From: Carla Ghisla
To: Cosmetic Surgery Review
Date: Tuesday, 8 March 2022 5:42:52 PM

Anyone who calls themself a surgeon should be a fellow of The Royal Australasian College of Surgeons. Anything else dupes the patient and cheapens the qualification.

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	Maryam Gholipour
Organisation (if applicable)	[redacted]
Email address	[redacted]

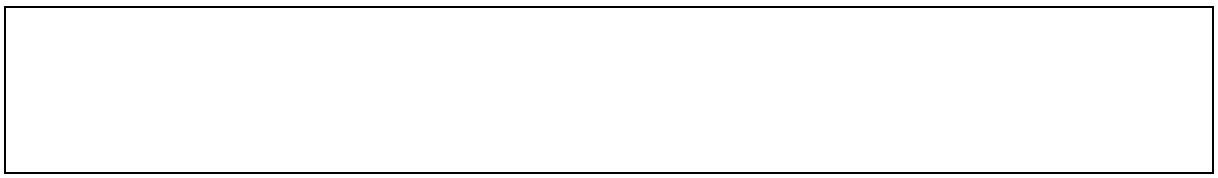
Your responses to the consultation questions

Codes and Guidelines

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

Management of notifications

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



Advertising restrictions

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

Title protection and endorsement for approved areas of practice

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

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

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

Cooperation with other regulators

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

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

24. If not, what improvements could be made?

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

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

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

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

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

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

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

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

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

Further comment or suggestions

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

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 [redacted] 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	A/Prof Mark Gianoutsos
Organisation (if applicable)	VMO Plastic Surgeon, [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 - the current guidelines are confused at best and misleading at worst. There is no reference to scope of practice nor any standard of training which equates with any other surgical specialty - that is, training in surgical principals and practice (not just a limited range of procedures). Currently, the accepted standard for all surgical specialties is that if the RACS. This is standard which patients and the community expect and, in fact, understand by the title surgeon.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
Assessment should be in person, as should the great majority of peri operative management Consent should be done in person and a cooling off period should be considered Financial inducement or payment in kind for favourable reviews or "influencer" posts should be considered inappropriate Qualification - as above, the community has an expectation and understanding of what a surgeon is which is currently not being met
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
AHPRA should know the spectrum of practice of cosmetic surgery and who is doing what. It needs to be known whether a practitioner is conducting themselves within the bounds of their training and that that training is adequate and appropriate Titling again is very misleading and deliberately so
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
7. What should be improved and why and how?
Advertising should be professional, factual, and not treat surgery like a commodity. It should not contain sexualised images, nor should it pray upon the insecurities of any group of patients. It should be regulated ideally by the group themselves, but failing that needs to be regulated closely and with meaningful deterrents
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
More specific
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 - most definitely Social Media can easily be utilized to commodities and trivialize procedures and is the ideal medium to pray upon insecurities. The sexualised nature of much of it is wholly unprofessional and represents those undertaking cosmetic procedures, surgeons in general and medical practitioners as a whole in a poor light
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)?
In the community's mind a surgeon is a specific title and conveys assumptions of thorough and appropriate training not just in specific procedures but in professional management of patients from assessment to post operative completion of care. Endorsement in my view is meaningless and creates rather clarifies confusion

12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
No - it would create greater opacity as to what a surgeon is
13. What programs of study (existing or new) would provide appropriate qualifications?
FRACS or equivalent 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?
There would certainly appea to be
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
Yes
18. Please provide any further relevant comment about cooperating with other regulators.
Regulators are reactionary and in many cases toothless

Facilitating mandatory and voluntary notifications

19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?
Largely yes
20. Are there things that prevent health practitioners from making notifications? If so, what?
Power imbalance, inappropriate inducements
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?
No
24. If not, what improvements could be made?
Many of the above points in relation to total patient management should be considered
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?
This should be considered

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?

Publish historical record of practitioners

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

Not well

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

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

Further comment or suggestions

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

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

You are invited to have your say about the regulation of medical practitioners (doctors) who perform cosmetic surgery by making a submission to this independent review.

