
# 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

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| **Name** | Ash Batten |
| **Organisation (if applicable)** | |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **1. Do the current *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?** |
| No. They do not have an expected standard of training and experience. There currently is not a recognised specialty of Cosmetic Surgery, which is needed! |
| **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.** |
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## Management of notifications

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|---|
| **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?** |
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| **5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.** |
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## Advertising restrictions

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| **6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?** |
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| 7. What should be improved and why and how? |
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| **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?** |
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| **9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?** |
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| **10. Please provide any further relevant comment in relation to the regulation of advertising.** |
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## 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)? |
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| I think it is essential if the public is to be protected.<br><br>Cosmetic surgery is not a specialty and so there are no official specialists. Other than word of mouth and the practitioner's own website and marketing, the public has no way of knowing ifthey are trained in cosmetic surgery or not.<br><br>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.<br><br>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? |
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| |
| **16. If yes, what are the barriers, and what could be improved?** |
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| **17. Do roles and responsibilities require clarification?** |
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| **18. Please provide any further relevant comment about cooperating with other regulators.** |
| |

## Facilitating mandatory and voluntary notifications

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

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

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| **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?** |
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| 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.** |
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## 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:** Adrian Bauze
**To:** Cosmetic Surgery Review
**Subject:** Submission to the independent review on cosmetic surgery
**Date:** Tuesday, 8 March 2022 12:38:35 PM
**Attachments:** Email-sig-resize_689288f5-63ab-4eb3-87c3-2f3fe3531e83.png



Thaks for the opportunity to contribute my view on this. It is quite simple. I do not believe anyone other than a Fellow of The Royal Australasian College of Surgeons should be able to call themselves a Surgeon or perform surgical procedures. This applies in other areas also, but the worst examples of the resulting poor standards and patient harm seem to be occurring in cosmetic surgery.
Regards,
Adrian Bauze

**Dr Adrian Bauze**
Orthopaedic Surgeon | Orthopaedics
[redacted]
T [redacted] | F [redacted] | E [redacted]

**From:** Emily Bek
**To:** Cosmetic Surgery Review
**Subject:** Submission to the independent review on cosmetic surgery
**Date:** Tuesday, 15 March 2022 5:26:23 PM



Hello,

My name is Emily Bek, I am currently a Paediatric registrar.

When I was a JMO and RMO at [redacted] in [redacted] there were multiple instances that I was asked to see patients in ED who had undergone cosmetic surgery procedures in a private hospital. Following complications of surgery, they had been advised by their surgeons to discharge from the (expensive) private hospital and present to the public emergency department to be admitted as a public patient. These patients often needed prolonged expensive inpatient management including blood transfusion and IV antibiotics, and significantly added to the workload of the surgical ward and inpatient teams.

There were also multiple presentations of patients who had travelled overseas for cosmetic surgery, returned to Australia and then presented with horrendous wound infections.

My impression was that this patient population came from a population subgroup for whom cosmetic surgery was normalised and glorified with very little appreciation for any negative aspects of the procedures.

Good luck with the enquiry,

Emily

**From:** Bernard Beldholm
**To:** Cosmetic Surgery Review
**Subject:** Submission to the independent review on cosmetic surgery
**Date:** Monday, 11 April 2022 4:14:11 PM



I'm Dr Bernard Beldholm and I'm a Specialist General Surgeon who focuses mainly on post weight loss body contouring surgery and Post pregnancy Tummy tuck surgery and have been in specialist practice for more than 10 years.

There are significant guidelines currently in place for practitioner in this area including:

1. Mandatory reporting about registered health practitioners
2. Advertising Restrictions for Practitioners: AHPRA's Guidelines for advertising a regulated health service
3. The Medical Board's code of conduct, Good medical practice: a code of conduct for doctors in Australia

These guidelines if followed should provide significant protection to the general public and creating additional guidelines will not make a material impact on patient safety.

The core issue as I see it currently is that doctors can call themselves Surgeons with no surgical training at all. As a Specialist General Surgeon, I have completed close to a decade of training in surgery and Continue to adhere to RACS guidelines and continual surgical education requirements.

However a doctor can finish medical school & their internship and then call themselves a surgeon even if they have never stepped inside an operating theatre. This creates a significant and severe risk for patients. [redacted] doctors with no surgical qualifications were provided with a couple of weeks of training and then started performing surgical operations with potentially serious complications.

There is absolutely no justification for the term "Surgeon" or "Cosmetic Surgeon" being able to be used by doctors with no surgical qualifications.

I advocate strongly that:

1. The term "Cosmetic Surgeon" should be banned as there is no AMC approved training in Cosmetic Surgery. It is a misleading term that confuses the public and implies that the surgeon is trained in this specialty.
2. Only Qualified surgeons should be allowed to call themselves surgeons. There are already nine surgical specialties in Australia and New Zealand (that are approved by AMC): Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery.

There should be significant consequences for doctors calling themselves surgeons when

they are not.

These actions would in a material way protect the public.

