ACCSM
AUSTRALASIAN COLLEGE
OF COSMETIC SURGERY AND MEDICINE

11 October 2021

Response to statements made by other witnesses during the Senate Community Affairs References Committee inquiry into Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law

Dear Ms Youhorn,

I refer to your email of 28 September 2021 in which you provide the opportunity *'to respond to statements made by other witnesses or provide additional information to the Committee.'* The Australasian College of Cosmetic Surgery and Medicine (ACCSM, formerly the Australasian College of Cosmetic Surgery), therefore responds below to statements made by **Dr Robert Sheen**, President, Australasian Society of Aesthetic Plastic Surgeons, **Professor Merrilyn Walton**, Professor of Medical Education, University of Sydney, **Dr Anne Tonkin**, Chair, Medical Board of Australia and **Ms Patricia Hall**, Member Community Reference Group, AHPRA. Some of the statements made were in relation to questions from **Senators O'Neill** and **Fawcett**.

We request that our responses are considered in context of the ACCSM recognising that patients are inadequately protected by the current regulatory framework, along with our proposal to address this by means of a **National Accreditation Standard and/or Endorsement Model** for **all** doctors performing cosmetic surgery. Please see attached a summary of the **Endorsement model** and refer to **Table 1** embedded within the attached cover letter which summarises the effects of the three different proposed methods to restrict the title cosmetic surgeon.

Statement 1: Dr Sheen. Proof Committee Hansard at Page 1, Paragraph 5:

'…The reality is manifest by an inexcusable litany of poor patient outcomes that arise when patients are deceived into believing that, when a practitioner sees the title 'cosmetic surgeon', they must be a registered specialist. This is confirmed by consumer research, where 81 per cent of respondents were of this view…'

Response of the ACCSM:

Dr Sheen's statement is very troubling. It relies upon 'research' conducted by a paid market research agency, McNair yellowSquares (the Agency), commissioned by ASAPS in 2019.

In fact, the Agency undertook only an online market research poll of *'…more than 2,000 Australians…'*, who were given 5 questions/statements and asked to respond in a binary manner by 'agree' or 'disagree'. Whilst the poll has been widely published in various forms by ASAPS, the following considerations are critical for proper analysis.

ASAPS purport the Agency's study to represent *'Australians'*.[1] However, given that only around 2000 participants (numerator value) took part out of an estimated population of 26 million (denominator value), in fact only 0.00769% (that is less than 0.01%) of 'Australians' may be represented, with self-evident implications.

Further, it is commonly accepted that reliable scientific medical research requires peer-review. This commercial poll has neither been published in the scientific medical literature nor has undergone any form of peer review.

Accordingly, there are a multitude of concerns associated with it. This submission will focus on the two matters considered most fundamental and relevant to the considerations of this Senate committee:

Firstly, ASAPS report that the responses to 4 of the 5 questions *'…in the 18-24 year old age group were significantly different from the rest of the population'*.[2] In other words, the age group perhaps most likely to undergo cosmetic surgery, answered differently to the rest of the study population, which in combination with an already tiny sample size, also has self-evident implications.

Secondly, at the time of original publication on 9 December 2019, ASAPS reported '…*81 per cent of Australians agree that the title cosmetic surgeon implies the doctor has* ***completed surgical training*** (emphasis added)*.'*[1]

However, on 30 April 2021 ASAPS published their submission to this Senate Inquiry changing that statement to read instead *'In fact, research conducted by ASAPS reveals that 81% of Australians believe that if a practitioner uses the title "Cosmetic Surgeon" then that practitioner must be a* ***registered specialist surgeon*** (emphasis added)*.'* This statement is entirely different in its content and meaning and misrepresents the 'research' as originally published.

However, in that misrepresented form it appears to have been relied upon by Senator O'Neill in her questioning of Mr Fletcher, CEO AHPRA (see Proof Committee Hansard at Page 41, Paragraph 3), where she stated *'Eighty-one per cent of people think that when they go to get cosmetic surgery they're getting it from a specialist who's qualified to do that. That is not the case'* and then at Paragraph 7 where she stated *'If 81 per cent of Australians think that they're going to a cosmetic surgeon – and they don't know the difference between who you look after and who you say you don't look after-why aren't you using the powers that you have under section 118 of the national law?'*

The ACCSM has already detailed 19 errors of fact, misrepresentation and omission made by ASAPS to this Senate Inquiry.[3] This further information is additive to ASAPS' claim 6 in submissions.

