.

The issue is that in assessing a complaint, a "one size fits all" approach is utilised, which more often than not treats minor infringements in the same procedural nature as a very serious infringement, and if the notification is based on frivolous or vexatious grounds, the current procedures of investigation further victimise the practitioner.

If a medical practitioner is wrongly complained against based on frivolous or vexatious grounds and is victimised by AHPRA, HCCC or the Medical Board of Australia, what recourse does this practitioner have? Is the practitioner afforded compensation? But the question remains, how do these regulatory bodies and medical investigative bodies restore a medical practitioner's reputation? Reputational harm cannot be easily negated or fixed once the damage has occurred.

20. Are there things that prevent health practitioners from making notifications? If so, what?

The important barriers preventing practitioners from making notifications are the following:

- What is the impact on the practitioner for making the notification? If the notification is not vexatious, the practitioner should be protected at all costs.
- Lack of trust in the regulatory bodies in treating the practitioner's colleagues fairly and justly. Sometimes a practitioner may report another practitioner on say cognitive decline or other impairments, however, the procedures of investigations again for these follow the same rules as investigating a practitioner engaging in negligent conduct or sexual misconduct.
- The practitioners own negative experience with the regulatory authorities.
- The view that AHPRA ought to be protecting the health and wellbeing of practitioners as well but no longer does. A yearly subscription fee/registration fee is not just for administrative purposes, or the considerable charge/registration fee is challengeable as being unreasonable and excessive under Sch 2 of the Competition and Consumer Act 2010 (Cth) - known as the Australian Consumer Law. The position of that fee is for the practitioners right to practice and with it AHPRA inherits a certain level of duty of care to its practitioners, given they list their names on a public register.
- AHPRA and the Medical Board of Australia should be aware that they are advocates for medical practitioners and they should then advocate for their practitioners and in their best interests. However, advocacy is not being demonstrated at the moment and has not been demonstrated for some time. It is questionable advocacy, if you would call it 'advocacy'.

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

As stated, the following would aid in improving reporting in the cosmetic surgery sector:

- Understanding that medicine cannot be governed by a "consumer is always right" approach. There is evidence based practice that needs to be adhered to.
- A drive to ensure the protection of good practitioners, their livelihoods, health and well being by the regulatory bodies, if they practice safely and well. This would instil a level of

trust in the regulatory bodies again.

- A revamp or restructure of the board of directors involved in regulatory bodies to be more reflective of a modern Australian society, which understands active issues within the practice of medicine.
- Listing of the cosmetic practitioners credentials on the public register: title, Fellowships, level of training/education, procedure they specialise in.
- Potentially involving general practitioners in care so a secondary medical opinion based on assessments can determine if there is a notifiable issue present.

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?

Yes, the current guidelines on what constitutes informed consent is very clear.

It is also important to remember that all surgeries, cosmetic or not carry certain risks. The development of a discussed and understood risk or complication is not a notifiable issue, unless there is evidence of significantly poor practice in pre-surgical, within surgery and post surgical care.

24. If not, what improvements could be made?

N/A.

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

Dissatisfaction should never be a reason to make a complaint to medical authorities. Dissatisfaction does not imply that a practitioner has practised in an unsafe or unethical manner.

The cosmetic industry is such that realities and expectations must be managed. The discussions of realities versus expectations should definitely occur in the consult and be thoroughly documented.

It is important to remember dissatisfaction exists in all scopes of medicine but surgeons, physicians and general practitioners alike do not routinely discus complaints avenues with patients.

Now, does the current medical authorities and regulatory bodies instruct patients to complain if they are dissatisfied with a medical practitioner's medical care? Doing so would form a very dangerous precedent for overzealous, vexatious, frivolous and downright silly complaints to come through, increasing the burden on the regulators and hindering their ability to investigate actual appropriate complaints in a timely manner.

However, it is not the role of the practitioner or within their scope to be giving medico-legal advice on complaints. That is quite inappropriate and gives rise to potential advice they are not equipped to give.

Again, complaints based on dissatisfaction rather than actual unsafe or unethical practice seems to be an agenda rising from a consumer advocacy based approach and their satisfaction. Medicine

cannot be governed from a “consumer knows best” approach.

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?

See above responses for proposed changes.

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

See above for proposed changes.

Also, if consumer choice is the aim, restricting cosmetic surgery practice to surgical fellows only horribly impairs consumer choice.