Warmly,
Dr Bernard Beldholm FRACS, Specialist Surgeon
[redacted]


*Disclaimer: Individual results vary. All surgery carries risks & you should seek a second opinion before proceeding. See full Disclaimer

**From:** Chris Bennett
**To:** Cosmetic Surgery Review
**Subject:** Cosmetic Surgery
**Date:** Thursday, 10 March 2022 9:57:28 AM



In my opinion cosmetic surgery should be limited to trained surgeons.

The RACS supervises surgical qualifications , and a FRACS should be necessary for cosmetic surgery to be carried out.

Cosmetic procedures such as Botox and Fillers could be administered by trained non surgeons (such as dermatologists) , but surgery should be

done only by FRACS trained surgeons.

Yours Sincerely

Chris Bennett

**From:** [redacted]
**To:** Cosmetic Surgery Review
**Date:** Wednesday, 9 March 2022 6:24:37 AM



There needs to be some better regulation but GPs should be able to do cosmetic surgery too, not just plastic surgeons. Plastic surgeons are protecting their turf. And their fees are enormous.
However cowboys doing breast augmentation under local anaesthetics is also painful, immoral and dangerous.
Perhaps a diploma course is an alternative with regular updates
Dr Ashley Berry


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## Your details

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|---|---|
| **Name** | Chris black |
| **Organisation (if applicable)** | |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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?** |
| I don't believe that they as 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.** |
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## Management of notifications

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| **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?** |
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## Advertising restrictions

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## 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)? |
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| I think it is essential if the public is to be protected.<br><br>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.<br><br>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.<br><br>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? |
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## 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? |
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## Facilitating mandatory and voluntary notifications

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## Further comment or suggestions

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

## Your details

| | |
|---|---|
| **Name** | Victoria Blake |
| **Organisation (if applicable)** | [redacted] |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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.** |
| 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

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| **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?** |
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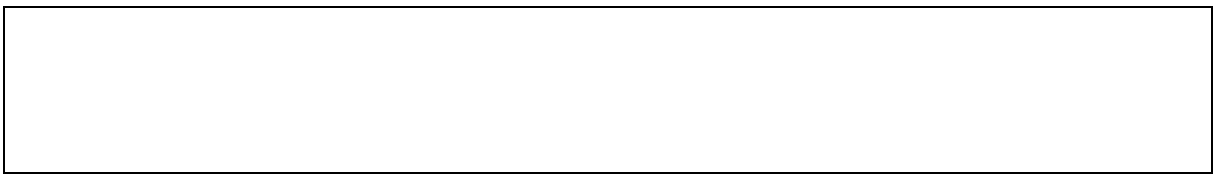

## Advertising restrictions

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| **6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?** |
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| **7. What should be improved and why and how?** |
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| **10. Please provide any further relevant comment in relation to the regulation of advertising.** |
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## Title protection and endorsement for approved areas of practice

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|---|
| **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.

During a Plastic Surgeon's training, there is an optional 6-month fellowship on Cosmetic Procedures. A Cosmetic Surgeon who is an Australasian College of Cosmetic Surgery(ACCS) fellow undertakes 2 years of mandatory training in Cosmetic Surgery.

Type of Surgeon Minimum Years of Training

Cosmetic Surgeon 12 years

(ACCS Fellow)

- Bachelor of Medicine/Surgery 4-6 years
- 5 years postgraduate surgery experience
- Mandatory 2 years ACCS dedicated cosmetic surgery training

Plastic Surgeon 12 years

(RACS Fellow and Australian Society of Plastic Surgeons (ASPS) Member)

- Bachelor of Medicine/Surgery 4-6 years
- 5 years postgraduate surgery experience
- Optional 6 months ASPS dedicated cosmetic surgery training

A recent British journal article letter from a young plastic surgical trainee made it clear some of the problems that plastic surgeons have with the field of cosmetic surgery. His main complaint was that he had received no training as a plastic surgeon trainee and this was widespread. Most cosmetic surgery is performed in the private sector where plastic surgical training is not based.

The British Association of Plastic Surgery stated on their website that the work of a plastic surgeon is predominantly non-cosmetic. It must be asked, if the public has

paid for plastic surgeons to be trained, should they be losing these reconstructive skills to cosmetic surgery that does not benefit society to the same degree. As we are all aware there are long waiting lists for plastic reconstructive surgery and these will probably worsen the more plastic surgeons perform cosmetic surgery.

In the turf war, there are many claims made that one should only see a plastic surgeon for this or that procedure. A very honest American plastic surgeon admitted that she had performed a labiaplasty and had never been trained to do so! She also admitted many years later that she had only sat in for 5 days with gynaecologists to hone this procedure. It must be asked how plastic surgeons can say that “you should only see a plastic surgeon for a cosmetic labiaplasty” when it is a well-known fact that a gynaecologist pioneered this procedure. One plastic surgeon that is experienced in cosmetic surgery admitted that he had done most of his fellowship training with cosmetic surgeons. When asked why he said they have the most experience and were full time in this area!

It is interesting to note that the use of the word cosmetic was rejected as part of the name for the plastic surgery society. Some [redacted] plastic surgeons admit they looked down on cosmetic work and thought that reconstructive was the more important prestigious work to be performed.

