



The Australasian College of Cosmetic Surgery
Raising Standards, Protecting Patients

**APPLICATION TO THE AUSTRALIAN MEDICAL COUNCIL
FOR RECOGNITION OF A MEDICAL SPECIALTY
COSMETIC MEDICAL PRACTICE**

OCTOBER 2008

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Purpose of this document

The purpose of this document is to present the case by the Australasian College of Cosmetic Surgery (ACCS) for recognition by the Australian Medical Council (AMC) of Cosmetic Medical Practice as a medical specialty. This application is in accordance with the AMC's Guidelines for Recognition of Medical Specialties Advisory Committee and follows the College's preliminary application which was given *prima facie* approval to proceed by the AMC in accordance with the Council's guidelines pertaining to the Recognition of Medical Specialties and Subspecialties (2007). Recognition is not being sought for the purposes of the *Health Insurance Act 1973*.

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Glossary

Accreditation – A formal system to evaluate a doctor's competence necessary to perform safely and effectively within the scope of the doctor's practice, assessed against specific criteria.

Advanced Beauty Therapists Association – An association that represents beauty therapists and aestheticians in NSW.

Australasian Society for Aesthetic Plastic Surgery (ASAPS) – A Society formed to promote research and dissemination of information on aesthetic surgery in plastic surgery and represent political and industry interests of Aesthetic Plastic Surgeons.

Australasian College of Dermatologists – The specialist medical college responsible for training and accrediting skin specialists. Most dermatologists do some cosmetic skin procedures. Those who actively provide cosmetic surgery procedures are known as cosmetic surgery dermatologists.

Australasian Academy of Facial Plastic Surgery (AAFPS) – The AAFPS provides education in the field of facial cosmetic surgery to its specialist members comprised of otolaryngologists, ophthalmologists and dermatologists.

Australasian College of Cosmetic Surgery (ACCS) – The ACCS provides accreditation training and accreditation for cosmetic physicians and cosmetic surgeons.

Australian Competition and Consumer Commission (ACCC) – A Commonwealth body established under the *Trade Practices Act 1974* to regulate the conduct of corporations in providing goods and services to the public.

Australian Medical Association (AMA) – The largest medico-political organisation representing medical practitioners in Australia through voluntary membership.

Australian Register of Therapeutic Goods (ARTG) – A register of therapeutic drugs and devices approved for therapeutic purposes in Australia by the Therapeutic Goods Administration.

Australian Society of Otolaryngology/head and Neck Surgery – This Society forms the Surgical Board in Otolaryngology/head and neck surgery jointly with the Royal Australasian College of Surgeons.



Australian Society of Plastic Surgeons (ASPS) – The Society provides training in plastic and reconstructive surgery under a contract arrangement with Royal Australasian College of Surgeons (RACS) and is an industry-political body which represents plastic surgeons' financial and political interests. All plastic surgeons are accredited by the Board of RACS.

Competence – Possessing the requisite obligations and qualities (cognitive, non-cognitive and communicational) to perform effectively within the scope of the practitioner's practice while adhering to professional ethical standards.

Cosmetic medicine – A range of cosmetic procedures including injections of collagen, hyaluronic acid and similar products, Botulinum toxin (BOTOX®) treatments, chemical peels, dermabrasion and laser procedures.

Cosmetic Nurses Association – A national organisation that provides a discussion forum and education for nurses within cosmetic surgery and medicine practice.

Cosmetic and Plastic Surgery Nurses Association – The Association represents nurses in the cosmetic surgery industry in NSW.

Cosmetic Physicians Society of Australia – The Society is a special interest group. Its members must be medical practitioners who have practiced in at least one area of cosmetic procedures for 12 months.

Credentialing – A process involving a group of peers ratifying the general ability of a practitioner to perform particular types of procedures, usually relying on information provided by the practitioner, such as *curriculum vitae*, qualifications or college fellowship, a log of procedures or treatments, evidence of continuing medical education and supervised assessment, where appropriate.

Health Care Complaints Commission (HCCC) – A statutory organisation established to assess, conciliate and investigate complaints about health services and health practitioners in NSW. In appropriate cases complaints are prosecuted before disciplinary committees and tribunals.

NSW Medical Board – The Board registers all medical practitioners in NSW and is responsible for maintaining professional standards prescribed under the *Medical Practice Act 1992* and regulations.

Physician – In Australia a medical practitioner with a specialist qualification from the Royal Australasian College of Physicians. The American usage of the term, which refers generally to medical practitioners, is often used in the cosmetic surgery industry in Australia.



Privileges – Credentialing committees provide advice on the competence of medical staff to perform particular roles within the facility. These are referred to as privileges. Privileges delineate the clinical scope of practice a practitioner is allowed to perform in the facility. The privileges may be broad, allowing general surgical work up to a certain level, or may be specific to treatments or procedures that are part of the practitioner’s training.

NSW College of Nursing – The College trains and accredits nurses in NSW.

Royal Australian College of General Practitioners – A national organisation concerned with the development and maintenance of standards for general medical practice and the training and education of general practitioners.

Royal Australasian College of Surgeons (RACS) – An AMC accredited non-government organisation that provides training, accreditation and surgical standards in nine recognised surgical specialties including plastic and reconstructive surgery.

Royal Australian College of Ophthalmologists – The College trains and accredits specialist eye surgeons who are uniquely trained in dealing with the structure of the eye, vision and diseases of the eye. Some ophthalmologists perform some cosmetic surgery. There is sub-specialty training in ocular plastic surgery.

Sclerotherapy Society of Australia – The Society represents and trains doctors, who are mostly general practitioners, in sclerotherapy (varicose veins and associated conditions). This organisation has now become the Australian College of Phlebology.

Therapeutic Goods Administration (TGA) – The Commonwealth body that regulates the import and marketing of therapeutic medications and devices in Australia.



Note on name of specialty being sought for recognition

The ACCS requests Recognition to be made under the title ***Cosmetic Medical Practice*** rather than Cosmetic Surgery as previously submitted under the College's preliminary application.

The name "Cosmetic Medical Practice" is preferred to prevent confusion among the public and patients.

"Cosmetic Surgery" is universally accepted to include procedures as diverse as BOTOX[®] injections, facelifts, breast augmentations and chemical peels. However some practitioners are trained in the more invasive surgical procedures and others specialise in less invasive, non surgical treatments. If the specialty is called "cosmetic surgery" the latter group will be specialists in cosmetic surgery even though they do not perform surgical procedures in the generally accepted sense of the term. This is likely to confuse patients.

Calling the specialty "Cosmetic Medical Practice" is inclusive of both surgical and non-surgical procedures and practitioners.¹ Should the specialty be recognised, organisations would apply for their qualifications to be accepted by the AMC as appropriate for the new specialty. Practitioners would either have a qualification in cosmetic surgery and be titled cosmetic surgeons or in cosmetic medicine and be titled cosmetic physicians.

This would provide an easily understood extra protection for patients allowing them to make more informed choices.

There are no implications for scope of practice, practice patterns, identified range of related specialties and interactions/overlaps, income sources or future needs.

The specialty is defined in the Executive Summary and in Criteria I.

¹ The term "Medical" is differentiated from "Medicine" in this Application. All AMC recognised specialties are medical specialties. Some are in medicine, some in surgery. Some, such as Obstetrics and Gynaecology, Intensive Care Medicine and Ophthalmology, include practitioners who have training and competencies in both. In the case of the ACCS, the College's surgical qualification includes training and examination in cosmetic medicine.



Executive summary

This application for Recognition of Cosmetic Medical Practice as a specialty has been submitted by the Australasian College of Cosmetic Surgery (ACCS).

The College's goal is to ensure the safe provision of cosmetic surgery and cosmetic medical procedures to the Australian community through the supply of appropriately trained and certified medical practitioners.

Cosmetic Medical Practice is a well defined and unique medical specialty, practiced by medical practitioners from various specialties including dermatology, general surgery, general practice, plastic and reconstructive surgery, oral and maxillofacial surgery, ophthalmology, otolaryngology and gynaecology. The factor which unifies this divergent group of practitioners is that they all need to obtain additional specialised education, training and experience beyond their original area of postgraduate specialisation before becoming competent in cosmetic medical practice.

The College defines Cosmetic Medical Practice as operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient's appearance or self-esteem.²

Cosmetic Medical Practice has evolved to become a specialty and should be recognised as such. Cosmetic Medical Practice is expanding both within Australia and abroad. Like any consumer product or service, there is a broad spectrum of views about the value or merits of cosmetic procedures. However, the widespread and continuing growth of the specialty throughout the Australian community is an evident fact – consumers have and continue to exercise their choice to obtain the services provided by the specialty. The important issue is how best to ensure high standards of care and patient safety.

Greater discretionary spending ability, demographic changes for example associated with ageing baby boomers, new techniques, improved technology and pharmacological innovations have increased consumer demand (this has

² Adapted from definition adopted by the UK Department of Health. Expert group on the regulation of cosmetic surgery: report to the Chief Medical Officer, January 2005, p. 3. And see e.g. Provision of cosmetic surgery in England: Report to the Chief Medical Officer Sir Liam Donaldson, 2004.



been accompanied, for the same reasons, by an increasing utilisation of cosmetic dentistry services). The availability of Cosmetic Medical Practice is no longer restricted to the affluent; rather, as in countries such as the Canada, the UK and US, for Australians it is a widely available and sought after service.

There can be no doubt Cosmetic Medical Practice is economically sustainable as a specialty.

In 2007, at least US\$12.5 billion was spent on cosmetic procedures in the US³, an increase of 59 per cent since the year 2000 and seven per cent over the previous year.⁴ It has been predicted that by 2015, over 55 million cosmetic procedures – one for every five Americans – will be performed a fourfold increase from 2005. Significantly, it is estimated only 12 per cent of the cosmetic procedures ASPS (US) plastic surgeon members perform will be surgical while 88 per cent will be non-surgical in 2015.⁵

A similar growth trend has been observed in the UK. According to the British Association of Aesthetic Plastic Surgeons (BAAPS), 32,453 surgical procedures were undertaken by its members in 2007, up 12.2 per cent from the previous year.⁶ According to the National Health Service (NHS), approximately 65,000 cosmetic surgery procedures (surgical and non-surgical) are carried out every year in the UK, an increase of over 50% in the past five years. The most common operation is breast enlargement, followed by nose reshaping (rhinoplasty), liposuction and face-lifts.⁷

3 National Clearinghouse of Plastic Surgery Statistics, America Society of Plastic Surgeons. The top five cosmetic surgeries performed in Canada and the US in 2007 were breast augmentation (348,000, up 6 percent), liposuction (302,000, unchanged), nose reshaping (285,000, down 7 percent), eyelid surgery (241,000, up 3 percent), and tummy tuck (148,000, up 1 percent). Report includes only procedures performed by ASPS members.

4 Similar growth has been witnessed in other cosmetic practice areas. For example, 9,000 US dental practices surveyed in 2006, reported cosmetic procedures provided in their offices grew an average of 12.5 per cent in the past five years, with some dentists and dental surgeons experiencing close to a 40 per cent increase. This projects to \$2.75 billion across all 5,500 practices represented by the survey sample, a 15 per cent increase over 2005. The most often performed service is crown and bridge. North American Survey: The State of Cosmetic Dentistry, American Academy of Cosmetic Dentistry, 2006.

5 Medical News Today, 28 June 2008 www.medicalnewstoday.com/articles/112583.php (Accessed June 2008).

6 See www.baaps.org.uk/content/view/280/62/ (Accessed September 2008).

7 National Health Service UK, November 2007 www.nhsdirect.nhs.uk/articles/article.aspx?articleId=528 (Accessed May 2008).