As a consequence, this new twentieth matter by ASAPS, appears to have led Senator O'Neill to conflate the issues of surgical training and specialist registration with considerations of section 118 of the National Law. Whilst Cosmetic surgery is not recognised as a surgical specialty and therefore has no associated protected title, it lies outside the related jurisdiction of AHPRA and National Law. That does not mean that the practice of individual medical practitioners cannot be regulated. This distinction was detailed carefully in submissions of the ACCSM regarding ASAPS' claims 3, 13, 14 and 19, that AHPRA *are* in fact using their powers correctly and appropriately. It was confirmed during the Hearing not only by Mr Fletcher (see Proof Committee Hansard at Page 41, Paragraph 8) *'I'm saying to you: we are using our powers'* but also by me (see Proof Committee Hansard at Page 7, Paragraph 1) *'The second thing is AHPRA are doing their job. Dr Sheen refers to section 118 in the national law. AHPRA are acting properly and they are acting effectively for three reasons. Firstly, 'surgeon' is not a protected title; secondly, 'cosmetic surgeon' is not a protected title and thirdly, 'cosmetic surgery', as we've said earlier on, is not a speciality, therefore, AHPRA are*

acting quite properly and quite effectively within the jurisdiction under the national law as it currently stands.'

Finally and related to the above, the ASAPS' commissioned McNair research omitted to inform respondents that cosmetic surgery is not recognised as a specialty and that AMC accredited specialist surgeons are not trained in it, according to the AMC itself.[4] The poll would have been perhaps more relevant had ASAPS ensured the public were asked whether or not they expected a doctor calling themselves a cometic surgeon to have had training and qualifications in cosmetic surgery.

The answer to that pertinent question is already known.

In a survey performed by Galaxy Research[5] as part of the Application for recognition of a new specialty in 2007 (which the ACCSM acknowledges is subject to similar limitations as the ASAPS' McNair research), 97% believed that doctors should have to pass an exam and get a 'licence' in cosmetic surgery before being are allowed to practise it. Further, 98% believed that patients have the right to know if the doctor performing their cosmetic surgery procedure is trained *specifically* in cosmetic surgery.

Given the lack of recognition of a speciality of cosmetic surgery, it is the regulation of the practice of cosmetic surgery that needs to be changed. It is in that context that the ACCSM has made a pragmatic proposal to address the problem by means of a **National Accreditation Standard** and/or **Endorsement Model** (see responses to statements 8, 9 and Conclusion). It is this which is consistent with the wishes of Australians.

Statement 2: Dr Sheen. Proof Committee Hansard at Page 3, Paragraph 4:

'Cosmetic surgery is currently practised by several surgical disciplines, including plastic surgery; ear, nose and throat surgery; ophthalmology; gynaecology; and general surgery. All of these practices incorporate cosmetic surgery within their scope of practice. The common theme is they've all gone through an Australian Medical Council accredited training program…'

Response of the ACCSM:

In his statement, Dr Sheen specifies five surgical disciplines practising cosmetic surgery and relates all to Australian Medical Council (AMC) accredited training. However, in the (current) 2017 AMC accreditation report of the Royal Australasian College of Surgeons (RACS) surgical training programs, not a single one of the specialities to which Dr Sheen referred is accredited for training in cosmetic surgery.[4] Further, cosmetic surgery is not even mentioned in the section addressing each respective speciality. In contrast, cosmetic surgery is only mentioned in relation to plastic surgery, in regard to which it is stated that AMC-accredited specialist plastic surgeons have a 'deficit' in their experience of aesthetic (cosmetic) surgery and qualify with a 'gap in this area of practice.'[4]

Therefore, the correct 'common theme' is that the surgical disciplines to which Dr Sheen referred have indeed all gone through an AMC accredited training program which provided most commonly no training in cosmetic surgery whatsoever and at best, in one discipline, had a 'deficit' leading to a 'gap' in that area of practice.