At [redacted] we have seen this first hand as a local plastic surgeon has asked to be trained in liposuction as he had never performed it in his training. The optional cosmetic fellowship is as little as 6 months for a plastic surgeon.

What many do not realise is that liposuction was first performed by a gynaecologist and was developed further by a dermatologist. The tumescent method of liposuction was developed by a dermatologist.

In our theatres, we have had both ENT, plastic and cosmetic surgeons, our theatre nurse said there was no difference in skill or knowledge. A US study showed that plastic surgeons were performing too many different types of operations and losing their surgical identity. When the general public was asked for examples of breast surgeons, skin surgeons etc plastic surgeons did not come to mind for the majority.

It should also be noted eye surgeons or dermatological mohs surgeons do not have a Royal Australian College of surgery qualification but are experts in their field.

The government advisor on PIP breast implants was a cosmetic surgeon, not a plastic surgeon. A professor of cosmetic plastic surgery in England named him as one of the most experienced surgeons with polyurethane implants worldwide. This

plastic surgical professor is very fair and even-handed and recognises quality skills whether these come from cosmetic, plastic, ENT or general surgeons.

In the recent PR turf war, the media has reported facts incorrectly. The [redacted] breast clinic in the eastern states that had multiple cardiac arrests was developed and headed by a plastic surgeon, not cosmetic. In Victoria, liposuction death was performed by a plastic surgeon, not cosmetic. [redacted] cases where many cosmetic surgeons have performed as many as 7 or 8 thousand. The recent Brazilian butt lift study that found that the death rate was 1 in 3000 was amongst plastic surgeons not cosmetic. It must be asked why the media is making these omissions.

Recently the turf war has extended between plastic surgeons [redacted] It was quite shocking to see that payments were allegedly being made for bias.

There are good and bad in all groups as most people are aware. All procedures have complications and good aftercare limits these in most cases. Being full time or spending the majority of a doctor's time in a particular field means more experience and practice which common sense tells us is important in performing a procedure.

**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?**

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| **16. If yes, what are the barriers, and what could be improved?** |
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| **17. Do roles and responsibilities require clarification?** |
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## Facilitating mandatory and voluntary notifications

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| **19. Do the Medical Board's current** mandatory notifications guidelines **adequately explain the mandatory reporting obligations?** |
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| **20. Are there things that prevent health practitioners from making notifications? If so, what?** |
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| **21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?** |
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| **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. |
| --- |
| Recently the Australian Medical Council, which is the body in charge of training doctors in Australia, has reported that plastic surgeons have a deficit in their cosmetic training and with the below facts it is easy to see why.<br><br>In the cosmetic vs plastic turf war, it is important to understand the history and the difference between cosmetic and plastic surgery.<br><br>The Difference Between Cosmetic and Plastic Surgery<br><br>Plastic or reconstructive surgery is to bring back to the normal e.g. an injury or a defect to make it normal again whereas cosmetic is to improve on the normal.<br><br>Sir Harry Gillies, a New Zealand otolaryngologist is considered to be the father of modern day plastic surgery.<br><br>Otolaryngology is the oldest medical specialty in the United States. Otolaryngologists are physicians trained in the medical and surgical management and treatment of patients with diseases and disorders of the ear, nose, and throat (ENT).<br><br>During the First World War, Sir Gillies took great pity on soldiers who had been disfigured. Some of these soldiers would not return home, as they did not want to distress their family at how badly they had been injured.<br><br>Sir Harry Gillies employed the services of an American wax figure maker to mould faces that were lifelike for these young men. He also embarked on the complex skin and muscle transfers to rebuild their face. Unfortunately, the first patient died of an infection and he quickly learned that small procedures or steps done |

sequentially were the safest way to reconstruct some of these horrific injuries. Sir Harry Gillies taught what he learnt widely to other surgeons and it was rumoured he was not included in the first plastic surgery college that was formed. This was probably the beginning of the turf war with plastic surgeons vs ENT surgeons, general surgeons, orthopaedic hand surgeons and cosmetic surgeons.

The reasons behind this are complex but include the fact that soft tissues are very hard to define or draw a boundary around unlike bones for an orthopaedic surgeon or the ears, nose and throat for an ENT surgeon. Many orthopaedic surgeons perform hand surgery although in the earlier days they conflicted with plastic surgeons over this piece of surgical turf. General surgeons that perform reconstructive breast surgery and plastic surgeons still have this ongoing conflict in some parts of the world.

In a recent lecture by a well-known professor of plastic surgery, it was mentioned that the finger pointing between both groups should stop. Probably the last turf war will be with the cosmetic surgeons.

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:** [redacted]
**To:** Cosmetic Surgery Review
**Subject:** Submission to Cosmetic Review
**Date:** Wednesday, 9 March 2022 3:44:50 PM



Thank you for your invitation to make a submission to The Medical Board's review into 'cosmetic medical and surgical procedures.' Some procedures if performed for medical reasons such as breast reductions to ease back pain are in fact covered by Medicare and private health insurance.

As a past medical director [redacted] for 18years, I had a particular interest in the quality and safety of medical practice to which our members were exposed and convened and funded a number of published translational research projects on the subject.