The consultation questions from the consultation paper are outlined below. Submissions can address some or all of these questions, and you can include any evidence or examples that you think are relevant.

Submissions can be emailed to:

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

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

Your details

Name	Susan Goldner
Organisation (if applicable)	
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
No because they do not have an expected standard of training and experience.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

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

Advertising restrictions

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

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

Title protection and endorsement for approved areas of practice

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

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

Cooperation with other regulators

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

Further comment or suggestions

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

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

Your details

Name	Michele Gould
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?
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?
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.
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

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Information to consumers

23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
The Medical Board's current codes and guidelines do not specifically outline a practitioners training in cosmetic surgery. Currently consumers are left in doubt as to whether their surgeon has had any specific training in cosmetic surgery, even if their surgeon is a specialist surgeon as recognised by the AMC.
24. If not, what improvements could be made?

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

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

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

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

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

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

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

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

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

It should be clear to consumers which doctor is trained *specifically* in cosmetic surgery, irrespective of their other previous training.

Further comment or suggestions

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

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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	Tony Hackland
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?
Absolutely NO, AHPRA responsible for allowing non specialist surgeons from operating beyond their qualifications, training & experience. In addition to suboptimal surgical results AHPRA has allowed the public to be exploited financially.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
Specialist surgery qualifications base line requirement for anyone who uses a scalpel plus peer review essential
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
There are innumerable examples of the article below which demonstrates AHPRAs failure to manage this situation of [redacted]: https://www.smh.com.au/business/consumer-affairs/never-ever-ever-own-up-cosmetic-cowboys-running-wild-in-the-billion-dollar-treatments-industry-20211022-p592ee.html?fbclid=IwAR1IGAN5mqVgtRqpUKUSnO8eRkKXtko9AqCMtJMbPEvRLa2uci5fn2fegVg

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?
No surgical qualifications = no surgery, especially outside of specialty of qualification eg. Cardiothoracic surgeon doing cosmetic surgery
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.
STOP non specialist surgeons from harming Australians asap

Advertising restrictions

6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
Definitely no
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?
NO
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
no
10. Please provide any further relevant comment in relation to the regulation of advertising.
Having been a theatre worker for 20+years, I have seen the gravity of this situation made permissible by AHPRA – I have watched these substandard 'surgeons', who are mostly overconfident in their abilities.

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)?
partial

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

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?
Duplication of regulatory authorities that don't talk to each other wasteful
16. If yes, what are the barriers, and what could be improved?
Do your job & keep Australians safe from underqualified service providers
17. Do roles and responsibilities require clarification?
yes
18. Please provide any further relevant comment about cooperating with other regulators.
AHPRA are culpable in allowing this substandard situation of non specialist trained surgeons doing highly specialised work & gouging the population……. Please address to avoid it being a perpetuated.

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

Further comment or suggestions

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

Assoc Professor PETER HAERTSCH AM
FRACS FRCS (Edin)

Plastic surgery
Surgery of the hand
Reassignment surgery
Burn surgery

Provider No. 052191A

[redacted]

16th March 2022

APHRA

Thank you for inviting me to comment with respect to cosmetic surgery practitioners.

As a qualified surgeon I would make the following points:

1. No medical practitioner should be able to call himself surgeon unless he has a registerable surgical qualification with the Australian Medical Council.

   This would go a long way to ensuring that the person involved is able to treat the complications of what he does.

2. No medical practitioner should be allowed to perform any invasive procedure unless he is a registered surgeon.

   I accept that dermatologists perform surgical procedures and that would be an issue that needs to be addressed somehow perhaps accepting that dermatologists are able to remove skin lesions but not perform any other surgical procedure particularly cosmetic procedures.

3. With respect to the [redacted] Australian College of cosmetic surgeon, my understanding is that they are not registered as a body to train surgeons an as such should be disqualified from the area of cosmetic surgery.

4. Cosmetic or spa clinics owned and run by non-medical people should not be allowed to advertise or counsel patients with respect to any cosmetic procedures that they then subcontract to various surgeons.

I trust these comments are helpful and I look forward to the outcome of your enquiry.