Another UK recent report estimated that the UK cosmetic surgery market — which includes both surgical and non-surgical procedures — to be £493m at the end of 2007, with annual growth rates of between approximately 22 per cent and nearly 70 per cent from 2003.⁸

The last comprehensive report on the specialty in Australia was *The Cosmetic Surgery Report*, prepared in 1999 for the NSW Minister for Health.⁹ The report estimated that in 1999 there were approximately 350 doctors with a substantial practice in cosmetic surgical procedures in Australia and about 150 doctors and 50 nurses providing cosmetic medicine. The report noted that the industry claimed that it doubled in the five years up to 1999. By 1999, the industry was estimated to be performing around 50,000 surgical procedures per year and as many as 200,000 non-surgical cosmetic medical procedures per year.

Estimates prepared for this application put the current annual Australian expenditure for breast augmentation and liposuction alone to be approximately \$130 million. There are no available figures for liposuction being performed by doctors outside the ACCS and anecdotal evidence and reports indicate that a number of Australians travel overseas to obtain cosmetic services.

Despite increasing public interest and demand for these procedures, there has been no appropriate development of attendant relevant specific training or certification of these techniques within the traditional AMC accredited learned colleges. In Australia, traditionally specialist medical practitioners are trained in the public hospital system. To this day, there is no specific post-graduate, public hospital-based training for registrars training within any specialty area in the techniques of cosmetic surgery.

This is so partly because cosmetic surgery procedures are generally not provided within the public hospital environment and are also not part of the MB BS primary medical degree. Therefore, the first exposure to cosmetic surgery techniques generally occurs when entering private practice upon completion of hospital based training. Until recently, appropriate specific cosmetic procedural training for *any* doctor, whatever their previous training

⁸ Cosmetic Surgery Market Report 2008.

⁹ Committee of Inquiry into Cosmetic Surgery. *The cosmetic surgery report: report to the NSW Minister for Health – October 1999*. Strawberry Hills (Sydney): Health Care Complaints Commission, 1999.



(e.g. surgical or otherwise)¹⁰ was either self-directed by journals and attendance at conferences devoted to cosmetic surgery or through mentoring by another physician already practicing in this area.

The Australasian College of Cosmetic Surgery was formed in 1999 to fill this training gap and certification of medical practitioners engaged, or wishing to engage, in the provision of cosmetic or aesthetic surgery. It is our contention that the breadth of scope of procedures, together with the rapid development of new and emerging technologies and techniques, requires, if patients are to be properly protected, this distinct, specialised field of practice be recognised as a separate medical specialty.

The issue is not whether Cosmetic Medical Practice exists as a separate area of specialised practice – clearly it does. Rather, the question is how best to raise standards and protect patients into the future as the specialty continues to grow. Formal recognition of the specialty of Cosmetic Medical Practice would represent a prudent course of action. Recognition would provide a basis upon which to properly regulate the industry, ensuring those providing the services are appropriately and specifically trained and assessed and consequently patients optimally treated and protected.

Indeed, as the UK Department of Health notes, though a surgeon or other practitioner may have a qualification in a related specialty such as plastic and reconstructive surgery, their core qualification “**may not indicate that they have received any special training in cosmetic surgery, or that they have experience in doing cosmetic surgery or [in a] particular procedure**”.¹¹

As the specialty has not until now been recognised by the AMC, there exists no government recognised training institute for cosmetic surgery that sets an appropriate relevant minimum training benchmark to inform consumers, regulators, insurers and the wider Australian community. Indeed, there cannot be one until there is recognition of the discipline as a separate specialty.

¹⁰ Although the RACS Plastic and Reconstructive training syllabus states that its fellows must complete aesthetic modules as part of its training requirement, the training is not comprehensive across the cosmetic surgery and medicine practice nor is it procedure specific for many of the most common forms of cosmetic surgery.

¹¹ (UK) Department of Health, 2008 www.dh.gov.uk/en/PublicHealth/CosmeticSurgery/DH_4124199 (Accessed May 2008).



As the recently drafted National Health Workforce Strategic Framework noted:

Empowered consumers will demand to know more about the treatments proposed for them, their effectiveness and the track record of the practitioners involved in their diagnosis, testing and treatment... this will affect the management of knowledge and the development of procedures, protocols and guidelines for effective safe care... the workforce imperative is for up to the minute knowledge and skills and therefore an education and training environment that effectively imparts, and promptly updates, this information. Consumers are also likely to seek out the most advanced, safest, lowest cost care options.¹²

The Australian Competition and Consumer Commission (ACCC) has also expressed the view that consumers should be able to receive accurate and relevant information in order to make informed decisions in their dealings with medical professionals.¹³

The College submits that Australian consumers would be better protected and more able to make informed decisions if they were able to choose practitioners who have undergone specialist training, assessment and accreditation specifically in cosmetic surgical and medical practice. Recognition of Cosmetic Medical Practice as a distinct specialty will provide clarity for consumers so that they can make informed choices.

If a new specialty is recognised, then any organisation of doctors or training facility in the country will be able to apply to have their training scheme, qualifications and accreditation processes assessed against the requirements of the specialty as set out by the AMC in order to be an accrediting organisation in the specialty of Cosmetic Medical Practice.

Independent research, conducted by Galaxy Research on behalf of the College, has demonstrated quite clearly that the Australian public wants to be able to identify who is and who is not a specialist in Cosmetic Medical Practice. In fact, an overwhelming 96 per cent of Australians aged between 18

¹² National Health Workforce Strategic Framework, Health Workforce Australia, April 2004.

www.nhwt.gov.au/documents/National%20Health%20Workforce%20Strategic%20Framework/AHMC%20National%20Workforce%20Strategic%20Framework%202004.pdf (Accessed May 2008).

¹³ See e.g. ACCC comments on proposed revision of advertising guidelines [by the Medical Practitioners Board of Victoria], 2007. www.accc.gov.au/content/index.phtml/itemId/796393/fromItemId/7126 (Accessed December 2007).



and 64 years polled believe cosmetic surgery should be recognised as a specialty with training and qualifications approved by appropriate medical authorities.

The College proposes that the recognition of this specialty will allow Australian consumers to determine who has reached the specific standards relevant to cosmetic medicine and cosmetic surgery. At the moment they cannot do this because no qualification has been specifically assessed by the AMC for this purpose. If recognition does not occur, no cosmetic medical or surgical qualification will be able to be assessed. This lack of a recognised pathway to measure the quality and relevance of a practitioner's qualifications specifically for cosmetic procedures applies to all practitioners offering cosmetic procedures be they plastic surgeons, facial plastic surgeons, Fellows of the ACCS, other RACS surgeons, dermatologists and others, however well trained they may or may not be.

Indeed, given the growth and expected continuing growth of the discipline, a decision to delay or forgo recognition of the specialty of Cosmetic Medical Practice will perpetuate the regulatory and patient information vacuum that currently exists to the detriment of standards and patient safety.

The application will address each of the four criteria:

- that the proposed specialty is a well-defined, distinct and legitimate area of medical practice with a sustainable base in the medical profession;
- that specialisation in this area of medicine is demonstrably contributing to substantial improvements in the quality and safety of health care;
- that specialisation in this area of medicine is demonstrably contributing to substantial improvements in the standards of medical practice; and
- that the recognition of the specialty would be a wise use of resources.



Recognition of Cosmetic Medical Practice would have several benefits for the Australian community.

The paramount requirement for any provision of any health service is patient safety. This is even more important when the health service is entirely elective and being undertaken solely to attain an improvement in appearance. In July 2008, the Australian Health Ministers Conference “expressed concern about a lack of consistent standards in the industry”.¹⁴

While the Ministers agreed to further investigate stronger regulation of the industry to provide greater patient protection, the recognition of Cosmetic Medical Practice will substantially contribute to the establishment of consistent standards and improved patient safety. Recognition will promote the goal of the Australian Health Ministers articulated in the conference’s joint communiqué through improved and more consistent national standards of practice, codification of practice, establishment of ethical guidelines, curriculum development, continuing medical education (CME) and through the attraction and training of qualified practitioners.

It will help remove the confusion about the training and skills of different types of doctors offering cosmetic services. Patients will be able to better ascertain the qualifications and training of practitioners against a defined medical specialty. As noted in Part 4 of this application, due to the absence of recognition of the specialty of cosmetic surgery, there is greater prevalence of information asymmetry gaps between practitioners and patients. If this vacuum persists patients will be exposed to otherwise avoidable risks.

Recognition will require, and therefore ensure, that the same high standards applied to other areas of medicine are matched in the training for, and provision of, Cosmetic Medical Practice.

Recognition of Cosmetic Medical Practice, which would allow for the subsequent accreditation of colleges to provide appropriate relevant training, would have the potential to reduce pressure on the shortage of surgeons.

The College agrees with the concern expressed by the AMC in its 14 September 2006 letter to the ACCC (with respect to the proposed revocation

¹⁴ Australian Health Ministers Conference, Joint Communiqué, 22 July 2008.



and substitution of authorisation A90765, Royal Australasian College of Surgeons) over “a system of medical training that would be driven by numbers alone, without reference to the resources necessary to adequately support training.”

However, it is the case that public health care resources are expended to provide training for a limited number of doctors to become plastic and reconstructive surgeons, some of whom then may apply only a portion of that public investment toward that specialty for public benefit. It is reported that in Queensland, as of 1 April 2008, 3,307 patients were on waiting lists for plastic and reconstructive surgery, and that the state’s allocation of plastic surgery trainee positions has dropped from ten in 2007 to five in 2008 and two for 2009.¹⁵

As the Commonwealth Minister for Health and Ageing, the Hon Nicola Roxon MP, recently noted, “Our health workforce is not meeting demand because of under-supply, uneven distribution, and rigid divisions between types of health professionals”.¹⁶ Recognition of Cosmetic Medical Practice, which would provide a recognised framework to establish specialist colleges to provide appropriate, relevant training for surgeons who ultimately do not wish to pursue a practice in plastic and reconstructive surgery would result in a more appropriate use of public health expenditure, release positions within the traditional FRACS training programme and, ultimately, have the potential to increase the numbers of practicing plastic and reconstructive surgeons.

Recognition of the specialty of Cosmetic Medical Practice will not prevent doctors with other backgrounds from practicing in this area and so they will not be disenfranchised. However, recognition will bring with it a framework to attain higher standards of care and empower patients with information to make more informed choices. Non-cosmetic trained doctors will benefit from having access to appropriately trained, experienced, and accredited doctors to whom to refer when necessary.

Historically, there has been a multi-disciplinary development and provision of the techniques and technologies involved in cosmetic surgery and cosmetic medicine. No existing specialty has been able to claim with any credibility

¹⁵ Sunday Mail, 10 August 2008, p 22.

¹⁶ “The Case for change”, The Hon Nicola Roxon MP, Minister for Health and Ageing. Speech to the National Press Club, Canberra, 13 August 2008.



cosmetic medicine and surgery as solely its own domain. This area now involves cosmetic surgical intervention, non-surgical cosmetic intervention and the application of the evolving technologies associated with pharmacological approaches. These areas frequently overlap and are usually involved in a holistic multiple technique approach applied to meet patients' goals.

Cosmetic Medical Practice is a well defined medical discipline. Recognition as a distinct medical specialty, the further recognition and promotion of relevant training and accreditation programmes such as those offered by the College, and which may be offered by other medical colleges, and well defined standards of practice will increase the efficient and appropriate use of health care resources.

The Commonwealth has often demonstrated its willingness to take the lead in establishing and maintaining superior regulatory regimes in areas under its jurisdiction (e.g. pharmaceutical regulation, corporations law, competition and consumer protection, prudential and banking regulation as well as in the area of medical practice) by being adaptable, pragmatic and putting best practice ahead of special interest. As a result, Australia has established an enviable reputation for good governance. Recognition of the proposed specialty as a first, prudent step will provide the necessary framework currently lacking in the Australian health care system, to raise public recognition of and confidence in the safe practice of the rapidly evolving skills and technologies related to Cosmetic Medical Practice.

Finally, it is instructive to consider who would benefit if the specialty is not recognised – certainly not patients. Recognition will, however, ensure patients are better cared for and surely this reason alone is sufficient.



Criterion I: That the proposed specialty is a well-defined, distinct and legitimate area of medical practice with a sustainable base in the medical profession.