The one point that I consider needs to be made emphatically is that there are no "medical" cosmetic procedures – they are all surgical and the providers performing them must be surgically trained.

This point was made abundantly clear to me when a plastic surgeon, with whom I often consulted in my insurance role and to whom I referred patients practice told me about a patient of his that narrowly escaped death.

She asked for an abdominal liposuction and on inspection he felt she had an unusual abdominal asymmetry and ordered an ultrasound that showed an extrapolated spleen (subsequent history taking confirmed the woman had been in a car accident some 10years earlier and quite forgotten. He advised reduction of the spleen before undergoing liposuction.

If this woman had seen a non-surgically trained practitioner – a GP or dermatologist with little if any skills of surgical assessment and observation, she would almost certainly have been killed.

As you say, these procedures are for the most part elective, making risk of death utterly unacceptable.

If nothing else, the Board must insist cosmetic procedures, all surgical in some shape or form, must be performed by qualified surgeons.

Thank you,

Dr Umberto Boffa
MBA MBBS GDOHSM GAICD FAFOEM FCHSM
Specialist Occupational & Environmental Physician
[redacted]

[redacted]

**From:** grant brace
**To:** Cosmetic Surgery Review
**Subject:** Cosmetic surgery
**Date:** Monday, 21 March 2022 9:49:56 AM



Dr Grant Brace MB BS FANZCA
[redacted]

Victorian Surgical Consultative Council  Victorian Department of Health and Human Services  2012-2018

Victorian Experts Council  AVANT

Chairman Board of Management Windsor Private Hospital  2018-2019

Former Director Albert Street Anaesthetic Group  2000-2010

Dear Sir,
The speciality of cosmetic surgery has gained media attention recently for all the wrong reasons. Problems within the cosmetic surgery industry date over many decades.
A significant part of my anaesthetic practice included cosmetic surgery as practiced by a trained plastic surgeon registered with the Royal Australasian College of Surgeons. I personally was aware of problems within the cosmetic surgery industry particularly where it was provided by non surgically trained operators. On occasion I would be involved with the care of patients requiring surgical revision of cosmetic procedures after an inadequate procedure performed by a non surgically trained operator.
In my opinion the public has not been protected by AHPRA from many “cosmetic surgeons “ operating at a standard well below what would be expected if performed by a qualified plastic surgeon.
Many of the procedures performed by non surgically trained “ cosmetic surgeons “ were predominantly those based on liposuction as this required little surgical expertise. Dermatologists or General practitioners with little, if any, surgical training feature predominantly. Of all the cosmetic surgical procedures available liposuction is known to be associated with the highest mortality.
Another feature of cosmetic surgery performed by non surgically trained surgeons are the facilities where these procedures were performed. These often fell outside the purview of the DHHS, did not require registration, and in my opinion were run at a substandard level. Fortunately while I sat on the VSCC I was able have changes made to the requirements for these facilities by virtue of a change to the Medical Treatment Act (1988 ) which now requires all day surgery facilities to meet minimum codes of practice.
Many years ago I wrote an expert opinion on a matter relating to cosmetic surgery, that of inadequate anaesthesia. I was not the least surprised by the occurrence of the issues raised by AHPRA and for which it asked an expert opinion.
Similarly, the collapse of a number of patients having breast augmentation under local anaesthetic in cosmetic facilities[redacted] was almost certainly local anaesthetic overdose. Retropectoral breast augmentation is a very surgically stimulating procedure and would require substantial amounts of local anaesthetic, in a small patient, often in the toxic range.
AHPRA has a lot of ground to make up on the standard of care of patients choosing cosmetic surgery

by non surgically trained operators. I also believe scope of practice needs a comprehensive review by AHPRA and revision if the public is to be appropriately protected.

In summary

The areas where significant deficiencies have occurred in " cosmetic surgery " are

1. Inadequacy of surgical competence

2. Inadequate anaesthetic competence

3. Substandard day surgical facilities where some " cosmetic surgery " has been performed

The solution

1. The level of training of non surgically trained " cosmetic surgeons " has to be improved and standardised. If the term surgeon is used there must be an implied minimum level of surgical training and competence. I believe the Royal Australasian College of Surgeons needs to be involved and oversee the training standards applied to non FRACS " cosmetic surgeons " The public needs this reassurance and protection. I know the RACS will be reluctant to take on this role but I see no other credible alternative

2. Only FANZCA trained or equivalent anaesthetists should provide anaesthetic care for patients having "cosmetic surgery". The days of GP's providing anaesthetic care in major cities should be a thing of the past. GP's can never have the training or experience of a qualified anaesthetist.

3. All facilities where cosmetic surgery are performed should meet a minimum Department of health or National standard.

AHPRA must rise to the occasion and implement the appropriate changes to the " cosmetic surgery " industry to protect a very vulnerable public.
AHPRA has failed the public. It's a pity that AHPRA is only acting now after media has raised this issue publicly. Problems in this industry have been known to us all for decades. Many doctors see AHPRA as a dysfunctional organisation. This would also be an appropriate time to review the workings of this organisation.

For your consideration.
I would be happy to review any preliminary recommendations your review

makes.