Kind regards,

[redacted]

PETER HAERTSCH

From: [redacted]
To: Cosmetic Surgery Review
Subject: FW: Request for cosmetic feedback and whinge that AHPRA has roadblocks to retirement as I wish but still be part of medical fraternity
Date: Thursday, 31 March 2022 2:55:30 PM
Attachments: image003.png
image005.png
image006.png
image007.png
image008.png
image009.png
image010.png
image011.png
image012.png
image013.png
image014.png
image015.png
image016.png
image017.png
image018.png

Received via MBA newsletter inbox.

[redacted]
Policy and Project Manager, Medical
Email [redacted]
Web | www.ahpra.gov.au

Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Melbourne VIC 3001 | www.ahpra.gov.au

From: Dr Neal Hamilton [redacted]
Sent: Thursday, 31 March 2022 3:07 PM
To: newsletters <newsletters@ahpra.gov.au>
Subject: Request for cosmetic feedback and whinge that AHPRA has roadblocks to retirement as I wish but still be part of medical fraternity

Dr Tonkin asked
Is she and AHPRA serious considering my experience with you
[redacted] (for how long ?)

OVERVIEW COSMETIC MEDICINE .
AN OPINION on the IMPORTANCE of keeping Cosmetic Practice perspective
or, to put another way,
The foolishness of keeping the great Cosmetic medical and surgical divide..

Over 7 international conferences in the last 3 years it is clear to this author, Dr. Neal Hamilton, that there is a continuing divide between the attitudes of Medical, as compared to Surgical, provision of Cosmetic services.
I am approaching 30 years in Cosmetic Service provision and have seen approximately, 85,000 cosmetic

patients over this time.
I have also been on the NSW Health Complaints register as someone to ask peer opinion about.
I stand corrected, but believe I own the largest Dr. only Cosmetic Medical Practice in Australia which sees approximately 1200 Cosmetic Patients per month and lectured in 15 countries.

Australia is uniquely placed to define who the spectrum of cosmetic providers are .
This seems to be a result of regulatory and medicopolitical issues that largely encouraged Dermatologists and Plastic Surgeons to ignore the discipline to a far greater extent than else where in the world.

As Cosmetic medical and surgical services are being increasingly sought by consumers, an accurate differentiation of "who does what" seems essential so that regulators can protect the public.

I will define, admittedly through Australian eyes, the expansion of cosmetic providers and so hopefully provide a framework for all practitioners and regulators around the world but especially in NSW better understand the discipline.

Given that Australia, with only 0.3% of the worlds population, ranks so highly as a market with the multinational companies who provide cosmetic injectables to countries with far greater population bases, emphasizes Australia's unique position.

BACKGROUND

In the mid to late 1980's, most consumers who wished to access cosmetic services had only 2 choices.
The first, I will define as the "beautician " level where the subjective experience seemed to outweigh the architectural changes associated with the visible signs of ageing.
Felt great, didn't do much.

The second was a surgical option, where solar damage and rhytids (wrinkles) were ignored in favor of SMAS based facelifts that irrespective of outcome standard, involved hospitalization, most often General Anaesthetic, and visible scarring. After a formal surgical experience and almost always looking different, hopefully they looked better.

In the 30 years since the industry has morphed, adjusted, responded to market based consumer demands.

This has largely been possible because Australia had a unique medicopolitical and regulatory environment compared to most other countries.

This largely meant that Dermatologists, sponsored in Australia by government based insurance (Medicare), and Plastic Surgeons similarly sponsored by government subsidized hospitals seem to have ignored the "Cosmetic market" to a greater extent.

This was exacerbated by decades old arguments in Australia about Supply limitation by the colleges that control entry to "clubs" or [redacted] not done to such an extent in other countries.

Further exacerbated by a division of regulatory responsibility at government level.
In effect, one beaurocracy saying its another beaurocracies responsibility to regulate the industry without PUBLIC SAFETY being more important than beaurocratic cross responsibilities or COMMERCIAL INTRESTS.

The Unique antipodean outcome has been the rise of the " Cosmetic Practitioner " (from all sorts of

health professsional backgrounds).
Especially considering that formal Cosmetic training by the Learned Colleges is not easy, desired, or even possible in Australia's public hospital system.