Statement 3: Dr Sheen. Proof Committee Hansard at Page 3, Paragraph 5:

'I refute the assertion that it's a new specialty. The Australasian Society of Aesthetic Plastic Surgeons held its first annual scientific congress in 1978. The American Society for Aesthetic Plastic Surgery was founded in 1967, and there has been high-level professional discourse and education within the profession for many decades.'

Response of the ACCSM:

The origins of surgery date back thousands of years.

Modern scientific surgery is generally accepted as only having commenced around 250 years ago from the pioneering work of John Hunter in London.

The Royal Australasian College of Surgeons, did not exist until 1927 and its reputation, by its own admission, did not *'become secure'* until the 1970s.[6]

Even younger, the modern speciality of plastic surgery as we know it today evolved from skills, techniques and expertise derived from other traditional surgical specialties during twentieth century wars.

Upon that background, modern cosmetic surgery did not emerge until the 1970s. In surgical terms, the approximate four decades that have since elapsed are merely 'the blink of an eye'. The young nature of cosmetic surgery and its practice is the most fundamental reason why many of the problems being grappled with by this Senate Committee indeed exist and why, despite numerous claims to the contrary, cosmetic surgery neither belongs to, nor is subsumed by, any traditional surgical specialty.[7] It should indeed be considered a new specialty but is simply unable to be recognised due to the constraints of the National Law as it currently stands.[3,8]

Statement 4: Dr Sheen. Proof Committee Hansard at Page 6, Paragraph 7:

'I'm conscious of the time, but Dr Sanki and Dr Teston were very prepared to present to this committee what happens when patients go through the system where the protective provisions are not enforced and AHPRA then has to pick up the pieces in a retroactive way. It is just human tragedy on a mammoth scale. ***It's all going under the radar*** (emphasis added)*. These people for their own personal reasons try to get on with their lives in a very damaged way.* ***Unfortunately, we have litanies of admissions to public hospitals, emergency departments and intensive care units*** (emphasis added)***.*** *There are all of these tragic outcomes. People have been financially ruined by being treated by these so-called cosmetic surgeons. This could all be mitigated by robust tighter compliance by AHPRA right now with the existing [inaudible].'*

Response of the ACCSM:

Due to time constraints Doctors Sanki and Teston did not in fact 'present' on this matter. Notwithstanding, the ACCSM submits the following perspective to provide balance to the suggested implications of Dr Sheen's statement.

Complications are a risk of any surgery and may occur even in the most experienced of hands. Whilst there have recently been high profile media reports of poor outcomes at the hands of some untrained cosmetic surgeons, what ASAPS has described as *'litanies of admission to public*

hospitals……' is anecdotal, emotive in nature and not evidence-based.[7,9-11] Sadly, such presentation of adverse outcomes from 'cosmetic surgeons' has become a regular refrain from plastic surgeons but the Committee must be aware that the eclectic collection and presentation of such cases as alleged 'evidence' of the competence or lack thereof of any group of surgeons is unscientific, sensational and is likely to mislead.

Indeed, Dr Sheen's statement implies that 'non-plastic surgeons' have disproportionately high cosmetic surgical complication rates, despite the absence of supportive data. During the Senate Hearing, Senator O'Neill requested any such data of Mr Fletcher, CEO AHPRA, also going on to enquire "*Would there be any other agency that could have a more accurate view about the safety risks to Australians of undergoing cosmetic surgery in the current regime where there are specialist practitioners and cowboys?"* (see Proof Committee Hansard at Page 43, Paragraph 3).

Firstly, to assist the Committee it is important to characterise correctly the types of practitioners performing cosmetic surgery. ASAPS conflate all practitioners performing cosmetic surgery into two groups – 'plastic surgeons' and 'non-plastic surgeons', irrespective of training and experience in cosmetic surgery. There are in fact three groups comprising:

(a) ACCSM Fellows;

(b) RACS Plastic Surgical Fellows (who the AMC identified as having a '*deficit*' in their experience of aesthetic (cosmetic) surgery and qualifying with a *'gap in this area of practice')*; and

(c) other practitioners many of whom may have no formal training, qualification or re-certification in cosmetic surgery.

Secondly, in relation to the request of Senator O'Neill, the ACCSM submits that relevant agencies would include the Medical Defence Organisations (MDO) which insure medical practitioners. They may hold data that might assist in the assessment of complications arising from the different types of practitioners (see above) who perform cosmetic surgery. Relevant parallel enquiry to that of Senator O'Neill was made by Senator Fawcett (see Proof Committee Hansard at Page 45, Paragraph 1).