(a) that the proposed specialty is a well-defined and distinct field of medicine

The ACCS Defines Cosmetic Medical Practice as:

Operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient's appearance or self-esteem.¹⁷

Cosmetic Medical Practice is different from plastic and reconstructive surgery in that no defined abnormality need be present. Discomfort with external appearance and combating the visible effects of aging are the prime motivations of patients seeking these techniques which represent a well-defined area of medical practice.

Cosmetic Medical Practice is a specialty of medicine and surgery that uniquely restricts itself to the enhancement of appearance through medical and surgical techniques. It is specifically concerned with enhancing a person's appearance. Unlike other areas of medicine, where objective outcome criteria exist (for example survival rates, exercise tolerance or range of movement in a joint), patient satisfaction is the outcome criterion which determines success or failure of the procedure. This is by definition subjective and is impacted not just by the technical outcome of the procedure but to a large extent the psychological make-up of the patient and his or her expectations of the procedure. Cosmetic Medical Practice differs from other specialties in this respect.

Cosmetic Medical Practice also differs from other specialties, specifically plastic and reconstructive surgery, in that it is primarily learned during a physician's post-residency through ongoing continuing education, training and experience in the private sector. The specialty encompasses a wide array of

¹⁷ *Supra* note 2.



cosmetic medical and surgical procedures, most of which are not performed in the public hospital system.

Cosmetic Medical Practice is a well defined and unique medical specialty, practiced by physicians from various specialties (dermatology, general surgery, oral and maxillofacial surgery, ophthalmology, otolaryngology plastic surgery and general practice) who, after obtaining the training required for their college, may seek to obtain the additional specialised education, training and experience necessary to become competent in Cosmetic Medical Practice, a well defined field of medical practice, distinct from these specialties and, as such, is its own specialty.

Alternative Definitions

Committee of Inquiry into Cosmetic Surgery. *The Cosmetic Surgery Report: Report to the NSW Minister for Health:*

Cosmetic surgery is any cosmetic procedure

- *"performed to reshape normal structures of the body or to adorn parts of the body, with the aim of improving the consumer's appearance and self-esteem";*
- *"is initiated by the consumer, not medical need"; and*
- *"excludes reconstructive surgery which is . . . [generally] performed to improve functions, but may also be done to approximate a normal appearance".¹⁸*

The NSW Cosmetic Report included the following common cosmetic surgical and medical procedures comprising the discipline:

abdominoplasty (tummy tuck): a surgical procedure to remove excess skin and fat from the abdomen and to tighten the muscles of the abdominal wall.

augmentation phalloplasty (penile enlargement): a relatively new (in 1999) procedure in cosmetic surgery to enhance the form and function of the penis. Although most phalloplastic operations are performed for aesthetic purposes, some are for functional reasons.

¹⁸ The cosmetic surgery report. *Supra* note 9.



blepharoplasty (eyelid surgery): a surgical procedure performed for correction of heavy upper or lower eyelids with excess skin. The surgery requires an incision in the skin fold. An ellipse of skin is excised, along with a strip of underlying muscle. It often involves the removal of excess fat as well.

BOTOX® therapy: Botox, purified neurotoxin complex, is a protein produced by the bacterium *Clostridium Botulinum*. The toxin is used to treat creases formed by the two horizontal muscles of the forehead located between the eyebrows. The Botulinum can be injected into these muscles causing them to 'go to sleep' for a period of up to six months. It has been used to treat ophthalmologic problems for nearly 20 years.

breast reduction (breast reconstruction, reduction mammoplasty): a surgical procedure to reduce the size of the breast or to correct asymmetry.

breast augmentation (augmentation mammoplasty): a surgical procedure for increasing the size of the breast by the insertion of a synthetic implant either behind the natural breast or behind the pectoral muscle.

chemical peel: a procedure to remove top layers of skin to achieve a similar result to dermabrasion. The most popular peeling agent now is trichloroacetic acid which produces a controlled chemical burn.

collagen/fat injection: a treatment that literally 'fills in' facial lines and wrinkles. The most common areas treated are lips, smile lines, crow's feet and sleep lines. Other products are used in injection procedures, including hyaluronic acids such as Restylane, a non-animal product. Since 1999, a plethora of new fillers have been approved for use; some permanent, others temporary.

dermabrasion: a procedure that removes the top layers of skin mechanically by use of a wire brush or similar and can be used either superficially to remove skin blemishes, or more deeply, for removing scars, especially acne scars.

facelift (rhytidectomy): a surgical procedure involving muscle modification combined with limited skin undermining. It aims to remove excess skin that is loose and sagging on the face and neck and to tighten the underlying tissue.



laser resurfacing: a treatment using resurfacing lasers for vapourising layers of skin to treat sun damage, acne scars, wrinkles, remove tattoos, spider veins, etc. Resurfacing lasers are also used to cut the skin, with laser blepharoplasty (eyelid surgery) being the most common.

liposuction: a procedure for the removal of localised fat deposits by aspirating fat using a cannula attached to a suction machine (a vacuum source or a syringe). It is also known as liposculpture, lipoplasty, lipo-aspiration, suction lipectomy, and suction-assisted lipectomy. The procedure is used to remove fatty deposits from the hips, outer thighs, abdomen, buttocks, front of the neck, waist, knees, calves and ankles. It can also be used for breast reduction (usually in conjunction with conventional surgery), including the treatment of gynaecomastia (excessive breast tissue development) in males.

otoplasty (surgery of the ear): a surgical procedure to reshape the ears by either removing a wedge section of cartilage from behind the ear, causing the ear to sit closer to the head, or by removing skin from the lobe or tip of the ear to reshape and mould the ear.

rhinoplasty (nose surgery): a surgical procedure for altering the contour of the nose by altering the supporting anatomy. The underlying structure of the nose, nasal bones and nasal cartilage are modified to produce a more pleasing shape or to improve breathing.

sclerotherapy: a procedure used to treat varicose and spider veins.

Queensland Health:

Cosmetic surgery refers to invasive (procedures that break the skin, such as collagen and BOTOX® injections) and non-invasive (procedures that do not usually break the skin, such as chemical peels, microdermabrasion and laser hair removal) procedures performed for non-medical reasons.

They are procedures that are performed on otherwise healthy people, purely for cosmetic reasons, not because of any medical reason.

However, 'cosmetic surgery' does not include invasive and non-invasive procedures done for medical reasons, as directed by a qualified clinician. Procedures done for medical reasons could be to



*treat and correct physical conditions which cause problems for the medical, psychological and social well being of people. For example, ear surgery (otoplasty), breast reduction in men (gynaecomastia) and corrective rhinoplasty (nose) surgery.*¹⁹

(UK) Expert Group on the regulation of cosmetic surgery: report to the Chief Medical Officer:

*Operations and other procedures that revise or change the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise to be within the broad range of "normal" for that person.*²⁰

(UK) Independent Healthcare Advisory Services:

*Cosmetic Surgery comprises operations or other procedures that revise or change the appearance, colour, texture, structure or position of bodily features to achieve what patients perceive to be more desirable.*²¹

(UK) Department of Health:

*The term 'cosmetic surgery' means operations that revise or change the appearance, colour, texture, structure or position of the bodily features to achieve what patients perceive to be more desirable. 'Non-surgical cosmetic treatments' means other procedures that revise or change the appearance, colour, texture, structure or position of the bodily features to achieve what patients perceive to be more desirable.*²²

19 "Have Your Say: Children and Young People Using Cosmetic Surgery and Solarium in Queensland", Queensland Health, October 2007: www.health.qld.gov.au/publications/cos_surg_child.pdf (Accessed May 2008).

20 Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer, Department of Health, 28 January 2005.

21 Independent Healthcare Advisory Services, UK.

22 Department of Health, UK, www.dh.gov.uk/en/PublicHealth/CosmeticSurgery/index.htm (Accessed May 2008).



(UK) National Health Service (NHS):

Cosmetic surgery means to have a surgical procedure for the purpose of improving your appearance. It is known as elective surgery, meaning that the patient chooses to have it although it is not essential.²³

Cosmetic surgery is different from plastic surgery, which is surgery to reconstruct or improve the appearance after injury or illness.

Medical Council of New Zealand, statement on cosmetic procedures:

Cosmetic Procedures are defined as operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal, bodily features with the sole intention of improving the patient's appearance or self-esteem.²⁴

American Board of Cosmetic Surgery:

Cosmetic Surgery is a subspecialty of medicine and surgery that uniquely restricts itself to the enhancement of appearance through surgical and medical techniques. It is specifically concerned with maintaining normal appearance, restoring it, or enhancing it beyond the average level toward some aesthetic ideal. Cosmetic Surgery is a multi-disciplinary and comprehensive approach directed to all areas of the head, neck and body.

Special skill and knowledge are essential and specialists in Cosmetic Surgery are competent in the anatomy, physiology, pathology and basic sciences. The educational profile of this specialty is unique in that it begins with a fully trained and certified physician. Through continued post-residency education, training and experience, cosmetic surgery is taught and learned across traditional disciplinary boundaries. The subspecialty fully incorporates the participation and knowledge from all contributing disciplines to attain a high level of skill and understanding. Contributing disciplines include dermatology, facial plastic surgery, general surgery, plastic surgery, otolaryngology, oculo-plastic surgery, oral-maxillofacial surgery and others.

²³ National Health Service, UK, website. 15 November 2007 (Accessed May 2008).

²⁴ www.mcnz.org.nz (Accessed May 2008).



The Cosmetic Surgeon offers specialised expertise in patient education and counseling, procedural skills, and the early recognition and treatment of complications. As a specialty, Cosmetic Surgeons have enhanced the knowledge and training of fellow physicians and directly benefitted society through educational publications, scientific journals and in the development of safe and innovative techniques.

Competency in Cosmetic Surgery implies a combination of knowledge, surgical judgment, technical expertise and ethics in order to achieve the goal of providing aesthetic improvement.²⁵

American Academy of Cosmetic Surgery:

Cosmetic surgery is a subspecialty of medicine and surgery that uniquely restricts itself to the enhancement of appearance through surgical and medical techniques. It is specifically concerned with maintaining normal appearance, restoring it, or enhancing it. Cosmetic surgery is a multi-disciplinary and comprehensive approach directed to all areas of the head, neck and body.

Through continued post-residency education training, and experience, cosmetic surgery is taught and learned across traditional disciplinary boundaries. The subspecialty fully incorporates the participation and knowledge from all contributing disciplines to attain a high level of skill and understanding. Contributing disciplines include dermatologic surgery, facial plastic surgery, general surgery, plastic surgery, otolaryngology, oculoplastic surgery, oral-maxillofacial surgery and others.²⁶

Encyclopedia of Surgery, a guide for patients and caregivers:

Plastic, reconstructive, and cosmetic surgery refers to a variety of operations performed in order to repair or restore body parts to look normal, or to change a body part to look better. These types of surgery are highly specialised. They are characterised by careful preparation of a person's skin and tissues, by precise cutting and suturing techniques, and by care taken to minimise scarring. Recent advances in the

²⁵ www.americanboardcosmeticsurgery.org (Accessed May 2008).

²⁶ www.cosmeticsurgery.org (Accessed May 2008).



development of miniaturised instruments, new materials for artificial limbs and body parts, and improved surgical techniques have expanded the range of plastic surgery procedures that can be performed.²⁷

Plastic surgery

Plastic surgery includes a number of different procedures that usually involve skin. Operations to remove excess fat from the abdomen ("tummy tucks"), dermabrasion to remove acne scars or tattoos, and reshaping the cartilage in children's ears (otoplasty) are common applications of plastic surgery.

Cosmetic surgery

Most cosmetic surgery is done on the face. It is intended either to correct disfigurement or to enhance a person's features. The most common cosmetic procedure for children is correction of a cleft lip or palate. In adults, the most common procedures are remodeling of the nose (rhinoplasty), removal of baggy skin around the eyelids (blepharoplasty), face lifts (rhytidectomy), or changing the size or shape of the breasts (mammoplasty). Although many people still think of cosmetic surgery as only for women, growing numbers of men are choosing to have facelifts and eyelid surgery, as well as hair transplants and "tummy tucks."