Grant Brace


# 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** | Alesha Brewer |
| **Organisation (if applicable)** | [redacted] |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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

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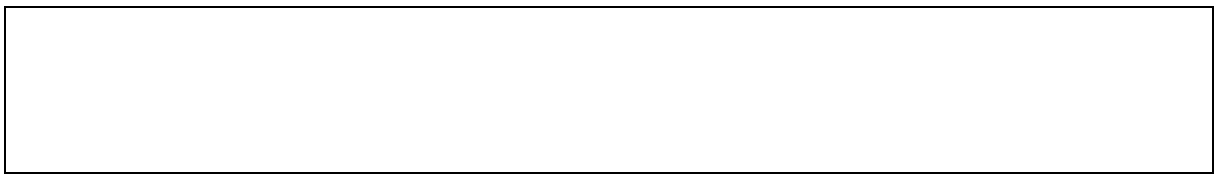
| **4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?** |
| |
| **5. Please provide any further relevant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



## Advertising restrictions

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|---|
| **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?** |
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| **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

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|---|
| **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? |
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| |
| **16. If yes, what are the barriers, and what could be improved?** |
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| **17. Do roles and responsibilities require clarification?** |

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

## Facilitating mandatory and voluntary notifications

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| **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

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

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?**

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| |

| **30. Please provide any further relevant comment about the provision of information to consumers.** |
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| 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 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
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** | Tim Brown |
| **Organisation (if applicable)** | |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|---|
| **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?** | |
| | An improvement would be to ensure that there are fixed standards by which practitioners can be judged. Currently there is no recognised specialty of Cosmetic Surgery, and no training programme recognised by the AMC for Patients are at risk because they are unable to identify if the practitioner offering cosmetic surgery has the relevant *specific* training for this scope of practice regardless of any other specialist qualification they may hold. |
| **2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?** | |
| | An endorsement specifically for medical practitioners who have met a National Accreditation Standard held on a public register. I would see this as a transition phase towards cosmetic surgery as a separate surgical specialty. |
| **3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.** | |
| | As with any other specialist area of practice, those practitioners specifically endorsed to undertake cosmetic surgery would be required to conform to a minimum set of standards, undertaken CME and actively assist in developing the specialty. If cosmetic surgery were subsequently recognised as a separate specialty, there are good pre-existing models for ensuring patient safety and improvements in delivery of practice. |

## Management of notifications

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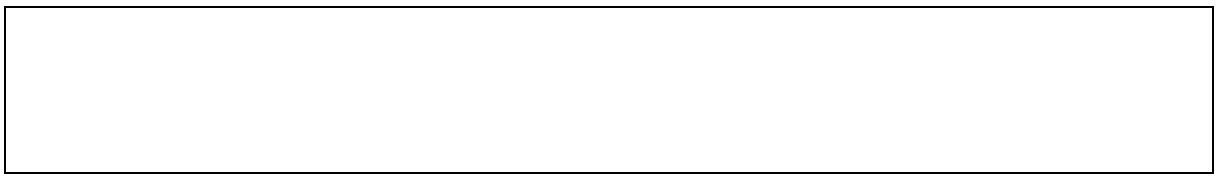
| **4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?** | |
| There is an element of partisan behaviour amongst practitioners involved with providing cosmetic surgical services.<br><br>To be impartial, I would recommend that AHPRA identified a group of recognised cosmetic surgery practitioners from different areas of practice (plastic surgeons, cosmetic surgeons, breast surgeons, dermatologists etc.) to act as an impartial technical advice group to AHPRA. | |
| **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?** |
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| Yes – but it is difficult to implement. |
| **7. What should be improved and why and how?** |
| It is difficult to police advertising, as a large proportion occurs via social media and is transient. By establishing an endorsement model as a stage towards developing cosmetic surgery as a specialty, AHPRA could police practitioners more effectively. |
| **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?** |
| This is difficult. There is a boundary between the letter of the law set out in the regulations and what would be regarded as the boundaries of good taste. The latter could be addressed with regulation, but would perhaps be more effectively managed via peer pressure through a professional body. Again, having a single coherent body of cosmetic practitioners would facilitate this approach. |
| **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)?** |
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| Establishing an endorsement model would protect patients from adverse outcomes by ensuring those on a register to practice cosmetic surgery would be appropriately qualified. |

| **12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?** |
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| Yes, by identifying practitioners who have the core surgical competence and *specific* cosmetic surgical training within a regulated environment.<br><br>The difficulty is in establishing the standards. Due to the diverse nature of providers of cosmetic surgery, it would require buy in and co-operation of a core set of individuals willing to develop and administer those standards. These individuals would need to be nonpartisan and be committed to development of cosmetic surgery as a specialty. |
| **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 organisation which has been established well over 30 years ago. This college has a structure on which standards which could act as a basis for an appropriate endorsement model. |
| **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. Currently it is not linked to competency in delivery of cosmetic surgery. Similarly, the arbitrary use of “cosmetic surgeon” as a title is not linked to competency in a universal manner. It is this disconnect which I would hope that this investigation could address. |

## 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?** |
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| **16. If yes, what are the barriers, and what could be improved?** |
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| **17. Do roles and responsibilities require clarification?** |

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| **18. Please provide any further relevant comment about cooperating with other regulators.** |
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## Facilitating mandatory and voluntary notifications

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| **19. Do the Medical Board's current** mandatory notifications guidelines **adequately explain the mandatory reporting obligations?** |
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| **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?** |
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## Information to consumers

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

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?**

Endorsement could be used as a vehicle to police cosmetic surgical practice. It could also be employed to develop cohesion between the various groups delivering cosmetic surgery as a prelude to producing a separate specialty.