In such context, the ACCSM wishes to draw the attention of the Committee to a 2012 study by the Melbourne University School of Public Health in cooperation with Avant (the largest Australian MDO which indemnifies half of all Australian doctors) and the Victorian Health Services Commissioner, which reviewed 481 informed consent disputes resolved between 2002-2008. 77 involved cosmetic procedures, in nearly two thirds of which, the practitioner against whom the allegation was made was a plastic surgeon.[12] Only one malpractice claim ended up in court and was settled in favour of the surgeon. In light of this, whilst it is unknown what percentage of cosmetic surgery is undertaken by practitioners of differing qualifications, the suggestion that there is a 'litany' of medical negligence because of cosmetic surgeons (ie non-RACS' trained AMC-accredited specialist plastic surgeons) undertaking cosmetic surgery does not stand up to scrutiny. There is no evidence for it at all.

Further, Dr Sheen fails to mention the documented poor cosmetic surgical outcomes at the hands of some plastic surgeons.[7,9-11] Whilst numerous examples exist, the most high profile and catastrophic is of course the tragic death of Ms Lauren James, to which I referred in the Senate Hearing (see Proof Committee Hansard at Page 7, Paragraph 1). Ms James' sad death is the only

example known to have occurred in a patient undergoing cosmetic surgery in Australia due to surgical error as a consequence of inadequate training. She lost her life in 2007, aged 26, following liposuction at the hands of a plastic surgeon who she had been led to believe was adequately trained in cosmetic procedures. According to the Victorian coroner, Ms James's death was avoidable, but her surgeon delivered a *'wholly inadequate clinical response'* when complications developed. Further, the Coroner specifically noted that *'irrespective of a practitioner's provenance or primary qualifications, there was a need for specific training and experience in performing liposuction surgery.'*[13] Consistent with the AMC's findings, the plastic surgeon was unable to evidence formal training in liposuction and the Medical Board of Australia subsequently required him to undergo further education.

Upon such background, the alleged '*…litanies of admissions to public hospitals, emergency departments and intensive care units…'* as alleged by Dr Sheen, may represent no more than complications arising as a consequence of the volume of cosmetic surgery being performed in the private sector due to ever-increasing demand. I also referred to this in the Senate Hearing (see Proof Committee Hansard at Page 2, Paragraph 7). In the absence of objective data, it is not possible to draw any further sensible conclusion.

However, there is an additional, important and relevant peculiarity that exists which will inevitably distort any alleged 'complication' data considered to arise from cosmetic surgeons. It relates to how practitioners are credentialled at hospitals and the Senate Committee must be alive to it as it may not be readily apparent.

Currently, when a patient requires public hospital admission for emergent complications following private cosmetic surgery performed by a cosmetic surgeon, that patient typically presents via an emergency department and may be referred to the 'on-call' plastic surgeon. Having been made aware of the patient in their role as a public hospital consultant, such complications are then frequently 'notified' to regulators as formal complaints by plastic surgeons and become 'data'. However, non-RACS cosmetic surgeons typically have neither admitting rights to public hospitals nor roles as public hospital consultants and so are not presented with similar complications, irrespective of the type of surgeon from which they arise. Similar notifications to the regulators as formal complaints that would counterbalance the interpretation of such data cannot therefore be made. Hence the 'data' reported by Dr Sheen as an apparent 'litany' is inevitably skewed as a consequence of inherent 'selection bias'.

Further, if a similar complication occurred following private cosmetic surgery by a plastic surgeon on an uninsured patient, that patient may transit or even bypass the emergency department altogether and be admitted directly to the surgical ward of a public hospital under the care of the same plastic surgeon (or even a plastic surgery colleague) without question, oversight or criticism. There may be no associated data presented to the regulators. This may be a circumstance that is actually "going under the radar".