Reconstructive surgery

Reconstructive surgery is often performed on burn and accident victims. It may involve the rebuilding of severely fractured bones, as well as skin grafting. Reconstructive surgery includes such procedures as the reattachment of an amputated finger or toe, or implanting a prosthesis. Prostheses are artificial structures and materials that are used to replace missing limbs or teeth, or arthritic hip and knee joints.

International Board of Cosmetic Surgery:

Cosmetic Surgery is a specialty dedicated to the elective enhancement of human appearance.

²⁷ www.surgeryencyclopedia.com (Accessed May 2008).



The International Board of Cosmetic Surgery defines cosmetic surgery specialty as the knowledge and expertise related to the diagnosis, surgery, peri-operative management, and prevention and management of complications related to the practice of cosmetic surgery.²⁸

Cosmetic Surgery Directory:

Reconstructive plastic surgery is used to correct abnormal structures of the body. These abnormalities are usually caused developmentally, or through tumors or diseases. Reconstructive plastic surgery is typically performed to improve functions; however it is sometimes performed where a normal appearance is desired.

On the contrary, cosmetic surgery is performed to improve your appearance and self-esteem. Cosmetic surgery involves reshaping parts of the body that are otherwise functioning properly.²⁹

Macquarie Dictionary definition of “cosmetic surgery”:

serving to beautify; imparting or improving beauty, especially of the complexion; designed to effect a superficial alteration while keeping the basis unchanged.³⁰

Online encyclopedia ENCARTA:

Cosmetic Surgery: surgery performed to improve a person’s physical appearance. While reconstructive plastic surgery is an attempt to return traumatised or congenitally deformed tissues to normal, cosmetic surgery is an attempt to achieve an improved appearance or rejuvenation.³¹

It can be clearly seen that many authorities distinguish between cosmetic surgery and other forms of surgery, most notably Plastic and Reconstructive surgery.

²⁸ www.ibcs-org.com (Accessed May 2008).

²⁹ www.the-cosmetic-surgery-directory.com (Accessed May 2008).

³⁰ The Macquarie Dictionary 1997, 3rd ed, The Macquarie Library Pty Ltd, New South Wales.

³¹ www.au.encycarta.msn.com (Accessed May 2008).



History of Cosmetic Surgery

The modern concept of Cosmetic Surgery is very recent and is often described in relation to Plastic and Reconstructive Surgery. However such descriptions are today antiquated as the very definitions of the two disciplines have become separate from one another. However, it is useful and instructive to compare the development of both disciplines to see the similarities and contrasts.

The field of Plastic and Reconstructive surgery stems from the need to repair or reconstruct some real defect caused by injury or disease process. The history of Plastic Surgery is documented on the website of the Australasian Society of Plastic Surgery.³²

Sections are reproduced here and the full text is documented in Appendix 1. It is clear from this representation of history that Plastic and Reconstructive surgery is performed for different reasons, with a different focus and generally different desired end results than Cosmetic Surgery. Cosmetic Surgery is performed for reasons of appearance on otherwise healthy people, purely for cosmetic reasons.

It is readily apparent that the clinical imperative is quite different as is the training imperative and there is a requirement to assess and counsel patients about their needs and desires quite differently than the repair process of injury or disease.

Plastic Surgery first began to be practiced in an organised fashion during World War I.³³ Early pioneers in Plastic and Reconstructive surgery were military surgeons, otolaryngologists and dentists, and experience was obtained by visits to colleagues' practices or by 'mentorship'. However, as noted in the (US) ASPS history:

Despite the great leaps forward in plastic surgery after World War I, the profession was still rather ill-defined in the American medical establishment in the 1920s.

³² www.plasticsurgery.org.au/plastic_surgery/history_of_plastic_surgery_2.html (Accessed May 2008).

³³ ASPS website (Accessed May 2008).



*Physicians specialising in this area had no formal means to share their new knowledge and innovations with like-minded physicians across the country.*³⁴

Around 1925, “the formal teaching of Plastic Surgery probably commenced with the work of Le Maitre, while Chief of the Otolaryngological Service at the Faculty of Medicine in Paris”.³⁵

The crucial point to be noted is that in the absence of a particular recognised specialty, a number of doctors from differing disciplines developed an interest and an expertise in Plastic Surgery. Initial development of the field and transmission of knowledge came from visitation, conferences and journal articles. Later, there developed a formal teaching model. During its formative years Plastic Surgery as a discipline was beset by factional and personal rivalries, disagreement over qualifications and a lack of common standards.

If we look now to Cosmetic Surgery there are parallels. Cosmetic Surgery has ancient origins. Cleopatra used sour milk for bathing and to lighten her complexion. Early Etruscans and Romans used tannic acid and the glycolic acids of fermenting fruit for skin treatments; lactic and glycolic acids are still used today for chemical skin peels designed to improve skin texture and quality and lighten pigment blemishes.

Ancient Turks used hot irons to irradiate heat to a similar purpose and also to tighten the skin to combat the appearance of ageing, but with obvious dangers.

The modern practice of Cosmetic Surgery came to prominence with the rise of the Hollywood movie star in post-World War II – particularly 1960s – America, whose quest for glamour drove the development of techniques for surgical facial rejuvenation and body shaping which quickly found a wider market beyond the studio lot. Just prior to this, Arpad Fischer (father of Giorgio – see below) opened the world’s first Cosmetic Surgery clinic in Italy, in 1956, after obtaining the permission of the Vatican.

³⁴ The History of Plastic Surgery, ASPS and PSEF, The American Society of Plastic Surgery (ASPS (US)), www.plasticsurgery.org/about_asps/history/History.cfm (Accessed June 2008).

³⁵ ASPS website.



Similarly to the formation of Plastic and Reconstructive surgery, Cosmetic Medical Practice practitioners came from many existing medical and surgical disciplines: ENT surgery, Dermatology, General Surgery, Plastic Surgery, Dentistry, General Practice and others. Innovations came rapidly in the development of facelift techniques and eyelid surgery (Blepharoplasty). The sophistication of lasers for cutaneous use in carbon dioxide and erbium lasers for skin resurfacing and the various non-ablative lasers for vascular and pigment blemishes dramatically expanded the scope of cosmetic surgery practice.

Lipoplasty (more commonly referred to as Liposuction) is a more modern development, invented in 1974 by Italian gynaecologist Dr Giorgio Fischer. This technique was later refined by French physicians Yves Illouz and Pierre Fournier. Early Lipoplasty was performed under general anaesthesia with its special attendant risks. American dermatologist Dr Jeffrey Klein developed the process of tumescent anaesthesia in lipoplasty, using large volumes of dilute lignocaine in normal saline solution. Tumescent anaesthesia (first presented at a scientific meeting in Philadelphia in 1986)³⁶ is today overwhelmingly the most popular method of lipoplasty because it offers much greater safety for patients than other methods. The first publication of the tumescent technique was in the American Journal of Cosmetic Surgery in 1987.³⁷

Dermatology has been a fertile ground for the development of skin rejuvenation procedures and for our understanding of the physiology of skin and how it relates to cosmetic practice. American Dermatologists have been at the forefront of this aspect of Cosmetic Medical Practice; in particular, Dr Arnold Klein (Professor of Medicine and Dermatology, David Geffen School of Medicine UCLA), Dr Mitch Goldman (Associate Clinical Professor of Medicine/Dermatology, UCSD), Dr James Fulton and Dr Michael Gold.

Botulinum Toxin has become a household word in cosmetic practice as "BOTOX®". This derivative of a refined bacterial toxin was first used in the management of strabismus and facial tics. In 1991, Drs Alistair and Jean Carruthers (Canadian Ophthalmologist and Dermatologist) presented the first paper on the cosmetic use of Botulinum toxin. The rest, as they say, is history.

³⁶ www.liposuction.com/history/history_tumescent.php (Accessed May 2008)

³⁷ AJCS 1987, vol 4, 263-267.



Australia

In 1992, a group of Australian doctors of different medical backgrounds and who were active in cosmetic medicine and surgery formed the *Association of Australian Cosmetic Surgeons*. The Founding President, Dr Robert Reid, is still a practicing surgeon in Victoria. This group saw the need for formal education and accreditation in the discipline of Cosmetic Surgery and developed the Australasian College of Cosmetic Surgery, which was inaugurated in May 1999. The foundation President, Dr Colin Moore, still practices cosmetic surgery and is a recognised world authority.

The development of Cosmetic Medical Practice is a worldwide phenomenon. Its impetus stems as much from the necessity to establish a benchmark for standards and accreditation in a new field of endeavour as from the increasing scope of practice and the consequent core body of knowledge required of a competent specialist practitioner.

Existing learned colleges and universities do not provide all the elements required for competency. Many medical areas overlap, but the existing academic structures do not allow for the cross-discipline education required for the specialty. Overlapping areas of medicine include Dermatology, Plastic Surgery, ENT and Ophthalmology, General Surgery, General Practice, Psychology, Psychiatry and Oro-facio-maxillary surgery.

For example, Dermatologists are skilled in the detection and treatment of skin disorders which have a cosmetic implication and in the use of ablative and non ablative lasers, but may not have a broad experience in surgical procedures. Ophthalmologists will have a thorough understanding of the principles of eyelid surgery (blepharoplasty and canthoplasty), but will not have expertise in facelift or breast surgery by virtue of their original specialty training. Similarly ENT surgeons may be skilled in the techniques for Rhinoplasty but will not have an appropriate training base for lipoplasty or abdominoplasty.

A specific Cosmetic Surgery training scheme will cover all of these aspects of procedural training to provide a comprehensive outcome which crosses disciplinary boundaries in a way not able to be addressed by the existing specialty colleges and their training programmes.



A sustainable base

Cosmetic medicine and surgery was initially only available to a select few wealthy individuals in the community. As the specialty has developed, access to practitioners has become more widespread. With the consequent reduction in costs brought by competition and innovation, this element of restriction has been reduced. Consequently, as noted in the Executive Summary and Part 4 of this application, the demand for and provision of cosmetic medicine and surgery has grown substantially.

It must be recognised that having a cosmetic procedure is an entirely voluntary activity. It is an elective procedure; there is no underlying pathological process and therefore no medical imperative driving the necessity of any cosmetic procedure. It is undertaken by patients as a voluntary use of discretionary funds.

All of the traditional areas of medical practice are becoming more sub-specialised and therefore narrower in their scope. The result of this is that no existing group can legitimately claim to be able to thoroughly prepare a doctor for Cosmetic Medical Practice.

As each medical area has over time split off a new subspecialty there has been an initial grey area of accreditation and inevitable divisions and dissent as to the scope of or even the necessity for the new discipline. This process has occurred continuously and increased over the last 150 years in the development of medicine as a profession, as indeed it has across all sectors of the modern economy.

Thus Cosmetic Surgery is yet another episode in the ongoing refinement and evolution of medical practice. As in all earlier medical evolutions a group of like-minded doctors with similar experience came together to firstly share their knowledge, develop their expertise further and then develop training programmes for those coming behind.

Recent examples of these phenomena include ENT and Ophthalmology, which separated into different and distinct disciplines from the earlier Eye, Ear, Nose and Throat discipline. Anaesthetic practice was once integrally a part of the discipline of surgery; it became a separate faculty within the College of Surgeons and eventually became a distinct and separate specialty with its own training programme, and accreditation system.



The field of surgery is now intensely sub-specialised into not just the divisions of, for example general surgery and orthopaedic. Today there are clear distinctions between Head and Neck surgery, Hepato-biliary surgery, colo-rectal surgery and so on.

This application is to establish the case for the separation of Cosmetic Medical Practice into its own discipline. It is sufficiently different in content and also draws from other established medical and surgical disciplines that it requires a specific training and recognition pathway.