**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. Without an endorsement model, it cannot do so effectively.

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

AHPRA could provide a register of practitioners endorsed to undertake cosmetic surgery.

**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.**

I would hope to see an endorsement model implemented as an initial step. Appointment of a group of stakeholders who are committed to working together in a non-partisan manner to develop the standards for endorsement is a critical step.

As a second stage, endorsement could lead to development of cosmetic surgery as a separate specialty in its own right. As with other specialties, an autonomous group would be responsible for developing standards, administering CME and training for future generations.

Inevitably, there will be a transition phase when different stakeholders from different training backgrounds would need to co-operate in a spirit of goodwill to form a basis for endorsement. I consider that this will be the greatest challenge in regulating cosmetic surgery. The appointment of broad minded, competent doctors from different training pathways, who have a track record of developing cosmetic surgery in a professional manner is critical to the success of this endevour.

| | |
|---|---|
| **From:** | Michael Butcher |
| **To:** | Cosmetic Surgery Review |
| **Subject:** | Cosmetic surgery |
| **Date:** | Thursday, 31 March 2022 2:44:29 PM |



Hello,

I am a GP with a significant metropolitan ED practice.

I see a small trickle of people with a bad outcome from a doctor advertising themselves as a cosmetic surgeon. To me it is notable that these doctors do not generally repair their bad outcomes and pass them onto a public or private ED and thus to a qualified true plastic surgeon. Who is justifiably unhappy about fixing a problem another doctor is not taking responsibility for.

It is also notable that patients are usually surprised to find the procedure was done by someone without a formal qualification as a surgeon. They almost universally assumed that a “surgeon” meant a trained true plastic surgeon, and some say they would not have gone ahead with the procedure if they had known.

I strongly suggest the title of “surgeon” becomes restricted.

I suspect self-regulation is not in the public’s interest.

*Michael Butcher*

[redacted]

**From:** Robert Byrne
**To:** Cosmetic Surgery Review
**Subject:** Independent Review into Cosmetic Surgery
**Date:** Wednesday, 9 March 2022 3:31:15 PM



I am a retired rural GP graduating 1963 , Sydney university. In 1999 I was chair of RDN , NSW. The board of this workforce network were unanimous about GP.s not only cherry picking the above such area of service without specialist training, also applying to advanced skin clinics doing specialized procedures without good surgical techniques. Many set up these so called special clinics in opposition to serving GPs in rural and regional areas. The regular practice work was either not done or of secondary interest and their main area of interest publicized. This I know caused friction amongst those doctors already serving communities as real generalists. The main interest of these cosmetic and skin specialist clinics was pecuniary and often gave adverse results o the clients involved. This type of performance often entices new graduates and recent fellowship recipients to do likewise. The number of generalist medical practitioners in rural areas is reclining and old doctors like myself and not replaced

Dr R P Byrne OAM MBBS (Syd) FACRRM about
Emeritus Associate Professor UOW LMM
[redacted]


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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 George Marios Calfas |
| **Organisation (if applicable)** | GMC Cosmedical Cosmetic Medical Clinics |
| **Email address** | [redacted] |

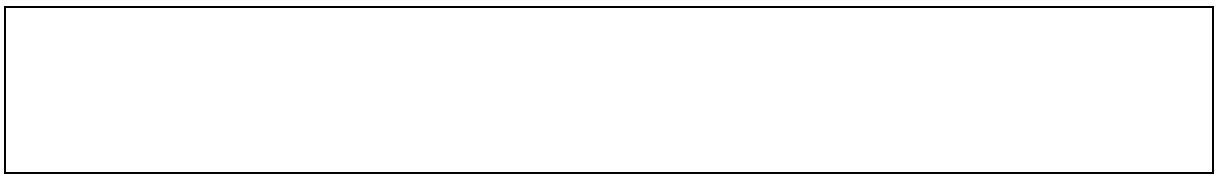
## Your responses to the consultation questions

## 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

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|---|
| **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

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|---|
| **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

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

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?**

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| |

| **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 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** | Peter Philip Callan |
| **Organisation (if applicable)** | Peter Callan Specialist Plastic Surgeon |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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 guidelines are more worried with issues that should only be of concern after the bona fides of the practitioner, their AMC recognised training, experience, and scope of practice are validated. The guidelines pay lip service to this. The guidelines make no mention of AMC recognised training. The guidelines don't even mention the AMC. |
| **2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?** |
| The guidelines leave it up to the practitioner to determine whether they are trained or not. There must be no confusion. The patient must be confident that they are seeing a practitioner with AMC recognised qualifications and a scope of practice that reflects that, even if the patient does not know what that means. Patients expect nothing less and shouldn't have to navigate AHPRA's codes. A passenger flying on a commercial flight does not need to verify if the pilot is qualified to fly that plane, nor would they be expected to know how to do so. |
| **3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.** |
| The codes and guidelines seem to be obsessed with matters that are secondary and soft on the primary concern ie are you seeing a practitioner with verified credentials? That means AMC verified, not some pop-up College or Academy. |