In such context, it is relevant and additive to the already published data[12] to reveal that ACCSM Fellows are regularly called upon to correct the work of Australian plastic surgeons untrained in cosmetic surgery. In a contemporary survey of ACCS Fellows in early 2021, it was found that 94% had been consulted by patients to address operative problems following cosmetic surgery undertaken by Australian qualified specialist plastic surgeons holding FRACS (Plast) and 87% had undertaken revisional surgery on patients to address operative problems following cosmetic surgery undertaken by such Australian qualified specialist plastic surgeons.[3] It is such data that

supports the need for a competency based Accreditation Standard and/or Endorsement Model specific to cosmetic surgery, as proposed by the ACCSM.

Irrespective, when patients are admitted to the public healthcare system following cosmetic surgery complications, the associated cost and diversion of resources is of course a concern shared by the ACCSM. However, proper assessment of any potential burden being placed upon the public system requires an objective and independent method of collecting pertinent data in order to be able to address any concerns adequately. Only such an approach will facilitate accurate assessment to guide future policy and decision-making.

Notwithstanding, the implementation for **all** doctors practicing cosmetic surgery of a competency-based National Accreditation Standard and/or Endorsement model and Register of cosmetic surgeons linked with appropriate title restriction, all as proposed by the ACCSM, would help to address the overarching issue in three ways. **Firstly**, by eliminating medical practitioners who have not met the required standard from performing cosmetic surgical procedures, thereby protecting patients. **Secondly**, use of the Register would facilitate objective credentialing of cosmetic surgeons by accredited operating facilities including private hospitals and day surgeries. This would effectively restrict operating privileges to only those surgeons who appear on the Register and who have therefore been accredited as competent and safe to perform cosmetic surgery. **Thirdly**, the Register could be used by Medical Defence Organisations (MDO) to identify practitioners appropriately trained in cosmetic surgery and thus appropriately restrict indemnity policies accordingly. Currently Medical Registration Standards require all medical practitioners to obtain annual Medical Indemnity insurance from an MDO to cover their scope of practice in order to renew their medical registration. If a medical practitioner were not on the Register and therefore appropriately denied indemnity insurance to practice Cosmetic Surgery yet continued to do so, that individual would automatically be liable to appropriate regulatory action by AHPRA for operating outside the scope of practice for which they were indemnified. The effect would be fewer overall complications with associated reduction in pressure exerted upon the public healthcare system.

Statement 5: Professor Merrilyn Walton. Proof Committee Hansard at Page 31, Paragraph 1:

'The reason for my concern is not that you might not be competent at doing liposuction or facelifts or any surgical intervention. It's can you manage an adverse event? Do you know what to do if you perforate the bowel wall? Do you know how to look after that patient safely?'

Response of the ACCSM:

Entry criteria for selection to the surgical training program of the ACCSM require that *prior* to commencing cosmetic surgical training, candidates are already trained, experienced and competent in safe assessment and management of patients during the three phases of surgical care - pre-operatively, at surgery and post-operatively. This mirrors the AMC accredited model of surgical training of RACS where trainees must complete basic surgical training before commencing training in a specialised area such as plastic surgery or orthopaedic surgery. In the example proffered - perforation of the bowel wall during liposuction - all such sensible, trained surgeons, cosmetic, plastic or other, would stabilise the patient an seek emergent assistance from general surgical colleagues.

The ACCSM agrees with Professor Walton's concern as it applies to the 'cowboy' cometic surgeons who have no such background training and expertise. The implementation of a competency-based National Accreditation Standard and/or Endorsement model and Register of cosmetic surgeons linked with appropriate title restriction, would address this directly (see response to statement 6 below).

Statement 6: Professor Merrilyn Walton. Proof Committee Hansard at Page 31, Paragraph 7:

'If the college actually has six years of surgical training, I'm very happy for them to call themselves cosmetic surgeons, but at the moment in this country the only accredited body to accredit surgeons is the Australian and New Zealand college of surgeons. If the college had an equivalent level of competence that was testable and acceptable then, yes, the college could call them cosmetic surgeons.'

Response of the ACCSM:

Unfortunately, Professor Walton's statement is incorrect. The 'Australian and New Zealand college of surgeons' is not the only accredited body to accredit surgeons in this country - for example, the Royal Australasian College of Obstetricians and Gynaecologists (RACOG) accredits Gynaecological Surgeons, the Royal Australasian College of Dental Surgeons accredits Maxillofacial Surgeons and the Royal Australian and New Zealand College of Ophthalmologists accredits eye surgeons, some of whom practice cosmetic surgery.