History Summary

Cosmetic Medical Practice is a relatively recent evolutionary development in medicine, which has grown rapidly, with a multidisciplinary base that takes advantage of innovations in technology, pharmacology and technique. Like other medical specialties before it, a group of dedicated doctors from a variety of medical backgrounds have come together to share knowledge and experience to form a structure to establish standards of practice and education in the field. As other areas of medicine have become more specialised and require specific training, so too Cosmetic Medical Practice has become a specialty field requiring its own education pathway and recognition of its status as a distinctiveness field.



(b) that the proposed specialty is based on substantiated and major concepts in medical science and health care delivery

Concepts

Cosmetic Medical Practice involves the application of physical therapies that create either biological (light therapies) or pharmacological effects (BOTOX® and cosmeceuticals). In addition, many techniques are directed at body shaping (via temporary or permanent fillers including fat transfer), augmentation (utilising implantable volumetric devices) or soft-tissue reduction (liposuction). Auto-grafting of hair (hair transplants) can be used to remedy balding or surgical and burns scarring in the hair-bearing areas. Other techniques are directed at skin tightening (facelift surgery, blepharoplasty, laser and suspension therapies).

Each of these techniques has an extensive basis and grounding in evidence-based medicine concomitant with the publication of numerous peer-reviewed scientific research papers validating the technologies. Some have been adapted from other medical uses (e.g. calcium apatite for bone grafting is now used in aqueous suspension as a dermal filler).

Cosmetic Medical Practice is a good example of an area of medical expertise where the combination of cross-disciplinary skills is special to those practicing in this field but not necessarily unique to them, given that:

- The basis of all medical care encompasses knowledge and understanding of the basic biological sciences, anatomy, physiology and pathology.
- Additionally, a competent cosmetic medical or surgical practitioner is required to possess a thorough understanding of the consultation process in particular to gauge from the patient their realistic requests and to impart realistic and achievable expectations of outcome.
- Risk management of adverse outcomes has an extra acute dimension in cosmetic practice due to emotional and financial investment the patient has made in the expectation of improving their appearance. An understanding of the psychological and emotional influences on patients is essential especially if complications occur.



- The doctor must be aware of the holistic nature of the care entrusted to him or her by the patient. Basic understanding of human psychology – in particular, anxieties, peer pressure and the possibilities of Body Dysmorphic Disorder and the influence of supportive circle of family and carers – is required.
- Additional requirements include manual dexterity, surgical judgment, clinical assessment, appreciation of the influence of other medical conditions and medication on the healing process, aesthetic outcome or even the advisability of the procedural plan.

(See Criterion III (c) for curriculum)

It is the synthesis of all of these factors which equips cosmetic physicians and surgeons to be able to formulate with the patient the most appropriate treatment plan for their needs. This is best achieved by comprehensive and specific training in this specialised area. To perpetuate the reliance on a piecemeal approach to cosmetic training, based on the eclectic cosmetic exposure delivered by existing recognised specialist training programmes, would be an abrogation of the profession's responsibility to raise standards and protect patients.

Current Role

Because of the disparity of exposure to and training in Cosmetic Medical Practice that currently exists, the Australian community requires a benchmark of education and an organisation with infrastructure to develop and monitor standards of practice and patient care. The Australasian College of Cosmetic Surgery (ACCS) fulfills this role. The ACCS has a well established training and accreditation programme in place which provides the framework necessary to administer the requirements of Cosmetic Medical Practice. None of the other existing learned colleges offer formal training in Cosmetic Medical Practice.

Relationship to other medical and healthcare providers

Medical

Cosmetic Medical Practice is largely a primary care activity in that the majority of patients are self-referred. Since Cosmetic Medical Practice functions



outside of the Medicare system referrals, other practitioners are not required for medical rebate or insurance purposes. However, referrals from General Practitioners and other medical specialists are increasing, which demonstrates the increasing recognition by the medical profession of the value of appropriately trained and experienced Cosmetic Medical Practice practitioners.

Cosmetic procedures are performed by doctors from a range of medical and surgical craft groups. Some Plastic and Reconstructive surgeons perform Cosmetic Surgery and some do not. Of those who do, some offer a wide range of cosmetic surgical and medical procedures and some focus on a small number of specific procedures.

Dermatologists will commonly perform cosmetic laser treatments, skin peels, injectable dermal fillers or Botulinum toxin. Some dermatologists with dermatological surgical training perform facelifts and liposuction. General surgeons may perform cosmetic breast surgery and abdominoplasty. Ophthalmologic Surgeons may undertake cosmetic blepharoplasty and brow lifting; and ENT surgeons may undertake cosmetic rhinoplasty and face lifting.

Recognition of Cosmetic Medical Practice would allow the broader community and others in the medical profession to determine who is and is not properly trained, experienced and accredited in cosmetic surgery. Independent surveys confirm that the community wants to see recognition of cosmetic surgery.³⁸

Paramedical therapists

“Paramedical” is a term applied to persons of varying backgrounds working in the medical sphere. Such persons may have nursing or beauty therapy training but may include some with an administration background who are active in the management areas of medical practice. Such a sphere of activity would encompass general practice administration, medico-legal issues such as informed consent, informed financial consent, counseling and preparation of patient information material or advertising.

These are areas not readily thought of by observers outside Cosmetic Medical Practice but are of great importance. Because of the elective nature of much of Cosmetic Medical Practice, accuracy of patient information and observance of proper informed consent procedures are vitally important for patient

³⁸ See Galaxy survey, Appendix 2.



protection. Some patients seeking cosmetic surgery may be particularly vulnerable to advertising; in the absence of any other national approach, the ACCS has developed Guidelines for Informed Consent and an Advertising Code.³⁹ ACCS offers an educational programme for “Paramedicals” through a dedicated portion of its Annual Conference.

Nursing

Nurses are an integral part of health care delivery in Australia and it is no different in Cosmetic Medical Practice. There are a growing number of nurses in Australia practicing in the field of Cosmetic Medical Practice. The roles range from the traditional nursing roles important in assisting with the care of patients e.g. post-operative management, wound care, support and advice for patients.

Newer roles are being defined including pre-operative and post-operative skin care (in this respect there is some significant overlap with traditional Beauty Therapist roles). Some nurses have developed expertise in injections (under physician supervision) as dermal fillers (Restylane, Esthelis, Collagen and Botulinum toxin).

Education in Laser use and IPL (Intense Pulsed Light) is available and suitably trained and licensed nurses (and Beauty Therapists) are active in these areas.

However, there are no *recognised standards* of training and monitoring of performance. The ACCS has experience in training for all these areas for Nurses and offers a Diploma of Cosmetic Nursing to those successfully completing the course.

In all of these areas, the role of the proposed specialty of Cosmetic Medical Practice is to enable the setting of benchmarks for practice, monitoring and monitoring of standards. It will also establish a resource whereby other members of the medical profession and allied health providers can look for advice and develop a logical basis of referral of their patients.

³⁹ See Appendix 3.



- (c) that the proposed specialty represents a widely accepted field of medical practice as indicated by:***
- (i) a comprehensive and developing body of international research and scholarly literature to support evidence based clinical practice***
 - (ii) significant representation within academic medicine***
 - (iii) formal recognition as a medical specialty (or other relevant category) in comparable countries***

Is Cosmetic Medical Practice a widely accepted field of medical practice? The answer to this is an overwhelming, yes. The evidence is clear and unequivocal.

Professional Doctors

Using again the issue of the feature magazines it is clearly seen that doctors of many disciplines of origin advertise in these magazines confirming their recognition of the special area of Cosmetic Medical Practice.

The fact that many plastic surgeons also advertise in the Yellow Pages' Cosmetic Surgery section also indicates that professionally they too recognise the distinct difference of cosmetic surgery. In fact, many Plastic Surgeons define for themselves their areas of expertise to indicate Plastic, Reconstructive AND Cosmetic Surgery. Alternatively, self-style or qualify themselves as "Aesthetic Plastic Surgeons".

Australasian Society of Aesthetic Plastic Surgeons (ASAPS)

The professional association Australasian Society of Aesthetic Plastic Surgeons (ASAPS) carries the statement that they only accept as members those Plastic Surgeons who are fully trained in Plastic Reconstructive AND Aesthetic Surgery. This clearly is evidence that ASAPS recognises the difference of Cosmetic Surgery.

Australian Medical Association (AMA)

The Australian Medical Association (AMA) is the premier professional medical body in Australia and is well respected in professional and government circles in Australia and internationally. The AMA released a "Position Statement" on



Body Image and Health in 2002 (Appendix 9). This position statement identifies Cosmetic Surgery as deserving of special consideration.

While the ACCS does not agree with some of the statements contained in the AMA position statement, there is no doubt that the AMA at least recognises the existence of Cosmetic Surgery and medicine as separate scopes of practice. Cosmetic Surgery is very much part of the framework of organised medicine with a multidisciplinary knowledge base and through ACCS a defined and monitored infrastructure.

The College is as concerned as the AMA that “some doctors operate outside the framework of organised medicine”. While the AMA does not elaborate on this point, it is the College’s experience and view that there are doctors, practicing either as plastic surgeons or cosmetic surgeons, who have not completed a formal regime of education, clinical training and examination in the procedures in which they purport to be properly qualified. Recognition of the specialty of Cosmetic Surgery and Medicine is a necessary first step to remedy this situation.

American Medical Association (AMA)

The specialty of Cosmetic Surgery is recognised by the AMA list of self-designated.⁴⁰ The American Academy of Cosmetic Surgery now holds two seats on the AMA’s House of Delegates.

Medical Insurance Groups

Key Medical Indemnity Organisations (MDOs) have already determined that Cosmetic Medical Practice is a distinct field of practice. MDOs have developed insurance bands and criteria for professional indemnity for doctors performing in this field. The largest MDO in Australia, AVANT (the recently merged United and MDAV), offer specific categories of indemnity insurance and structure the cosmetic category into four subsections with separate levels of activity, and therefore, risk.

MIGA, based in South Australia, has a national coverage of insured doctors, also maintains a specific insurance category for cosmetic practice, called RMIP–COSMETIC.

⁴⁰ Letter from the American Medical Association to the American Academy of Cosmetic Surgery, 20 December 2002, confirming recognition of the specialty of Cosmetic Surgery. Appendix 4.



Representatives of both AVANT and MIGA have expressed support for the rationale of recognition of cosmetic surgery. Although Avant does not have an expressed view about whether or not cosmetic surgery should be recognised as a specialty, its representative recently stated:

“Avant believes patients should be provided with or have ready access to information regarding the skills, training and accreditation of a medical practitioner offering cosmetic surgery.”⁴¹

MIGA, however, provide unqualified support for the recognition of cosmetic surgery and medicine in order to better protect patients. Avant’s head of medico-legal advisory services, Andrew Took, recently stated:

“It is MIGA’s view that patients need to have certainty over the qualifications of the doctors that are providing cosmetic medicine or cosmetic surgery. Fundamentally, we think it is a logical step that there should be a recognised cosmetic surgery and medicine specialty.”

“Logic tells me that it must be the better position for the patient in that there is one set of recognised standards that determine whether a person is a cosmetic surgeon versus anything else. From an insurer’s point of view, it would make things a lot easier for us as well because at the moment we have doctors that come to us seeking to do things and our ability to question their qualifications in seeking the insurances that they are seeking is very limited and we would absolutely support an outcome that made that simpler.”⁴²

Government

New South Wales

In 1999, the NSW Minister for Health initiated an Inquiry in Cosmetic Surgery in NSW. There were numerous submissions to this enquiry from professional groups, individual medical practitioners, members of the public and government agencies. There were a number of recommendations resulting from this Inquiry and many of these have been implemented by ACCS to the benefit of patient care. Interestingly, no other professional medical groups have implemented any of the chief recommendations. However, the fact of the

⁴¹ Andrew Took, National Manager of Medico-Legal Advisory Services, Avant, ACCS Roundtable, Sydney, 16 June 2008. Appendix 5.

⁴² Maurie Corsini, Underwriting Manager, MIGA, ACCS Roundtable, Sydney, 16 June 2008. Ibid.



establishment and conduct of the inquiry confirms the distinct place of Cosmetic Medical Practice in Australia.