Which in turn allowed 4 significant outcomes.

Firstly, groups not limited to the traditional medical surgical divide.
Creating a market place for Cosmetic consumers to have a group of professionals who CROSSSED the old Medical vs Surgical Divide.

Secondly, acknowledged that the Cosmetic consumer is, in fact, a wellness consumer who is happy to ignore the normal AUTHORITY given to the specialists in supply limited clubs/ colleges.

Thirdly, it has allowed corporate entities to commodify certain parts of the Cosmetic world where profits outweigh the protection of standards and dictate what health professionals can and can't do.

Fourthly, allowed the rise of the " Nurse Practitioner ", who over a short 10 years, now clearly, for example, dominate the provision of cosmetic injectables in this country.

Australia is a western capitalist society, but the LACK of wisdom of allowing "nurse injectors" to provide these services, especially Volumising Fillers UNSUPERVISED is consequence not yet dealt with by our Regulators.

THE SUGGESTION

Look at Cosmetic Practice differently from the traditional Medical/ Surgical divide .

So that, a language that more represents the reality of this growing market place,
can allow better discussions at consumer, practitioner, scientific conference and regulator levels.

THE PROPOSAL

That Cosmetic service delivery can be thought of in a categorical manner with 7 clear areas definable.

So that practitioners and practices that become multi dimensional can still be understood without the burden of commercial interests confusing the issues of
*Safety
*Training
*Disciplinary committees
*Ongoing Professional development
*And protection of an organizations memberships
These outcomes Can occur constructively as
Shades of grey creep into discussions at all industry levels.
I think it just requires modern definitions and a representative language of an area where no consumer actually, most usually, needs anything!

THE 7 AREAS

Important disclaimer
The nomenclature I choose, I don't feel, is anywhere near as important as the concepts

1. Beautician Practice

2. Day spa practice
3. Medispa practice
4. The Cosmetic practitioner
5. The Cosmetic proceduralist
6. The Cosmetic Surgeon
7. The Plastic Surgeon

1.-5. Main Value being Rejuvenation and Restoration (reduction of the visible signs of ageing)
"Change "and a lack of "natural result " being highly regarded main aims.
6.-7. Main value being Enhancement and Change ("no change no success" definable by cephalometric measurements)

Also and VERY IMPORTANTLY
1.-5. Office based
Minimizing cost, downtime, complications and sidestepping General Anaesthetia
6.-7. Day Surgery and Hospital based
Incurring Hospital costs, general Anaesthetic costs, generally more complications and patient downtime.

NOTE on the term "SURGICAL"

In 1982, in medical school, in Sydney Australia, I was taught that "surgery " was best defined as the "treatment of local disease"
Whether a paronychia need a Poltus, lancing, AB or scalpel based intervention was irrelevant.
That the term "surgery " is being used as a Political tool is regrettable.
A better separation would seem to be
Hospital or Non Hospital based procedures with higher complication rates and often General Anaesthesia as opposed to office based procedures
With most often less complications and no need for General Anaethesia.

With definitions of treatment aim:
enhancement and appearance change, or
Rejuvenation/ Restoration with little appearance change.

The acknowledgement of taking out inaccurate emotive language from world wide discussions would , to me, allow a much more logical discussion of what consumers actually want.

NON HOSPITAL BASED PROCEDURES WITH LOW COMPLICATION RATES AND NATURAL RESULTS.

BEAUTICIANS

skilled and customer service based with very little capital equipment
Typical procedures offered may be
Lotion and Potion Advice
Waxing
Facials
Massage
Training either being "on the job" or at "vocational " schools resulting in certification.

DAYSPAS

A natural extension of the Beautician model where, the addition the addition of capital equipment allows higher professional fees .

IPL
Cellulite reduction
Microdermabrasion
Equipment are typical of these additions
The entrepreneurial day spa owner may choose
Untrained personnel with superior customer service skills and train in the job(the improvements in equipment almost totally taking the need for safety judgement out of the equation)
Employees with Vocational Training
Or increasingly employees with tertiary degrees in Health Science(cosmetic).
Often called “Dermal Therapists”.