The pertinent issue for consideration here is not the ACCSM per se, but rather medical practitioners from all backgrounds, who have inadequate training in cosmetic surgery. As cosmetic surgery not being able to be recognised as a speciality and 'Cosmetic Surgeon' is not a protected title under the Health Practitioner Regulation National Law Act 2009 (National Law), currently **any** medical practitioner may call themselves a 'Cosmetic Surgeon.' This is the issue that causes confusion and is the very problem that the ACCSM is seeking to be addressed by regulatory authorities.

Notwithstanding, the ACCS (and now the ACCSM) has trained medical practitioners in the field of cosmetic medical practice for almost 3 decades and arguably to the highest level in Australia. It has promoted and maintained an inclusive approach, welcoming surgeons from a variety of specialty backgrounds, including not only plastic surgeons, but also ophthalmologists, ENT, facio-maxillary surgeons and gynaecologists. Where applicable, its training program is structured around the 10 Standards set out by the AMC for assessment and accreditation of Specialist Medical Programs.[14]

To become an ACCSM Fellow, doctors must typically complete a minimum of 12 years of medical and surgical education and training and demonstrate competency specifically in cosmetic medicine and surgery. At initial selection, all candidates must have at least five years post-graduate experience, including three years of accredited (non-cosmetic) surgical training in posts approved by the College and be a fully registered practising medical practitioner. This is to ensure that *prior* to commencing cosmetic surgical training, candidates are already trained, experienced and competent in safe assessment and management of patients during the three phases of surgical care - pre-operatively, at surgery and post-operatively. This mirrors the AMC accredited model of surgical training of RACS where trainees must complete basic surgical training before commencing training in a specialised area such as plastic surgery or orthopaedic surgery. Most recently under my Presidency and as practice in the field has evolved, preference

is now given to candidates who have attained Fellowship of one of the Royal Colleges of Surgeons or an equivalent post-graduate surgical qualification (as determined by the College).[15]

The ACCSM' registrar training program provides 24 months of advanced training in cosmetic surgery during which candidates for Fellowship are required to master a set of skills in consultation, clinical judgement and performance and are subject to direct observation and evaluation prior to undertaking written examinations. The training program includes 8 clinical rotations of 3 months each, involving attachment to at least 4 cosmetic surgical preceptors (Fellows of the ACCSM) who are responsible for the Registrar's clinical training. Registrars are required to complete a minimum of 25 hours clinical attendance each week (minimum 1100 hours per year) including 6 major procedures per week (minimum 250 per year) and 10 hours of academic time. Evaluation reports are submitted about the Registrar at the end of each clinical rotation. If performance is satisfactory, candidates are invited to sit written examinations conducted by the American Board of Cosmetic Surgery. This long established examination is independently validated. Only following successful completion, amongst other academic requirements, are candidates then invited to sit Viva Voce examinations, successful completion of which allows the grant of Fellowship. No Fellowship can be awarded without successful completion of the formal examination process. This is the only qualification specific to cosmetic surgery in Australia.

Thereafter, all Fellows are required to comply with Continuing Professional Development of the College, in order to recertify on an annual basis. Requirements include, but are not limited to, at least 80 hours of continuing medical education, audit and being credentialled at hospital(s) accredited by the Australian Council on Health Care Standards.[16] In toto, this requirement ensures that Fellows undertake career-long continuous education specific to cosmetic surgery, thereby enhancing patient safety.

Despite the absence of specialty recognition, by means of the above, the College has delivered a training program that aims to meet applicable AMC standards for assessment and accreditation of Specialist Medical Programs.[14]

Statement 7: Professor Merrilyn Walton. Proof Committee Hansard at Page 31, Paragraph 11 (corrected from audio transcript from the video):

'I think that with the accredited surgeons (ASAPS)*, I don't think see-one do-one should apply either. If you're a surgeon and have never done cosmetic surgery, just seeing one and then doing it in my view is unsafe.'*

Response of the ACCSM:

The ACCSM agrees with Professor Walton that the public should not be exposed to specialist surgeons, plastic or otherwise, learning by a 'see-one, do-one' approach to cosmetic surgery in private practice. Ms Lauren James was the tragic consequence of such conduct and restricting the title 'surgeon' to holders of specialist registration and by such mechanism banning the title 'cosmetic surgeon' *without* linkage to accreditation specifically in cosmetic surgery, would not have saved her life.