Queensland

In 2007, Queensland's Premier Anna Bligh and the Minister for Health released a "Discussion Paper" and requested a submission from the ACCS on the issue of teenage cosmetic surgery. The ACCS provided a submission.⁴³ The discussion paper also provided a definition of cosmetic surgery (noted above) confirming the distinct place of cosmetic surgery in Queensland. The results of the discussion paper and the submissions were released in November 2007.

Victoria

The Medical Board of Victoria recently conducted a discussion group regarding the advertising of cosmetic surgery. The ACCS provided a submission as did many others. The clear implication is that the Medical Board of Victoria recognises the distinct place of cosmetic surgery in that State.

New Zealand

The Medical Council of New Zealand (MCNZ) has recently introduced a Statement on Cosmetic Procedures. Although there is some disagreement as to the qualifications necessary to perform cosmetic procedures, it is clear that the MCNZ recognises the distinct areas of Cosmetic surgery and medicine.

However, the MCNZ has confirmed that the ACCS training programme is an appropriate qualification to satisfy the requirements of the Council's Level 1 surgical scope of practice, should the ACCS be accredited to provide post-graduate qualification.

The Health and Disability Commissioner has written to the MCNZ, agreeing with the Council on the need for "further consideration to find a suitable arrangement until there is a recognised scope of practice for cosmetic surgery in New Zealand."⁴⁴

43 ACCS Submission to the Queensland Department of Health concerning teenage cosmetic procedures. Appendix 6.

44 Letter from Ron Patterson, New Zealand Health and Disability Commissioner to the Medical Council of New Zealand, 8 October 2008. Appendix 7.



It should be noted that the situation in New Zealand crystallises the point made in the Executive Summary and in Criteria IV: that until such time as the specialty is recognised, no organisation can be properly assessed and accredited in order to provide the necessary education, training, examinations and monitoring of practitioners necessary to raise standards of care and protect patients.

A survey of international literature shows a plethora of journals and texts dealing if not solely with Cosmetic Medical Practice at least significantly. An indicative bibliography encompassing international research and scholarly literature is attached at Appendix 33.

There are very few full time positions involving cosmetic medical and surgery internationally and none known in Australia, though globally there are throughout the specialty many who provide education and contribute to research. This is because Cosmetic Medical Practice is largely outside of the usual ambit of public health funding and private insurance availability. However, there are number of practitioners associated with Cosmetic Medical Practice internationally with academic affiliations. An indicative list of practitioners with academic affiliations is provided below.⁴⁵

Australia

Dr Greg Goodman

Dr Goodman completed his Fellowship of the Australian College of Dermatology in 1984. He has a private practice in Toorak specialising in medical, surgical and cosmetic dermatology. Dr Goodman has a strong interest in laser treatments, including photo-rejuvenation, photodynamic therapy and laser resurfacing. He also has been an investigator and trainer in dermal augmenting agents (fillers) and Botulinum toxin (BOTOX®). He has an ongoing research interest in the treatment of post-acne and keloid (thickened) scarring.

⁴⁵ Growth of field and lack of formal training organisations is precisely the issue being addressed by the College's submission for accreditation of Cosmetic Surgery as a recognised specialty. That is, the lack of recognised representation within academic medicine is in part due to the fact that Cosmetic Surgery / Medicine is not formally recognised.



He is a director of the Skin & Cancer Foundation of Victoria, director of the Mohs Micrographic Surgery Unit and a senior lecturer at Monash University.

USA

Mitchel P. Goldman, MD

Dr Goldman is an expert in the areas of dermatology, phlebology (the branch of science dealing with veins), laser surgery, and liposuction. He is especially renowned for his pioneering research and development of multiple laser techniques, and for advancing the technique now widely used for getting the best results with liposuction.

Currently a Clinical Professor of Dermatology/Medicine, University of California, San Diego, Dr. Goldman has written eighteen books, several of which are medical texts considered the definitive texts in the fields of laser surgery, cosmetic surgery, vein removal, and dermatology.

Dr Michael Gold

Dr Gold is the founder of Gold Skin Care Center and Advanced Aesthetics Medi Spa located in Nashville, Tennessee. He is the author of over 75 published scientific articles. In 1989, Dr. Gold became the first dermatologist to begin study on the use of topical silicone gel sheeting for the treatment of hypertrophic scars and keloids.

Dr Leslie Baumann

Leslie Baumann, M.D. is the unique combination of doctor, professor and researcher. She is both a Professor and the Director of Cosmetic Dermatology at the Miller School of Medicine at the University of Miami. It is here that she founded the university's internationally recognised Cosmetic Center (UMCC) in 1997, the first university-run cosmetic research center in the United States. This unprecedented combination of skills has led to Dr. Baumann's status as a leading global expert in dermatology.

Dr Arnold Klein

Dr Klein, an internationally renowned cosmetic dermatologist, is a world authority on minimally invasive aesthetics. He graduated *cum laude* with a BA degree in Biology from the University of Pennsylvania in 1967, and was graduated *cum laude* and Phi Beta Kappa from the University of Pennsylvania, School of Medicine, in 1971. Dr. Klein completed his post-graduate education as a medical intern at Cedars-Sinai Medical Center in Los



Angeles, and went on to complete medical residencies in dermatology at the Hospital of the University of Pennsylvania and the University of California at Los Angeles, where he was the Chief Resident in Dermatology in 1975.

Currently, Dr. Arnold Klein maintains a busy private practice in Beverly Hills, CA, where he has been for more than 30 years. He is a Professor of Medicine and Dermatology at the David Geffen School of Medicine at UCLA, and has been honored with the establishment of the Arnold W. Klein Chair in Dermatology at UCLA, where he is a member of the academic and clinical staff. He is also an attending physician at the Cedars-Sinai Medical Center in Los Angeles.

Dr Jeffrey Klein

In 1985, Dr Klein, invented the tumescent technique for liposuction, revolutionising liposuction surgery. His "Tumescent Technique" allowed patients to have liposuction performed totally by local anesthesia using much smaller cannulas. Patients could now have liposuction surgery without the fear of excessive bleeding and undesirable skin depressions. Since 1985 to present Dr Klein has been appointed as the Associate Clinical Professor, Dermatology, University of California, Irvine.

Dr Rox Anderson

Dr Anderson is an interdisciplinary researcher in photo-medicine. Dr Anderson is the director of the Wellman Center for Photo-medicine at Massachusetts General Hospital in Boston, MA, and Professor of Dermatology, Harvard Medical School. His contributions include laser hair removal, photodynamic therapy (use of light-activated localised drugs for cancer and macular degeneration), and basic research into the free electron laser for the selective destruction of lipids (i.e. fats) for possible treatment of acne, cellulite, and atherosclerosis, as well as various uses of photothermolysis using pulsed dye lasers.

Dr Rhoda Narins

Dr Narins is one of the USA's top dermatologic surgeons, selected by her peers as one of only 12 dermatologists in the United States listed in "Best Doctors in America" under Aesthetic Surgery. Dr. Narins is currently President of the American society of Dermatologic surgery and Clinical Professor of Dermatology at New York University Medical School where she teaches advanced dermatologic surgery and is Chief of the Liposuction Surgery unit. Dr. Narins has lectured extensively world wide on Dermatologic Surgery



including liposuction, fat transfer, collagen and other fillers, chemical peels, Ultra-Pulse CO₂ & other lasers, sclerotherapy, BOTOX®.

Dr Paul Carniol

Dr Carniol specialises in plastic surgery, using state-of-the-art lasers, technology and procedures for the treatment of wrinkles, lines, acne scars, facial spider veins, brown or red spots, acne, ageing skin and hands and other cosmetic concerns. Author of numerous articles and editor of three books on cosmetic surgery procedures, lasers and skin rejuvenation, Dr. Carniol is an active trainer-educator and speaker regarding the latest procedures for cosmetic surgery including BOTOX®. Dr Carniol is currently a Clinical Associate Professor with the University of Medicine and Dentistry New Jersey.

Dr Fred Brandt

Dr Brandt has written a top selling anti-aging manual, “age-less”, the definitive guide to lasers, peels, and other solutions for flawless skin. Dr Brandt is continuously called upon to provide his expertise in research, treatment and diagnosis regarding all issues of dermatology. Beyond this contribution to his field, Dr Brandt publishes numerous professional papers and conducts in-depth industry-wide research programmes. He is a board certified member of the American Board of Internal Medicine and the American Board of Dermatology, and holds membership in prominent professional societies on a regional and national level.

Canada

Dr Alistair Carruthers

Dr Carruthers is a cosmetic dermatologic surgeon who operates his own clinical practice (Carruthers Dermatology Centre Inc.) in Vancouver, BC. He is also a clinical professor of dermatology with the Faculty of Medicine at the University of British Columbia (UBC).

Dr Carruthers has made several major contributions to the field of dermatology. Foremost among these was the use of the BOTOX® procedure in cosmetic applications, a discovery he made with his wife, Dr Jean Carruthers, in 1987. Since this time, they have been at the forefront of BOTOX® research, development and education, publishing numerous articles using their data



Dr Jean D. Carruthers

Dr Carruthers is Clinical Professor in the Department of Ophthalmology at the University of British Columbia in Vancouver, where she specialises in facial cosmetic surgery. Dr Carruthers is a Diplomat of the American Board of Cosmetic Surgery and Fellow of the American Society of Ophthalmic Plastic and Reconstructive Surgery. She has been invited to give more than 200 presentations worldwide on topics in cosmetic surgery and has authored more than 206 scientific articles and book chapters. With her husband, Dr Alastair Carruthers, she pioneered the cosmetic use of Botulinum A exotoxin and has remained at the forefront of research and teaching about this procedure.

South America

Dr Mauricio de Maio

Dr de Maio graduated from the Faculty of Medicine of the University of Sao Paulo in 1990 and became a Master of Medicine in 1999 and Doctor of Science in 2006 by the Faculty of Medicine of the University of Sao Paulo. Dr. de Maio was Assistant Professor of Plastic Surgery at the Faculty of Medicine of the University of Sao Paulo from 1996 to 2002; recognised Consultant and preceptor for training specialists in the areas of Plastic Surgery, Laser, Fillers, Botulinum Toxin and Aesthetic Medicine; recognised nationally and internationally, he has published three books.

Dr Eduardo Krulig

The Krulig Peel was developed by Dr Krulig, a plastic surgeon from Venezuela and first introduced in the UAE in July 2004, by Aesthetica Clinic. Amelan[®] is the result of several years of research by Dr Krulig, a plastic surgeon, in the field of hyper pigmentation and melanic origin blemishes.

Dr Ivo Pitanguy

Professor Pitanguy is a regular speaker and educator at conferences and universities across Brazil and around the world and is the author of over 800 scientific works in Brazilian and international magazines, and published a series of books. His work "Plastic Surgery of the Head and Body" was awarded at the Frankfurt book Fair and became an important font of academic and scientific information.



Europe

Dr Anthony Erian

Mr Erian is a renowned established Aesthetic Plastic Surgeon with over 25 years experience in the field of aesthetic surgery, a fellow of two Royal Colleges, F.R.C.S. (Erg), F.R.C.S. (Ed). American Board Certified and Accredited in Cosmetic Surgery. He is also a member of the American Academy of Aesthetic and Restorative Surgery and President of the European Academy of Cosmetic Surgery and sits on the Editorial Board of the journal of Aesthetic and Restorative Surgery; he has himself published articles on this specialty. He is also president of the European and International Board of Cosmetic Surgery. He has recently been made a professor by Oradea University. Mr Erian has an active teaching programme in the field of aesthetic surgery and is the Medical Director and Principal Surgeon at The Cambridge Private Hospital and also has an established practice at 10 Harley Street, London. Recently, Mr. Erian was made an honorary fellow of the Australasian College of Cosmetic Surgery and was instrumental in establishing a Fellowship Programme. Mr Erian has also been honoured in several countries for his contribution in this field. They include Japan, Russia, India and Europe.