A couple of years ago I helped design and teach a curriculum for such degree aspirants.
Commercially that institution failed, but the value to the community of doing such,
seemed obvious given the superior advice these health professionals can give consumers

Addendum
The internet means all information is available but
the internet allows no perspective and requires health professionals to negotiate the jigsaw puzzle of information overload available to anyone online, with no respect for any health specialty.

MEDISPAS

Where
Cosmetic Dermatology
Cosmetic Laser Medicine
Cosmetic Injectables
Are the main offerings.
Most often these services are provided by Nursing Professionals
Either
“Enrolled Nurses” with one years formal education at a vocational institution
“Registered Nurses”with a University based degree but no cosmetic training until exiting into the commercial Retail Medicine World.
“Nurse Practitioners” who have a higher qualification that, if done as a “Post Surgical Nurse Practitioner “
In certain Australian states have an appendix that allows them to prescribe cosmetic injectables COMPLETELY independent of any Medical Practitioner.

What Cosmetic,outside hospital,Botulinum Toxin and Soft tissue fillers have to do with, for say, the Post Surgical management of a Cholecystectomy is lost on most medical practitioners.

That the Nurse Practitioner (Post Surgical subtype) can, in Australia, then prescribe cosmetic injectables to other RN and EN, independent of medical practitioner oversight, is an anomaly not most medical practitioners who have extensive experience in this area believe isn’t good for the community.

Botulinum Toxin ? Cosmetic laser Medicine? Cosmeceutical advice?

I believe these are no big deal with complication rates very low, close to zero.

But Volumising fillers, given the seriousness of monocular blindness and tissue necrosis worries me immensely.
Especially given that the only training that occurs at the Medispa level are often “weekend” or “2 day courses “.

I, and my close cosmetic colleagues, find it hard to think, outside of a hospital setting or anaphylaxis, what can cause in any Medical Specialty more damage than the Volumising fillers can.

It is also at the MEDISPA level that most corporate interest in Australia has occurred.

Australia now seemingly has “dozens” of corporate chains that have allowed inexperienced injectors to perform these procedures.
Often with no Medical Practitioner on the premises where the service is delivered.

In contrast, the last 2 medical practitioners who joined my practice had 75 hours of lectures and 200 hours of observation of Medical Practitioners performing Cosmetic Procedures before any patient contact.

COSMETIC PRACTITIONERS

Essentially solo or group Medical Practioners.

Cosmetic Dermatology
Cosmetic Laser Medicine
Cosmetic injectables.

Cosmetic Practitioners are a group with diverse backgrounds.

Family Medicine, Skin Cancer Medicine, Dermatology, Surgical displines.
This may be full time or part time.
This group may have, or not have, Nursing support.

What is common is NO FORMAL TRAINING PROGRAMME.
Medical practitioners are on site when services , especially Volumising fillers, are delivered.
Cosmetic services are office based, and with the exception of Volumising fillers,have very little morbidity and largely no down time for the patient.

COSMETIC PROCEDURALISTS
(deliberately not using the emotionally charged nomenclature of “minimally invasive cosmetic surgery “)

These services are largely Restorative and Require Patient downtime. However,
Provide solutions to patients who don’t want to “change” their appearance.
Just look fresher, better, younger.

What is crystal clear, is that this outcome is not consistent with what most patients experience when they enter the formal day surgery or hospital environment.
What they don’t need is hospitalization or General anaesthetia, as the design of these procedures are low risk, low pain, quick recovery procedures easily done within an office / procedure room.

The similarity to skin cancer practitioners and sclerothearapists is apt.
Both might be “needed” but are quite appropriately outpatient procedures and would be foolish to push into hospital biased environments.

This group of procedures, “ Minimally Invasive”, is quoted as being the fastest growing area of “

It's easy to see how nomenclature can confuse the real issues of who does what to whom with patient safety, Hospitalization and General anaesthetic avoidance, natural results and low complication rates being very worthwhile goals.

These patients DO NOT NEED medical intervention and are quintessential "RETAIL" medical patients within the broader context of "WELLNESS " medicine.