The fact is that specialist plastic surgeons are not trained and qualified in cosmetic surgery upon registration as specialists with AHPRA. The Australian Medical Council (AMC), the independent national standards body for medical education and training recently reported that plastic

surgeons trained by RACS have *'a deficit'* in their experience of cosmetic surgery and qualify with a '*gap in this area of practice'*. So damaging was the AMC's finding to the Australian Society of Plastic Surgeons (ASPS) political narrative that it lobbied to have the report revised[17]. The AMC refused.

Both ASPS and the Australasian Society of Aesthetic Plastic Surgeons (ASAPS) are 'pay to join' private organisations. Neither is a regulatory authority nor government agency. ASPS previously publicised it existed *'…to represent the economic and political interests of those plastic surgeons who choose to belong to it…'*[18] Upon such background, the Committee ought be aware that annually, cosmetic surgery in Australia is worth $1bn. It is commonly accepted that cosmetic plastic surgeons can earn more than $2m per year.

The ACCSM proposal to implement a competency-based **National Accreditation Standard** and/or **Endorsement Model** and **Register** of cosmetic surgeons linked with appropriate title restriction, would protect patients by ensuring that any medical practitioner, including plastic surgeons, performing cosmetic surgery under the title 'cosmetic surgeon or aesthetic plastic surgeon' would have to achieve the benchmark Standard and undertake recertification. AHPRA would maintain a Register of such practitioners to whom the title 'cosmetic surgeon or cosmetic/aesthetic plastic surgeon' would then be **restricted**, thereby protecting the public by practitioner regulation. This would remove confusion for consumers, allowing them to identify competent, safe practitioners and also prevent any monopoly. Competition between safe practitioners based on competence, price and service, would benefit and protect patients by improving standards

Statement 8: Dr Anne Tonkin. Proof Committee Hansard at Page 43, Paragraph 18

'I think the fundamental point here is that, given the way that the national law has been constructed, we do not regulate scope of practice at all. We regulate title. As Mr Fletcher said before, we regulate what training people require in order to call themselves by a protected title…We rely on medical practitioners to practise in a scope of practice for which they are adequately trained and experienced and have adequate expertise, and that is fundamental to the way in which the national law has been set up. So title protection is how we operate. We don't operate on restricting people's scope…So there are two things here that I think might assist in understanding our role here: we regulate title and not scope, and we rely on practitioners to practise within a scope that is suitable for them.'

Response of the ACCSM:

The manner in which Dr Tonkin has characterised the National Law illustrates well the problem of cosmetic surgery in Australia. As the area of cosmetic surgical practice is not recognised as a speciality and neither the titles 'surgeon' nor 'cosmetic surgeon' are protected, **any** Australian medical practitioner may call themselves a 'Cosmetic Surgeon', irrespective of any training in cosmetic surgery they may or may not have undertaken and irrespective of any specialist title.[7-11] Three groups do so:

(1) ACCSM Fellows, who are trained in cosmetic surgery

(2) RACS Plastic Surgical Fellows, who the AMC identified as having '*deficit'* in their experience of aesthetic (cosmetic) surgery and **qualifying** with 'a *gap in this area of practice.'*[4]

(3) other practitioners many of whom may have no formal training, qualification or re-certification in cosmetic surgery. This is the group of untrained (cowboy) practitioners who are the most worrisome.

The ACCSM acknowledges this situation is confusing and unsafe for consumers.[7,9-11] As the National Law was not constructed to accommodate the relatively new practice of cosmetic surgery (see ACCSM response to statement 3), it was to address this very problem and lack of regulation that the ACCSM made its Accreditation Standard proposal to COAG Health Council in January 2021.

That proposal is to develop a **National Accreditation Standard** in cosmetic surgery requiring essential training, qualifications, competency and recertification in cosmetic surgery, along with a **Register** of Cosmetic Surgeons detailing those who have met and maintain the Standard, linked with **restriction of the title** 'Cosmetic Surgeon.'[19] This pragmatic solution would protect patients by allowing them to identify easily those practitioners who have met the competency standard in cosmetic surgery, irrespective of background.