Dr Berthold Rzany

Dr Rzany is the C3-Professor for Evidence Based Medicine in Dermatology, Head of the division of Evidence Based Medicine at the department of dermatology at the Humboldt-University in Berlin. His research topics include aesthetic medicine (e.g. Botulinum toxin A, collagen, hyaluronic acid, polyactic acid & other injectables, middle depth peelings as well as hyperhidrosis).

Pier Antonio Bacci

Dr Bacci is Professor of Aesthetic Surgery, Siena University Surgery School, Italy and Chairman of Leg Center, Aesthetic Pathologies, S. Chiara Private Hospital, Florence, Italy and Director of Beauty Medical School of Tuscany, Italy.

Nickola Zerbinatti

Dr Zerbinatti graduated in General Medicine and Surgery with an experimental thesis about "Immunological, tissue and haematological alterations in patients affected by Lichen Planus and in treatment with Cyclosporin A" with Prof. Rabbiosi as chairman. From 1997 to 1999 he was teacher of Aesthetic Medicine at the University of Pavia. From November 2000 is professor of Dermatology and Venereology at the University of Insubria, Italy.



ASIA

Dr Song Jianxing – Shanghai China

Dr Song is an internationally renowned plastic surgeon, and one of the leading plastic surgeons in Shanghai. He is a certified member of the Chinese Board of Plastic Surgery, holds memberships in several committees for the international Society of Plastic Surgery, as well as numerous other prestigious medical organisations. He is Associate Clinical Professor in Plastic Surgery at the 2nd Military Medical University in Shanghai

Dr Woffles Wu

Dr Woffles is one of Asia's most talented plastic surgeons. Facial sculpting, chin rejuvenation and breast augmentation are some of the medical procedures Dr Woffles excels in, but he is most famous for, the Woffles Lift, a face-lift with no skin excision.

Dr Corazon Collantes – Jose

Over 27 years of experience as a Cosmetic Surgeon with an extensive background as an Eye, Ear, Nose, and Throat Specialist. Experience as a Professor in Otolaryngology and as a Level 1 Speaker in numerous conventions (both local and international) involving the latest trends, techniques, and concerns in Cosmetic Surgery. Winner of several prestigious awards including "Most Outstanding International Cosmetic Surgeon" by the Consumer's Union and Angkan Awards of the Philippines, as well as "Best Cosmetic Surgeon in Asia" awarded by the International Society of Aesthetic Surgery.

A widely diverse group of countries and institutions have endorsed cosmetic medicine and Surgery as distinct disciplines by virtue of official recognition of the specialty or by virtue of departments within teaching institutions.

In Italy, the University of Ancona has a Department of Aesthetic Surgery. The Oradea Medical University, in Romania has a Department of Plastic *and* Aesthetic Surgery. Singapore General Hospital operates a Department of Plastic, Reconstructive *and* Aesthetic Surgery. Taiwan's Ministry of Health has approved Cosmetic Surgery as a specialty taught in the University. Japan's Health Ministry has recognised the specialty of Cosmetic Surgery for about 20 years (see *Declaration of Tokyo 2000*, Appendix 8).



In the USA, Cosmetic Surgery is now recognised by the American Medical Association as a self-designated specialty. The American Board of Cosmetic Surgery qualification has been found equivalent to Plastic Surgery the Oklahoma and Florida Medical Boards. The Tustin Hospital and Medical Center, Tustin, California has a distinct Department of Cosmetic Surgery.

The ACCS is currently in discussions which will see education partnerships with Universities in Australia, and Asia.

(d) that the medical specialty has a demonstrable and sustainable base in the medical profession as indicated by a sufficient number of practitioners:

- ***with capacity to meet existing clinical need***
- ***who possess the knowledge and skills to practice in the specialty, and who practice predominantly in the specialty***
- ***to sustain activities such as vocational training and assessment and continuing professional development***

Cosmetic procedures are said to be increasing approximately 10 per cent per annum. Anecdotal information indicates that most practitioners are busy. The current work force in Cosmetic Medical Practice is not known completely since a number of practitioners are not aligned with any particular professional group. Of those known to be in the industry, the numbers appear adequate to the current demand. Several of the professional groups have mechanisms in place to cater for new members but only one group, the Australasian College of Cosmetic Surgery, has a dedicated formal education and accreditation programme focused entirely on Cosmetic Medical Practice.



Table 1: Numbers of practitioners in predominantly Cosmetic Practice

Australasian College of Cosmetic Surgery	174
Cosmetic Physicians Society of Australasia	180
Australian Society of Cosmetic Medicine	40
Australian Academy of Facial Plastic Surgery	70
Australasian Society of Aesthetic Plastic Surgeons	120
Total	584
Dermatologists	Unknown
Non-aligned FRACS	Unknown
Non-aligned GPs	Unknown

Each of the above organisations conducts workshops and clinical meetings for their members and there is overlap in membership and, apart from the ASAPS, attendance at meetings is open to members of other groups and non members. ASAPS and ASPS have some members who are practitioners in predominantly cosmetic practice. However, the ACCS is unable to obtain accurate up-to-date information from these two organisations. According to the NSW Cosmetic surgery report, ASPS reported 190 of its 217 members performing cosmetic procedures but no information was provided to indicate what percentage of these physicians' practices were predominantly cosmetic. To the College's knowledge the ASAPS has not released membership numbers.

The ACCS has a formal training programme, which allows doctors to train extensively in cosmetic surgery and cosmetic medicine and offers a two year registrar course (see ACCS curriculum provided in Criteria III).

Non Fellows of the ACCS are able to access diploma courses in lipoplasty, cutaneous laser and light therapies, Cosmetic Medicine and Cosmetic Nursing. Each of these diplomas is conducted over a two year time frame and involves a set study programme, completion of set assignments, attendance at workshops, lectures, continual assessment and examinations.

The majority of membership of the groups listed above practice predominantly in cosmetic practice. The workshop programme is generally oversubscribed and the ACCS has seen the need to constantly expand its programmes. Demand from doctors throughout Asia, ensures viability of training programmes. The Annual meeting of the ACCS is usually combined with the



CPSA and AAFPS and attracts 500-700 delegates per year and attendance shows approximately 15-20% annual growth, and there are numerous cosmetic medicine and surgery conferences held throughout the world each year which attract thousands of practitioner delegates from dozens of countries.

Thus it is clear that numbers of practitioners involved is sufficient to support a comprehensive education programme.

The ACCS also has a mandatory annual requirement for Continuing Professional Development which further underpins the performance of training events. The ACCS is the only organisation with a mandatory CPD programme. The ACCS has capacity for a number of training positions in various categories.

“Typical week” of ACCS Fellows

Results from 33 surveys received from ACCS members:

(Taking into consideration that majority of Members who took survey were FFMACCS)

1 The hours per activity in a typical week

Direct patient contact	35.9
Consultations	13.9
Procedures	21.0
After care	4.1
Patient related research	1.7
Clinical administration	2.9
Practice management	2.9
Professional development	3.0



2 Proportion of work in each of the major areas described as typical of practitioners

Fillers	14%
Botox	19%
Skin care	7%
Laser and light therapies	12%
Sclerotherapy	7%
Skin cancer	9%
Facial surgery	5%
Breast surgery	9%
Liposuction	8%
Body contour surgery	2%

3 Number of investigations ordered or carried out per week:

Blood pathology	100
X-ray/ imaging	94
Histopathology	183

4 Proportion of the week spent in each following activity:

Third-party funded activity	8%
Public hospital activity	2%
Medicare	12%



Table 2: ACCS Training positions available

ACCS Training Registrar positions	18
Diploma of Lipoplasty positions	10
Diploma of Cosmetic Medicine positions	15
Diploma of Cosmetic Nursing positions	30

The ACCS has 43 practitioners available to support education and training.

Table 3: Availability of practitioners to sustain academic activities and training programs:

Supervisors

Suturing	4
Liposuction	7
Surgical Mentors	14
Medical Mentors	17

Examiners

Surgical	5
Medical	2
External	1



Criterion II: That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the quality and safety of health care.

(a) that specialisation can be demonstrated to have improved the quality of healthcare in Australia across the following dimensions:

- increased effectiveness of care as defined by improved health outcomes***
- increased appropriateness of health care as defined by providing care relevant to the patient's needs and based on established standards***
- increased safety of care (e.g. significant reduction of harm experienced as a result of receiving healthcare)***

Cosmetic medicine and surgery have been stereotyped by some as an unregulated area of medicine disproportionately plagued by bad operators and bad outcomes. The true nature of the proposed specialty is in fact far removed from this unfair and inaccurate characterisation, particularly as far as the ACCS and its membership are concerned.

It is a claim of every training programme and every training organisation that proper training leads to better outcomes. This is axiomatic and applies to every human endeavour. Specialisation in a particular medical discipline inevitably brings standards, a code of conduct, benchmarks to be met, training goals set and achieved and monitoring of performance. Moreover, specialisation driving increased procedure frequency undoubtedly increases clinical competence and reduces patient risk.

Mortality and morbidity data are often used as indicators of performance in medicine. Because of the nature of cosmetic practice in that it falls outside the HIC and public funding mechanisms of health care delivery, this information is not collected by any single regulatory agency and is not readily obtainable.

However, some of the indicators that could be considered are insurance claims data as referenced against other groups and the amount of litigation as referenced against other groups. Other known indicators involving operating



theatres are readily available due to the reporting conditions attached to licensing.

Insurance claims data are a presumptive indicator of unsatisfactory outcomes. Naturally, many insurers guard such information as commercially sensitive and it is not readily available. However, that information that is accessible disproves the notion that the cosmetic medical practice is the source of a disproportionate number of claims.

Health Rights Commission Queensland

This claims data reflects the number of complaints received over a six year time frame from 2000 to 2005. What is clear from this data is that overall claims have been falling since 2002. (The ACCS was inaugurated as a College in 1999). Some of the early entries do not distinguish between Plastic Surgery and Cosmetic Surgery but in the later entries the distinction *is* made, and it shows **a lesser number of claims in cosmetic practice than in other forms of surgery and a steady reduction in claims over this period**. This data also shows the same information for General Surgery and Orthopaedic Surgery as a reference group.

Avant Data

Avant is the largest medical indemnity insurer in Australia. It was formed in 2007 with the amalgamation of United Medical Protection (UMP) and Medical Defence Association of Victoria (MDAV). Prior to its formation, claims history was sought from UMP as to its experience of claims in cosmetic practice. Over a five year period from 2001 to 2005, there were only seven claims in total and none in the years 2004 and 2005.

More recently, Avant has released a claims profile (chart below) showing the medical disciplines most commonly involved in litigation.



MIGA

Medical Insurance Group of Australia (MIGA) is based in South Australia but has members throughout Australia. MIGA has collected claims data over several years and this also shows that the rate of insurance claims is the same for plastic surgeons and for non-plastic cosmetic surgeons. Also the size of the claim is similar, approximately \$35,000 (See Appendix 9).

Court Actions

An examination of legal indicators such as successful court actions through the public record, especially in New South Wales, suggests there have been five successful cases of professional negligence against plastic surgeons. Three of these were against one particular practitioner who has been successfully sued in NSW where the judgment specifically included a finding of professional negligence. These cases were brought against a plastic surgeon who is a former president of Australian Society of Plastic Surgery.

Mortality

There are four known deaths attributed directly to cosmetic surgery in Australia. On the Gold Coast, a patient of a plastic surgeon died after a facelift; in Melbourne a patient of a plastic surgeon died ten days after Liposuction from a DVT and pulmonary embolus; in Melbourne, in 2007, a patient of a plastic surgeon died three days after liposuction; and in January 2008, a death was reported of an Adelaide patient of a cosmetic surgeon due to gas gangrene following liposuction. Coroner's inquests are proceeding in the 2007 and 2008 cases.