COSMETIC SURGEONS

Again, emotive terms seem to get the way of sensible differentiation of who this group are.
They have diverse backgrounds, and
may or may not be members of traditional colleges.
Cosmetic procedures best done inside of a day surgery facility or hospital seems a better way to discern this group.
Breast Augmentation
Simple face lifting
And liposuction involving more than 500 ml of lipoaspirate are 3 examples that come to mind.

The ANAESTHETIC ISSUES are more pressing than the technical issues in this group.

PLASTIC SURGEONS

The most technically trained group who enter the cosmetic area.
I can't help but think F1 drivers wanting to drive taxis as an appropriate analogy.
The 6 levels beneath them seems a waste of their reconstructive, burn and hand skills apart from "fame and fortune".
So be it but make no mistake, at my level (4 and 5) all but a few of these highly skilled would be incompetent.

SO
In Conclusion
My (humble) recommendations are

1. Don't be sucked in by guilt trips from [redacted]
2. Nurses are fine (Volumising fillers excepted)*
3. Cosmetic Surgeons are fine (as long as appropriate anaesthetic control is done) **
4. leave all else alone. We DO NOT want Australian consumers traveling offshore and bringing back exotic antibiotic resistant bugs as I've seen.

- No Dr on site no Nurse Injecting. no exceptions
- no volumising injections from drs or nurses until adequate certification

** licensed day surgery or hospitals compulsory for breast implants, high volume liposuction, large facelifts and the like

Tightening just these 3 areas would I believe prevent most, if not all, of the complications we worry about including the recent NZ and Sydney blindnesses, and the Sydney cardiac arrests and death whilst undergoing breast work.

Yours
Neal Hamilton
Concept Cosmetic Medicine

PS I’m more than happy to sit before you and be grilled until I burn if you think I could be of value. This is really important to get right.

On 31 Mar 2022, at 2:47 pm, Medical Board of Australia <newsletters@ahpra.gov.au> wrote:

March 2022

Message from the Chair

There’s a great opportunity for anyone interested in the many challenging issues around cosmetic surgery to share their insights. Independent reviewer, former

Dr Anne Tonkin,
Chair, Medical Board of Australia

Queensland Health Ombudsman Andrew Brown, is calling for feedback in a public consultation open now. He's keen to learn from people with lived experience on all sides of the sector, to understand issues and challenges and barriers to reporting when things go wrong. The Medical Board of Australia and Ahpra commissioned the review to make sure regulation keeps pace with this multimillion-dollar entrepreneurial industry. I encourage you to share your perspective.

Medical Board of Australia News

The latest news from the Medical Board of Australia

CPD changes begin in 2023, with extra time for doctors who don't yet have a CPD home

CPD changes begin in January 2023, but doctors who don't have an approved CPD home when the revised standard takes effect can continue their current CPD in 2023.

Read more

Minor changes to acupuncture endorsement start July 2022

If you're a doctor with an approved acupuncture qualification, you might be interested in small changes to the acupuncture endorsement registration standard.

Sharing insights from complaints

The Board regularly receives complaints from patients about physical examinations, especially when doctors are performing skin checks, respiratory examinations or breast examinations. This is often due to poor communication and inadequate informed consent.

Read more

Accreditation

The Board has approved a specialist medical college program, a medical school program and four intern training accreditation authorities.

Read more

Read more

Consultation

Cosmetic surgery independent review consultation now open

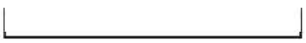
Interested in cosmetic surgery or its impacts? Have your say in the independent review of cosmetic surgery consultation.

Read more

News and alerts

New policy makes extra English language tests acceptable short-term

If you've had trouble accessing English language tests, you might be interested in short-term changes to English language tests for registration.



2020 pandemic response sub-register – opt in to keep practising

On the 2020 pandemic response sub-register and keen to keep practising? Act now before your registration expires on 5 April 2022.

Supervised practice framework now in place

The new supervised practice framework for medical practitioners does not affect supervision arrangements for international medical graduates, interns or specialist trainees.