As an alternative regulatory mechanism that would have the same patient protection benefits, we have also provided in correspondence to this Committee details of an additional **Endorsement Model** for cosmetic surgery that could operate under Section 98 of the National Law. Please see attached a summary of the **Endorsement Model.**

Only two groups of practitioners might be anticipated to object to the implementation of such a process and national Register of competent providers of cosmetic surgery. **Firstly**, medical practitioners performing cosmetic surgical procedures who do not meet the required standard. This would for the most part be anticipated to comprise the third (cowboy) group who *should* be eliminated from undertaking cosmetic surgery. **Secondly**, medical practitioners (or their craft-group representatives) who seek to manipulate the regulatory reform process primarily to protect themselves rather than to protect patients, by eliminating competent alternative providers.

Once implemented, the competency-based **National Accreditation Standard** and/or **Endorsement Model**, **Register** of cosmetic surgeons and associated **protected title** would ensure that:

- The public can be provided clear assurances regarding practitioners who are trained, experienced and properly accredited in cosmetic surgery, thereby improving safety.

- Medical practitioners who undertake cosmetic surgical procedures be required to maintain and enhance their knowledge and skills to deliver the highest levels of patient safety by means of ongoing cosmetic surgery specific Continuing Professional Development.

This would offer a pragmatic solution to the problem within the structure of the current National Law.

Statement 9: Ms Patricia Hall. Proof Committee Hansard at Page 53, Paragraph 14:

'We're encouraging consumers to ask the cosmetic practitioner to show them their qualifications. They can then go the AHPRA register to see if they are a registered practitioner.'

Response of the ACCSM:

As a member of the Community Reference Group of AHPRA, Ms Hall is already encouraging consumers to follow exactly the path advocated by the ACCSM, but in the absence of a useful indicator of the desired information actually needed.

The ACCSM proposal (see statement 8) would ensure that such a consumer searching the AHPRA website would be able, easily and without confusion to go the Register of Cosmetic Surgeons in order to check that the practitioner by whom they were considering undergoing cosmetic surgery had met the competency-based **National Accreditation Standard** and/or is **Endorsed** on the **Register** to practice cosmetic surgery and accordingly, properly holds the relevant **restricted title**. That is why the proposal of the ACCSM is a pragmatic comprehensive solution that would advance the matter of protecting patients.

Conclusion

The ACCSM considers that **ALL** of the issues and concerns raised and discussed by parties involved in this Senate Inquiry would be resolved by implementation of a competency-based **National Accreditation Standard** for Cosmetic Surgery and/or **Endorsement Model**, applicable to all practitioners performing such surgery, in combination with an independent, mandatory **Register** of such practitioners holding the linked **restricted title** 'cosmetic surgeon'.[3]

Further, the ACCSM notes that in a communique published by the COAG Health Council in November 2019, following the 2015 Independent Review of the National Registration and Accreditation Scheme for health professionals, Health Ministers agreed to *'…progress changes to restrict the use of the title "surgeon" to provide better information for the public about the qualifications of surgeons, including those who call themselves cosmetic surgeons. The use of the title "surgeon", including by way of "cosmetic surgeon", by medical practitioners, non-specialist surgeons* ***or those without other appropriate specific training*** (emphasis added) *can cause confusion among members of the public. Ministers agreed that further consultation should be undertaken on which medical practitioners should be able to use the title "surgeon".*[20]

Later that month, The Hon Greg Hunt, Minister for Health, communicated this to ASAPS whilst also stating '*I note that further work will be required prior to the changes being made to the National Law* ***to determine which medical practitioners should be given the right to use the title 'surgeon'*** (emphasis added)*. This will include consultation with community consumer groups and medical professions.'*[21]

The ACCSM considers that both the **National Accreditation Standard** and/or **Endorsement models**, **Register** and **linked restriction of title**, as proposed by the ACCSM, are entirely consistent with the stated positions and intentions of both the COAG Health Council and Minister Hunt and provide appropriate mechanisms to achieve their aims.

Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

Patrick Tansley

President

Australasian College of Cosmetic Surgery and Medicine

MB BChir (Cantab) PGDipSurgAnat BSc (Hons) MScAesPlasSurg MD FRCS (Eng) FRCS (Plast) FACCSM (Surg)

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