## Management of notifications

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|---|
| **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 needs to stop using in-house words like "protected title" that have no meaning to the average consumer. They should instead limit what a practitioner can call themselves to AMC and AHPRA recognised titles. After that, further descriptors that refine the skillset could be allowed if these descriptors are within the scope of practice of the qualification. Then they should collect information about who does what, and what the scope of practice should be. You should not be able to call yourself something that does not exist. AHPRA's response when practitioners do is "Oh that's not a protected title". Seriously? That is an abrogation of responsibility. |
| **5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.** |
| AHPRA has been traditionally weak on this in the past, going hard where it needn't and soft where it should investigate. The first thing AHPRA should do is investigate without prejudice. And the first thing to do is determine what right a practitioner has to do what they are doing. A sensible interpretation should be then made to go and investigate further. Relevant peers may help here. But not unqualified peers. Those who have appropriate AMC qualifications and standings. |

## Advertising restrictions

| **6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?** |
|---|
| There needs to be truth in advertising in such an industry. Realistic images, controlled before and after pictures. Correct AMC recognised qualifications. |
| **7. What should be improved and why and how?** |
| It's obvious. If AHPRA is designed to protect the public in these matters, then it should start by ensuring truth in advertising. And not accept spin.<br><br>The reasonable consumer test should apply. The consequences of being misled are severe and often irreversible. It's too late to take recourse. |
| **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 risk relates to the training and professionalism of the practitioner. Current guidelines do not address this. |
| **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?** |
| Targeted advertising to the young who become consumers later should be regulated. |
| **10. Please provide any further relevant comment in relation to the regulation of advertising.** |
| AHPRA should listen when it gets a complaint and not look for technicalities. At the moment AHPRA looks for technicalities in difficult issues that avoids it investigating, and goes for the low hanging fruit the rest of the time. AHPRA should look at it in a consumer sense, not a legal one. If a patient is likely to be misled it should be called out. |

## 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 ridiculous suggestion. Being a surgeon takes years of training and should be recognised as such. To say you could get an endorsement is as absurd as saying a private Cessna pilot could get an endorsement to fly an Airbus A380 without being a commercial pilot and the years and hours that involves.<br><br>Asking this question means that not even AHPRA understands what surgery is. Trivialising the skills and training involved is why this review is occurring in the first place. |

| **12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?** |
|---|
| See 11. Trivialising surgery. Is that what the peak regulator is about? |
| **13. What programs of study (existing or new) would provide appropriate qualifications?** |
| Fellowship of the Royal Australasian College of Surgeons in the appropriate title and program of study. It's an open entry, so anyone can apply. [redacted] unrecognised by anyone except themselves. Yet AHPRA never calls this out. |
| **14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.** |
| AHPRA continues to hide behind this concept of protected title. AHPRA should stop using it and instead have only titles people are allowed to use and no others are permissible. Martin Fletcher's response on Four Corners using this protected title defence was typical of what AHPRA does presently. It is a problem that needs to be recognised. |

## 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?** |
|---|
| Yes. The utmost imperative is to protect the consumer. AHPRA needs to know why there is an AMC accreditation process and use it.<br><br>As far as I can tell AHPRA is an insulated, non-responsive body. It is expensive, and the Medical Board is funded by doctors and is supposed to protect patients! It is hard on certain easy areas to judge, but soft on incompetence and rarely gets into that area. |
| **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.** |
| AHPRA should see itself as a learning organisation. |

## Facilitating mandatory and voluntary notifications

| **19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?** |
|---|
| They do but are misguided. |
| **20. Are there things that prevent health practitioners from making notifications? If so, what?** |
| Of course there are. AHPRA taking no notice of the notification or giving our name to the offending practitioner when it is easy to verify the information given. |
| **21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?** |
| AHPRA is hamstrung by its own definitions and uses them to defend itself. |
| **22. Please provide any further relevant comment about facilitating notifications** |
| |

## Information to consumers

| **23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?** |
|---|
| Yes I think so, apart for truth in credentials. However there is no evidence base behind many of the recommendations such as testimonials. And there is poor enforcement of truth in advertising. |
| **24. If not, what improvements could be made?** |
| Truth in credentials. |
| **25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?** |
| Yet again this is after the harm has occurred. Otherwise why would you complain? |

| **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?** |
|---|
| Not at all. Patients have no idea what they are looking at. It is in AHPRA terminology and not consumer friendly. |
| **27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?** |
| AMC qualifications and scope of practice. However, I know of no patient that knows what AHPRA is, let alone has looked at its website. |
| **28. Is the notification and complaints process understood by consumers?** |
| When it's too late. |
| **29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?** |
| Reduce the need for complaints by ensuring everybody ion the space is up to it. |
| **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.** |
|---|
| Responding to this is an onerous process and will cause thousands not to respond. This review looks self-serving. AHPRA is failing in making it so difficult and will defend itself by saying afterwards "we received very few responses or complaints". AHPRA needs to understand human behaviour. That is the crux of everything. Putting up a sign or a warning may satisfy AHPRA, but may also have no effect. |

**From:** Donald Cameron
**To:** Cosmetic Surgery Review
**Subject:** Cosmetic surgery is unethical
**Date:** Monday, 14 March 2022 7:27:17 PM



Dear AHPRA

I believe cosmetic surgery is unethical. A doctor's role is to treat illness. Wrinkles, small breasts, or a desire to have a different shaped nose do not represent surgical pathology. While these patients may have psychological issues related to their body image, surgery is not the correct way to address these issues.