If consumer choice is at the forefront, then if restrictions are made, pricing regulation, appropriate refund policies as per Australian Consumer Law needs to exist. Enforcement and compliance monitoring of these consumer rights and guarantees also needs to exist.

Monopolisation is a dangerous trend which will limit access to these cosmetic services to certain consumers and offer minimal choice for consumers to cater their care to their own budget and circumstance.

The availability of non-surgical college affiliated practitioners offers viable alternatives with the majority of practitioners being quite safe.

Competition creates a better market for the consumer and helps advocate for public safety as well. Australia is a free market and AHPRA, the COAG Health Council and the Medical Board of Australia need to stop interfering with normal economic and consumer affairs.

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

This is a matter for the regulatory bodies to ascertain. If the consumers do not understand the complaints process, it is because the regulatory bodies have not presented their mission statement and objectives appropriately.

As stated, a more modern, inclusive and diverse board would be able to better resonate with consumers as well as practitioners to create a safer cosmetic industry

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

See above.

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.

The Senate - Community Affairs References Committee in regards to the review/hearing into the 'Administration of Registration and Notifications by the AHPRA and Related Entities under the National Law' was predominately about the handling of complaints/notifications by AHPRA and if the current framework was effective in handling complaints/notifications against practitioners. Unfortunately, this hearing was essentially hijacked by a non-issue of whether certain medical practitioners can use the surgeon title.

It is evident that certain [redacted] had ulterior motivations/agendas. That is, such [redacted] engaged in an abuse of parliamentary process in order to prevent and ultimately stop other medical practitioners from engaging in cosmetic procedures and surgeries, all because there is too much competition and their profit margins are currently affected. These [redacted] do not have patient safety at the forefront, rather profits and the monopolisation of the cosmetic industry is their main aim and goal.

Keep in mind there are other areas of concern in medicine that need immediate attention and have been neglected, for example:

- The ongoing institutional bully of interns, residents, registrars and practitioners who are Fellows of medical colleges.
- The issue of excessive hours of work, if safe work practices are being adhered to by hospitals, AHPRA, clinics and other relevant bodies that schedule mandatory hours of work for medical practitioners.
- The correct remuneration and allocation of pay for all hours worked including overtime hours worked, hours completed on public holidays and on weekends.

<u>Important Considerations: General</u>

- It is very important to note that there are too many numerous avenues that a consumer can utilise to submit a complaint/notification against a practitioner. That is, a consumer can submit a complaint to respective health and medical bodies, a complaint/notification can be submitted to AHPRA, the Medical Council of NSW, Health Consumers NSW, the relevant Commonwealth, state or territory Ombudsman (e.g. the National Health Practitioner Ombudsman), the HCCC and the Medical Board of Australia. It is evident that only one body should initially receive the complaint/notification and assess it, and if necessary refer that matter onto the next relevant body in a timely and reasonable manner.
- All complaints/notifications need to be resolved in a timely manner according to Administrative Law. A statutory limit of only 60 days should be allowed, this includes the day when the complaint/notification is received by the investigative body. If there are any delays, a statement of reasons should be provided to both parties, which outlines the reasons for the delay and in the interim, written progress updates should be provided to both parties. Clear sanctions should exist for investigative bodies and persons who exceed the allowable 60 days for investigation, especially if a timely resolution has not been determined and communicated to both parties. Silence on such matters is not golden and should not be tolerated. Silence = incompetence.
- The protection and safety of the public is NOT paramount during the complaints handling process. Due regard needs to be given to the health and wellbeing of practitioners and their reputation.
- Please note that Mr Andrew Brown, the independent reviewer appointed by AHPRA, only just completed his tenure as the Health Ombudsman of Queensland early this year, 2022. If a reviewer is to be truly independent then surely the reviewer cannot be appointed by AHPRA themselves. An example of a truly independent reviewer is and could have been the current and newly appointed ACCC Chair Ms Gina Cass-Gottlieb.

Furthermore, the expert panel/advisory group that has been appointed to work alongside Mr Brown does not include any individuals that have experience within the practice of medicine or the practice of cosmetic surgery and procedures. This expert panel is heavily aligned with the interests of the consumer and this is problematic because this can and will jeopardise the interests of medical practitioners, especially those that practice cosmetic surgery. There are legitimate issues and concerns that are raised in this submission that may get neglected due to this shortfall in relevant expertise.