Media statement – Doctor convicted for practising while suspended

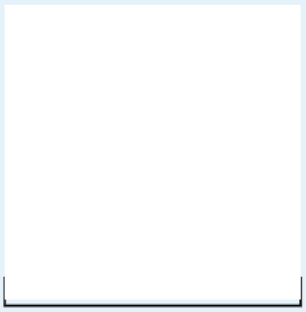
Melbourne doctor convicted for practising while suspended and obstructing an Ahpra investigation, after

Ahpra laid charges.

New podcasts – eliminating family violence, and improving workplace culture for patient safety

Listen to new episodes on health practitioners' role in eliminating family violence, and tackling the blame culture to improve patient safety, in our latest *Taking care* podcasts.

Medical regulation at work



Recent tribunal cases

Recent tribunal decisions include failing to keep adequate clinical records and providing substandard patient care, exploiting vulnerable patients, and practising without professional indemnity insurance.

Read more

Ahpra supports the Medical Board of Australia by managing the registration and notification processes. For registration matters or to update your contact details, please contact Ahpra.

Call Ahpra customer service team on 1300 419 495 (from within Australia)

Go to www.ahpra.gov.au/Login (practitioner log in)

Contacting the Board

Share

Tweet

Share

Forward

Please note: Practitioners are responsible for keeping up to date with the Board's expectations about their professional obligations. The Board publishes standards, codes and guidelines as well as alerts in its newsletter. If you unsubscribe from this newsletter you are still required to keep up to date with information published on the Board's website.

From:	Andrew Harper
To:	Cosmetic Surgery Review
Subject:	Independent review into cosmetic surgery
Date:	Tuesday, 8 March 2022 4:57:29 PM

Dear Dr Brown

There is a great need for evaluation of the quality of clinical services through systematic documentation of patients' experiences. This applies across the board in addition to specific areas of medicine. Cosmetic surgery is a high priority domain as is Aboriginal health as illustrated by the ABC last night.
Medical schools have a key role in the promotion and training for evaluation of patient satisfaction and clinical outcomes.

Sincerely

Andrew Harper
Occupational physician

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	Katie Hartwick
Organisation (if applicable)	
Email address	[redacted]

Your responses to the consultation questions

Codes and Guidelines

1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
No, because they do not have an expected standard of training and experience.
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.

Management of notifications

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

Advertising restrictions

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

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

Title protection and endorsement for approved areas of practice

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

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

Cooperation with other regulators

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

Further comment or suggestions

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

From:	Steven Hatcher
To:	Cosmetic Surgery Review
Subject:	Podiatrists" use of term " surgeon "
Date:	Wednesday, 9 March 2022 5:46:06 PM

This may not strictly be within the scope of the review as it does not pertain to cosmetic surgery as such but I have been informed that during discussion at the annual Australian Orthopaedic Foot and Ankle Society meeting this year it was suggested that we use this forum to highlight the misleading practice of Surgical Podiatrists or Operating Podiatrists using the term "surgeon" or " Foot & Ankle Surgeon" in their practice.

These individuals are not trained to the same standard as Podiatrists in the USA, where there exists some ' crossover ' in scope of practice between Orthopaedic Foot and Ankle Surgeons and Podiatric Surgeons - in many ways akin to the way Orthopaedic and Neurosurgeons both deal with spine conditions, and Orthopaedic and Plastic Surgeons deal with hand conditions.

To my knowledge in [redacted] there are [redacted] individuals currently practicing, and one that has ceased practicing, who are Podiatrists, but are performing Foot & Ankle surgery on patients. They use the title "doctor" by virtue of their higher education qualifications, and the term "surgeon" , in my opinion inappropriately. This is confusing and misleading to patients who are often not aware that they are not medically trained practitioners. In this context , the term "doctor" is also potentially misleading, although I concede there are other fields in which the title " doctor" does not necessarily connote being a Medical Doctor.

In my opinion it is misleading and unfair on patients for these individuals to use the term "surgeon" to describe their practice, and I feel that AHPRA has a responsibility and duty to limit use of this term to medically trained doctors who have trained in recognised Programs through the relevant surgical colleges .

Apologies if this is the incorrect forum, if there is an alternative route to address this issue, please direct me accordingly.