Given that all surgery carries risks it is unacceptable that operations are carried out to alter normal variations of healthy human anatomy. The community invests considerable expense in the training of doctors, and it is disappointing to see qualified doctors abuse their training to engage in lucrative cosmetic surgery, when there is a large unmet demand for surgery for genuine indications.

I also think it is hypocritical of the Royal Australasian College of Surgeons to be critical of non FRACS doctors performing this surgery while members of the College perform these procedures.

Cosmetic surgery may be regarded by some as a legitimate commercial transaction between a willing, informed customer and a service provider, but it cannot be regarded as legitimate medical care. When unnecessary invasive procedures are performed on potentially vulnerable people, I believe AHPRA should be working to eliminate these commercial transactions undertaken by registered medical practitioners.

Regards Donald Cameron, Surgeon, [redacted]

operating, protecting, maintaining and ensuring appropriate use of its computer network.

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# 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.

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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** | Alison Cawte |
| **Organisation (if applicable)** | NA |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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? |
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| |
| **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.<br><br>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.<br><br>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.<br><br>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?** |
| 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? |
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| |
| **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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|---|
| **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?** |

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| **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.** |
| 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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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 Yuk Man Chan |
| **Organisation (if applicable)** | ACCSM |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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|---|
| **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

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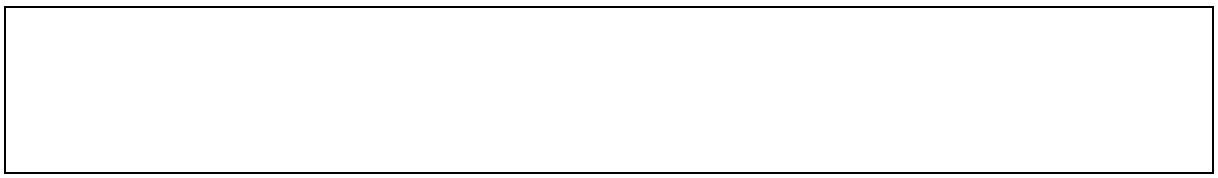
|---|
| **4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?** |
| |
| **5. Please provide any further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



## Advertising restrictions

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|---|
| **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?** |
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| **9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?** |
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| **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? |
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| **16. If yes, what are the barriers, and what could be improved?** |
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| **17. Do roles and responsibilities require clarification?** |

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| **18. Please provide any further relevant comment about cooperating with other regulators.** |
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## Facilitating mandatory and voluntary notifications

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

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

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?**

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| **30. Please provide any further relevant comment about the provision of information to consumers.** |
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| 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.** |
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| 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:** | dilip chauhan |
| **To:** | Cosmetic Surgery Review |
| **Subject:** | Public consultation on cosmetic surgery |
| **Date:** | Tuesday, 15 March 2022 9:37:07 PM |



None other than a plastic  surgeon be allowed to perform cosmetic surgery
In the public interest.They are mascurading as plastic surgeon s and duping the public
Sent from my iPhone


# 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.James Chen |
| **Organisation (if applicable)** | |
| **Email address** | [redacted] |

## Your responses to the consultation questions

## Codes and Guidelines

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| **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

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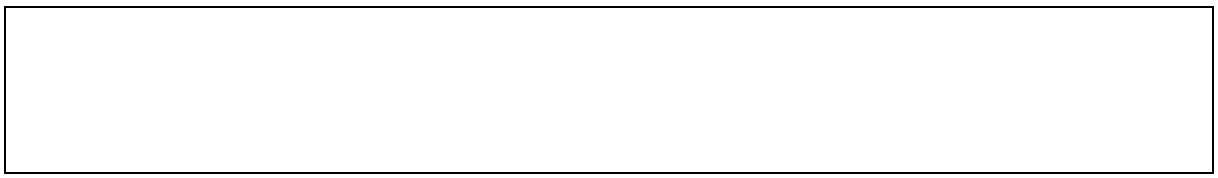
| **5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery.** |



## Advertising restrictions

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| **6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?** |
| Ahpra at this stage has quite extensive regulation already to advertising in cosmetic surgery . |
| **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?** |
| The current guidelines for advertising are quite extensive and should not be made more complicated . |
| **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 current advertising guidelines should be applied similarly to social media . |
| **10. Please provide any further relevant comment in relation to the regulation of advertising.** |
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## Title protection and endorsement for approved areas of practice

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| **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? |
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| 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?** |
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