- There are two submissions in regards to the use of the surgeon title, one is commissioned by AHPRA and the other is commissioned by the Victorian Department of Health. Why is there a double up on submissions and consultation processes on the same issue? This is ineffective and clearly different outcomes will occur, leading to more confusion about the issue.
- The fact that this consultation process and submission was only allocated approximately three months for review is quite poor and not enough time has been allocated especially considering that medical practitioners are still dealing with the after effects of the COVID-19 pandemic.
- The questions contained in this submission are structured as leading questions in that the questions are seeking a pre-determined answer that is bias and subjective.
- The Medical Board of Australia's relevant codes, guidelines and policies should operate cohesively with the National Law of each state and territory. That is, there should be no conflict or inconsistencies with the National Law and if the National Law is silent on the issue, then there is no need to fill the silence with restrictive and arbitrary policy in order to achieve a specific agenda.
- A separate expert medical panel consisting of medical practitioners and/or maybe other health practitioners (if applicable) needs to be established, which exclusively deals with and investigates corruption, maladministration and administrative negligence within AHPRA, the Medical Board of Australia and the HCCC in regards to the medical complaints/notifications handling process. That is, this body should exist solely in the interest of practitioners who have had complaints lodged against them and such practitioners are subject to complaints where there are questions of unreasonable and undue delays in finding a decision by the relevant investigative body. Or rules of due process and procedural fairness are not being respected, there are issues of conflict interest and other issues within the complaints handling process that maybe an abuse of power/process, principles of case management are not being adhered to, etc.
- A vast majority of cosmetic surgery consumers are women of all ages. This consumer group has a very solid grasp and understanding of the differences between a cosmetic surgeon and a plastic and reconstructive surgeon. They know the difference in qualifications and experience. To assume that consumers are not fully aware of such differences is ignorant and ill-founded. This consumer group knows exactly what areas of concern they would like to address and the type of medical practitioner that specialises in cosmetic surgery that is best suited to them.

<u>Important Considerations: At Law</u>

Applicable Criminal Legislation

- It is quite alarmingly to note that this consultation paper commissioned by AHPRA and the Medical Board of Australia presumes that the Crimes Act 1900 (NSW), and other similar criminal legislation in other states and territories, would be deployed in order to hold medical practitioners criminally accountable for supposed 'negligent' cosmetic surgery procedures that the patient or AHPRA and the Medical Board of Australia may not be satisfied with.

  It needs to be made clear, if the Crimes Act 1900 (NSW) is to be utilised against such medical practitioners, this would mean that the matter has been referred to the police for investigation and AHPRA and the Medical Board of Australia are no longer investigating, period. Furthermore, the act or omission would have to be so grave in order to warrant it as a criminal offence and thus it must be a matter that the police and DPP consider a serious breach of the criminal law and thus there must be serious harm committed against the community as a whole.

This consultation paper fails to note which criminal offence maybe applicable, that is, is the negligent cosmetic surgery procedure a criminal offence because it caused actual bodily harm, grievous bodily harm or since the consultation paper referred to 'criminal charges for negligent acts or omissions', is the offence involuntary manslaughter by criminal negligence? If it is, just so AHPRA and the Medical Board of Australia is aware, this particular form of manslaughter does not require mens rea, intention or the requisite state of mind to be established. The medical practitioner would originally have to be charged with murder and thus charge would later be downgraded to manslaughter by criminal negligence.

Criminal negligence within the scope of the Crimes Act 1900 (NSW) means that the acts and omissions of the accused accelerated the death of the victim. Could AHPRA and the Medical Board of Australia please provide a recent case law example where a cosmetic surgery procedure performed by a medical practitioner caused the intentional death of a patient?

Also just so AHPRA and the Medical Board of Australia are aware, the Criminal Code 1995 (Cth) is definitely not applicable in regards to cosmetic surgery performed by medical practitioners, for obvious reasons.

There would be no benefit achieved if a medical practitioner is charged with a criminal offence relating to criminal negligence in the performance of cosmetic surgery. In fact, this just means there would be one less Doctor to ease the public hospital burden.

I am still not sure why the criminal law would be applicable and if any current criminal offences would even apply. Trying to apply the criminal legislation is overreaching and unnecessary. Please do not unnecessarily waste the police's and DPP's time and the court's time - they are already inundated with an overflow of excessive cases within the legal system.