Kind Regards
Steven Hatcher
Orthopaedic Surgeon
MBChB, FRACS (Orth), FAOrthA
Member of Australian Orthopaedic Foot and Ankle Society.

From:	Susan Hawes
To:	Cosmetic Surgery Review
Subject:	Re: Public consultation now open – Independent review of the regulation of health practitioners in cosmetic surgery
Date:	Monday, 14 March 2022 11:58:05 AM

I qualified as a general surgeon in January 2021, I have also started fellowship training as a breast surgeon. Having undergone rigorous formal training I am confused how cosmetic surgery is regulated. I understand that there is blurring of the lines with plastics and breast general surgery as both perform breast reductions and implant insertions with or without breast cancer surgery. I feel that given there are formal avenues for proper training, people performing “cosmetic” procedures should have a similar level of training as we are doing the same operations and they certainly at risk of complications.

Susan Hawes.

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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 Russell Hills
Organisation (if applicable)	[redacted]
Email address	[redacted]

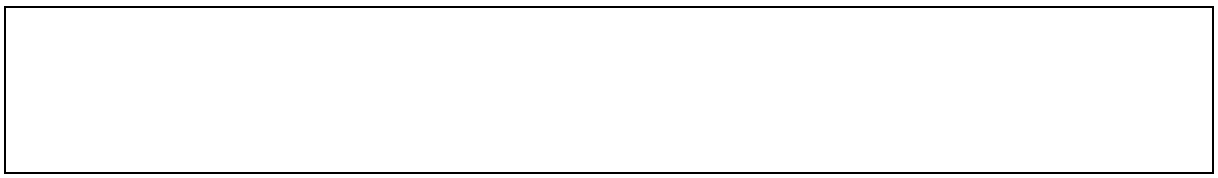
Your responses to the consultation questions

Codes and Guidelines

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

Management of notifications

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



Advertising restrictions

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

Title protection and endorsement for approved areas of practice

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

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

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

Cooperation with other regulators

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

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

Facilitating mandatory and voluntary notifications

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

Information to consumers

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

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

24. If not, what improvements could be made?

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

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

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

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

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

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

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

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

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

Further comment or suggestions

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

From: Pedram Imani
To: Cosmetic Surgery Review
Subject: Submission to the independent review on cosmetic surgery
Date: Monday, 25 April 2022 12:03:51 AM
Attachments: image001.png
image006.png

Dear Sir/Madam

I am writing my submission below as specialist surgeon who also practices in the field of cosmetic surgery.

In my opinion AHPRA needs to pay attention to the following points:

1. Cosmetic surgery has been performed by various specialist surgeons who practice in their chosen field and it is NOT only confined to Specialist plastic and reconstructive surgeons. Various anatomical regions have dedicated surgeons. For example: face and neck cosmetic surgery performed by otolaryngologists, head neck surgeons – facial plastic surgeons, facial surgery performed by maxillofacial surgeons, eyelid and periorbital surgery performed by oculoplastic ophthalmic surgeons, cosmetic breast surgery performed by general oncoplastic general surgeons, cosmetic genital surgery performed by urological surgeons, body contouring surgery performed by general surgeons especially post weight loss surgery, etc etc.
2. There has been challenges launched by various plastic surgery groups against other specialists conducting cosmetic surgery – the objection being that these surgeons are not cosmetic surgeons and that they are misleading the public. This has been counterproductive in that patients are actually best served by specialist surgeons who perform surgery in their particular anatomical area of expertise. In contradictions these surgeons are in fact best placed to serve the public.
3. The real problem is non surgeons performing various cosmetic procedures namely the untrained self-proclaimed cosmetic GP calling themselves a cosmetic surgeon, and nurses practicing cosmetic medicine under a GP supervisor.
4. AHPRA should play a pivotal role in educating the public in that they are best served by the various specialist surgeons from various surgical fields if they chose to have cosmetic surgery.
5. Advertising should be restricted to qualified specialist surgeons and the public will need to be aware of the qualifications and registration if the practicing doctor.

Thank you for considering these points

With Kind Regards

Dr Pedram Imani

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