Negligence, Damages (Compensation) and Applicable Civil Liability Legislation

- The key issue in cases of medical negligence is the breach of duty of care. Yes, reasonable foreseeability of harm through an objective standard is assessed, however, the main issue usually considered by courts in the breach of duty of care is causation, especially in regards to damages.
- Negligence and damages is predominately governed by case law, which provides clear guidance.
- The amount of damages awarded to plaintiffs in medical negligence suits is always capped by courts and strictly assessed. Just because respective civil liability legislation exists in each state and territory does not mean that damages is always easily afforded to plaintiffs.
- How courts calculate damages in each state and territory is always constantly evolving, as is the respective civil liability legislation.
- Damages are always calculated differently depending on the type of medical negligence issue raised. Sometimes the court may apply a 25 percent reduction on the total original damages amount awarded to the plaintiff on the basis that it is excessive and no one person's annual income would be able to account for it, let alone pay for such damages.
- The calculation of damages is a complicated formulation, many factors and issues are considered before a specific amount is reached.
- Medical litigation is costly, time consuming and involves a lot of emotion - it is not for the faint hearted.

Regardless, given prior evidence, there is nothing to suggest that the regulatory medical bodies would take any court judgments seriously while respecting the judgment and the court.

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 H PREVEDOROS
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. IT IS ESSENTIALLY AN UNREGULATED INDUSTRY WHERE PRACTITIONERS ATTEMPT TO ESCAPE THE INCOME RESTRICTIONS OF THE MEDICARE SCHEDULE. THEY UNDERTAKE PROCEDURES WITH INSUFFICIENT TRAINING AND PROMOTE THEMSELVES WITH GLOSSY WEB PAGES AND ADVERTISING. IT HAS BECOME THE PROCEDURAL INCOME ARM OF GENERAL PRACTICE.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
PROPER TRAINING PROGRAMS SIMILAR TO OTHER SPECIALTY TRAINING PROGRAMS, REGULATED BY COLLEGE OF SURGEONS. SURGEONS NEED SURGICAL TRAINING.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
COSMETIC SURGERY NEEDS TO BE PERFORMED BY PRACTITIONER WITH PROPER SURGICAL TRAINING, IN A PROPERLY ACCREDITED FACILITY WHERE IT IS ACCREDITED FOR ANAESTHESIA EVEN THOUGH ONLY "SEDATION" MAY BE GIVEN. THE DISTINCTION BETWEEN SEDATION AND ANAESTHESIA IS NOT ALWAYS CLEARLY DELINIATED

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?
NOTIFICATION SSHOULD BE REVIEWED BY PROPERLY ACCREDITED SURGEONS AND ANAESTHETISTS, TOGETHER WITH A REVIEW OF THE FACILITY IN WHICH PROCEDURES ARE PERFORMED.
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?
NO. DECLARATIONS OF QUALIFICATION ON ALL ADVERTISING SHOULD BE MANDATORY IN ACCORDANCE WITH A PRESCRIBED FORMAT AND CLEARLY DISPLAYED TO AVOID PATIENTS BEING MISLEAD AS TO THE EXPERIENCE QUALIFICATION AND EXPERTISE OF THE PRACTITIONER.
7. What should be improved and why and how?
AS ABOVE
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
AS AN AREA CONCERN THE GUIDELINES SHOULD BE MORE STRINGENT AND ACTIVELY AUDITED AND ENFORCED
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?
DEFINITELY, AS IT GIVES PRACTITIONER TO THE OPPRTUNITY TO ENGAGE IT CONSULTANTS AND "INFLUENCERS" THAT ARE HIGHLY SKILLED AT DISTORTING THE REALITY OF THE REPUTABILITY OF A FACILITY THROUGH SEARCH PRIORTY MANIPULATION, AND MANIPULATION OF THE REVIEWS PROCESS. THIS IS EVERTHING THAT MEDICINE SHOULD NOT BE.
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)?
It would be an essential step.

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?
Formal surgical training for anything beyond injectables. These people do a weekend course or enter a practice on a “see one do one teach one” basis of on the job training
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.

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?
Well if they do it is not enforced because the patients are being mislead.
24. If not, what improvements could be made?
Rules governing truth in advertising, so that true declarations as to who the practitioner is whether they are an appropriate practitioner to be providing the care and advice sought
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?
NO.

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?
HAVE MORE ABOUT THE PRACTITIONER AVAILABLE TO THE PUBLIC. WHRE TRAINED, WHAT IN, WHAT QUALIFICATIONS. WHAT RESTRICTIONS. ETC.
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?
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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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	Dr Antony Prochazka MBBS (Melb) FACCSM (Med) FCPCA
Organisation (if applicable)	
Email address	[redacted]

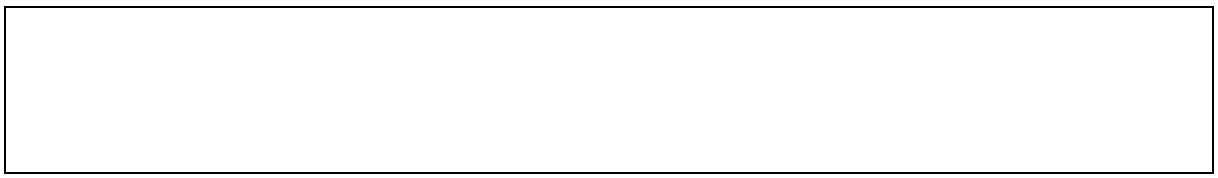
Your responses to the consultation questions

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?
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.

From: George Quittner
To: Cosmetic Surgery Review
Cc: [redacted]

Subject: INDEPENDENT REVIEW ON COSMETIC SURGERY
Date: Wednesday, 9 March 2022 6:44:44 AM

THE ENTHUSIASTIC YOUNG DOCTOR HAS STUDIED cardiology, neurology, paediatrics, gynaecology, dermatology etc etc.
She has a good grasp of renal and liver function. Pharmacology. Mental health interventions.
She is ready to work in the most interesting and challenging job – GENERAL PRACTICE.

Within a year or two, she is disillusioned, burned out, frustrated and disappointed…. SO
SHE THROWS ALL THAT TRAINING DOWN THE TOILET and chooses instead to do :

"COSMETIC MEDICINE" most of which is a waste of time at best and harmful at worst.

WHY?

"WHY WHY WHY "YOU ASK?

The answer is one ugly word:

"MEDICARE"

Medicare has destroyed general practice and deprived the entire Australian community of decent health care. Despite this, successive governments keep trying to "fix" Medicare.
They are polishing the gun which has killed general practice … and produced the cosmetic medical circus.
The sooner someone in authority tells the truth about the Emperor's new clothes and Medicare, the sooner it can be scrapped*.
Maybe then doctors will be attracted to do the job they were trained for.

*There are better ways to look after poor people. Feel free to ask me.

Have your say

Independent review of the regulation of **health practitioners in cosmetic surgery**

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 Maria Rachinskaya, MABS
Organisation (if applicable)	Medical Fellow of ACCSM
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. **Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?**
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. MR
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. MR
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. MR

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. MR
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. MR
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. MR

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

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.

MR

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	Professor Ajay Rane
Organisation (if applicable)	James Cook University.
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?
Partially. While defining the boundaries of cosmetic medicine the term 'improving patients self-esteem' remains ambiguous and my concern is the potential for exploitation based on this. The ability of a practitioner to exploit patient vulnerabilities for financial or other gain needs to be stopped
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
The process of patient selection and indication for procedures needs to be more regimented to stop this slippery slope. Before any vaginal plastic surgery is performed surgeons should have to show evidence of psychological counselling, take photos before and after and have a detailed follow up plan. Consideration should be made for a financial cap on cosmetic surgery.
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
Specific examples that are beyond the realm of cosmetic medicine like 'designer vaginas' should be highlighted as problematic.

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?
Yes
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?
Yes
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
Yes, the advent of social media with its targeted sponsorships seems to bypass the traditional advertising paradigm and the stringent regulations around it.
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)?

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?
Current plus reskilling courses
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
Our concern is mainly genital cosmetic procedures including laser devices and its unregulated application throughout Australia by medical and NON medical practitioners There is no education or warning about these devices to the consumers

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.
Cosmetic 'surgeries' should have to undergo annual accreditation like other specialist bodies and have specific AHSA systems in place.

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?
○ Extensive public education on the matter starting at a school level – pressure to 'conform' and image issues. This should be part of the guideline
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.