In 2006, the ACCS completed a five-year survey of its fellows' performance of liposuction, which covered 27,000 cases and reported no mortalities preceding the one noted above. It is a record which compares favourably to a 1999 survey conducted by the American Society of Plastic Surgeons of more than 1,500 plastic and reconstructive surgeon, which reported a mortality rate of one in every 5,224 (or 19 per 100,000) liposuction patients. The (US) ASPS



stated then that the relatively high mortality rate “may be due to an increase in unqualified *plastic surgeons* performing liposuction during that period”.⁴⁶

The ACCS is unaware of any similar publicly available studies undertaken by the Australian Society of Plastic Surgeons.

State Regulations

Each state has as part of its health facility licensing requirements an obligation on facilities to report incidents such as patient return to theatre, emergency transfer to another facility and deaths in the operating theatre. There is no evidence of cases of cosmetic surgery making up a disproportionate proportion of these numbers.

⁴⁶ In 1997, US plastic surgeons formed a task force to investigate liposuction safety. Their research led to increased efforts by ASAPS and other plastic surgery organisations to re-educate plastic surgeons about risk reduction in lipoplasty procedures. Several measures were identified as ways to increase patient safety, including: 1) using stricter patient selection criteria, 2) limiting the length of surgery, 3) avoiding pre-injection of excessive amounts of fluid and local anesthetic, 4) removing a smaller volume of fat, 5) avoiding the combination of liposuction and certain other procedures, and 6) careful postoperative monitoring. CE Hughes, Reduction of lipoplasty risks and mortality: An ASAPS survey. *Aesth Plast Surg* 2001;21:120-127.



Summary

The above data effectively dismisses the myth that cosmetic surgery has a disproportionate number of insurance claims, or complaints and in particular indicates that at least where Fellows of ACCS are concerned there is an enhanced safety profile.

Recognition of Cosmetic Medical Practice as a distinct specialty will inevitably bring with it further emphasis on training, accreditation and a requirement for CME. This can only enhance the safety profile of Cosmetic Medical Practice. An enhanced training programme as is necessary will also produce a greater awareness and understanding of patient requests and an enhanced ability to identify and instill realistic expectations of cosmetic procedures.

Undeniably patient safety will be enhanced by all cosmetic practitioners undergoing a training and CPD programme similar to that established by ACCS. It is difficult to address the issue of patient needs in this section because cosmetic procedures are by definition 'elective' and there is no 'illness imperative' by which to measure patient needs in this context.

Patient needs

The greatest patient need is a need for safety, followed by:

- Competent and well trained doctors to undertake their procedures;
- Ability to identify who is and who is not trained in the cosmetic procedures they wish to undergo and not just in some other medical discipline;
- Confidence in knowing that their doctor participates in ongoing education and re certification in cosmetic procedures and not just in some other medical discipline;
- Confidence in knowing that their doctor can advise them of realistic and achievable outcomes;
- Confidence that their doctor can identify abnormal cosmetic or aesthetic desires and act to protect them against their own unrealistic attempts at change; and
- Confidence that their doctor can utilise a network of other specialists to help support them in the event that this necessity arises.



The recognition of Cosmetic Medical Practice as the distinct specialty it already has become will further these goals.

All medical disciplines are subject to less than optimal outcomes and sometimes corrective procedures must be entertained. It is a clear and intuitive logic which supports the contention that better training in and specialisation of a particular discipline will improve outcomes overall. This consequently means that there will be a lessened requirement for corrective procedures. In itself this result of improving patient outcomes and reducing the requirement for corrective procedures provides sufficient impetus to support recognition of cosmetic surgery as a distinct specialty.

However, as noted throughout the application, the issue is not whether the specialisation exists or will continue to grow – it does and will. Rather, the issue is how best to manage that growth in order to ensure high standards of care and appropriate use of resources. Recognition of Cosmetic Medical Practice will provide the necessary regulatory regime suited to achieve that goal.



- (b) that specialisation is not adversely affecting the quality of healthcare in Australia, and will not in the future, by promoting:**
- (i) the unnecessary fragmentation of medical knowledge and skills (e.g. where this serves to increase the risk of medical errors and/or inefficient or inappropriate care)**
 - (ii) the unnecessary fragmentation of medical care (e.g. where patients are required to see multiple practitioners for care at a significant coordination cost)**
 - (iii) the unnecessary deskilling of other medical practitioners (e.g. general practitioners and other primary health care providers)**
 - (iv) inequitable access to health care as defined by socioeconomic status, geography or culture**

The history of medical progress is one of specialisation. “The fundamental justification for specialisation in medicine from the eighteenth century on,” George Weisz has written, “was the commonsense idea that, given the limits of human intelligence, it was preferable to master a part of the vast medical art rather than attempting to know and do everything.”⁴⁷

Continued appropriate specialisation, driven by technological and pharmacological innovation, clinical expertise and healthcare demand has continued to deliver **medical progress** in the form of improved standards, patient safety, efficiency and greater access. The growth and development of Cosmetic Medical Practice is no exception.

Specialisation is a logical consequence of the evolution of medical practice. However, there are several distinct issues which have been raised throughout the many years debate has taken place over the issue of medical specialisation. The concerns raised over so-called over-specialisation primarily involve patient management and over-consumption of scarce public health funding, competency and legal indemnity. And, importantly for Australia

47 Weisz, George. “Divide and conquer: a comparative history of medical specialisation”. Oxford University Press, 2006, p.12.



– though not unique⁴⁸ – is the impact upon health workforce distribution in regional and remote areas.

The tremendous growth in surgical knowledge, new technologies and techniques continue to impact upon practitioners' ability to remain current in all areas of their specialisation, which has in part led to the development of subspecialties and fragmentation into so-called "super-subspecialties" or "proceduralists".⁴⁹

There are advantages and disadvantages of this trend of specialisation. However, recognition of the specialty of Cosmetic Medical Practice will not adversely affect healthcare in Australia. ***The specialty already exists and is being provided by practitioners with a variety of medical backgrounds. The issue is whether or not recognition of the specialty will or will not improve outcomes. The College is firmly of the view that recognition and, therefore, proper regulation will improve outcomes.***

Recognition of the specialty will provide a framework to raise the skills and training of its practitioners, and specialisation will enhance the quality of care of patients undergoing cosmetic procedures.

In contrast to the fear of fragmentation of medical skills and knowledge, cosmetic medical practice draws together the various elements of skill and knowledge of the overlapping spheres of General Practice, Dermatology, Plastic Surgery, Ophthalmic Surgery, ENT, as well as providing the framework to develop and enhance purely cosmetic skills and knowledge base.

This specifically will help to reduce the number of practitioners a patient might be obliged to see to achieve their realistic expectations. Identification of specialists in Cosmetic Medical Practice will also allow for more appropriate referral by other doctors or paramedical personnel and, consequently, reduce inappropriate referrals forcing patients into added expense in money and time to find an appropriate specialist.

48 See e.g. Loeffler, IJP, "The drawbacks of over-specialisation". Journal of the Royal College of Surgeons of Edinburgh and Ireland. Loeffler nonetheless appreciates the importance of specialisation in order to improve clinical outcomes. Feb99, Vol. 44 Issue 1, p11-12, 2p

49 See e.g. Landro, L "To reduce risks hospitals enlist 'proceduralists'", Wall Street Journal, 11 July 2007, p. D4.



As cosmetic medical practice becomes more defined and more practitioners are trained in this discipline the normal market forces of competition can be expected to reduce costs and improve efficiency.

A key element in cosmetic practice is the recognition and understanding of cultural and ethnic differences and so these barriers to treatment are reduced. And because the overwhelming majority of patients seeking cosmetic procedures are considered to be 'in good health', travel for treatment is less onerous than it is for other patients with illness to contend with. Moreover, because cosmetic procedures are purely elective, they are not viewed in the same way as other, essential, health services are in the context of geographical access.

Last, recognition would have the potential to reduce pressure on the shortage of surgeons. Government expenditure partly supports training of plastic and reconstructive surgeons. A portion of that public investment is lost when that training is then applied to provide cosmetic procedures, while waiting lists for plastic and reconstructive procedures remain quite long in some states.⁵⁰

Recognition of Cosmetic Medical Practice, which would provide a recognised framework to establish specialist colleges to provide appropriate, relevant training for surgeons who ultimately do not wish to pursue a practice in plastic and reconstructive surgery would result in a more appropriate use of public health expenditure.

⁵⁰ Sunday Mail, 10 August 2008, *Supra* note 15.



(c) that where the specialist medical services are already provided or could be provided by practitioners in a recognised specialty or a combination of recognised specialty groupings, provision of these services by this new specialty enhances the quality of health care and/or efficiency of healthcare

NB Complementary specialties may develop that share some common skills and knowledge. Whilst recognising the benefits of specialisation, the AMC expects groups representing developing specialties to have identified existing specialties whose scope of practice or training programmes are similar. It will encourage dialogue and cooperation between developing specialist groups and existing specialist groups, in order to maximise the use of limited resources.

Several currently existing medical specialties overlap the scope of practice of cosmetic surgery and medicine. All have something to offer but in the present medical education context none can deliver the breadth of training required for a competent cosmetic surgeon or medical practitioner.

Dermatologists have a particular understanding of skin anatomy and physiology and the interaction of dermatological disease processes on cosmetic treatments. Although training in laser and other light therapies is not as thorough as might be expected in dermatology, nevertheless these practitioners have an obvious interest in cosmetic medical practice.

ENT surgeons are typically involved in facial and specifically rhinoplasty surgery and have a particular experience with facial anatomy and surgical expertise. Similarly, ophthalmology overlaps the cosmetic field. One would naturally accept a preponderance of facial surgery including rhinoplasty, blepharoplasty and perhaps facelift surgery within this group.

Oro-facio-maxillary surgeons, albeit from a dentistry background, offer some particular expertise in the area of facial cosmetic surgery.

Plastic Surgery is another surgical discipline, with more of a reconstructive surgery imperative, but nevertheless many of its adherents practice very competently in the field of cosmetic surgery. Many plastic surgeons differentiate themselves from their non cosmetic/aesthetic colleagues by membership of the Australasian Society of Aesthetic Plastic Surgeons and commonly advertise their services as 'Aesthetic Plastic Surgeons' or offering the description of 'cosmetic *and* plastic and reconstructive surgeon'.



General Practice has a long history of procedural medicine and GPs are particularly skilled in consultation and the concepts of 'whole patient care'. With their broad general medicine experience GPs are uniquely placed to undertake (non-surgical) cosmetic medical practice with the proper extra training. (As indeed is any doctor for that matter with the appropriate extra training.)

Much like other recognised specialties such as the recently recognised Sports and Exercise Medicine, the ACCS contains members from all of these professional disciplines and by virtue of its position as an authoritative body in cosmetic surgery is able to utilise this cross fertilisation of ideas to consolidate the education opportunities required for a successful and competent cosmetic medical practice.

Dialogue is already underway with other professional groups to enter into teaching arrangements to maximise the use of resources. Specifically, anatomy courses and cadaver dissection courses have been organised with University of Sydney and The Facio Maxillary Society. An anatomy course in conjunction with Monash University is being negotiated and when completed will benefit both post graduate and undergraduate education.

Negotiations have been entered into with Griffith University Medical School to enable undergraduate exposure to Laser and Light based therapies as part of their medical school curriculum.



Criterion III: That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the standards of medical practice

(a) that there is a professional body:

- responsible for setting the requirements and standards for training and assessment in the specialty***

The ACCS was inaugurated in 1999 at the University of Sydney and has since successfully conducted formal training programmes and carried out many of the recommendations flowing from the NSW cosmetic surgery report including the development of a standard for recognition of skill and competence in cosmetic medical practice and the establishment of standards of training and practice benchmarks.

Historically, medical practitioners who wish to specialise obtain post graduate training from the learned Colleges. Cosmetic medical practice has emerged as a new specialty and thus has not been a significant part of the training of any of the existing Australian Medical Council accredited Colleges. Indeed, any doctor wishing to specialise in this field had no option but to acquire privately organised training on an apprenticeship basis. This training was not subject to appropriate quality controls and varied greatly in its quality. Some doctors obtained adequate training; others did not.

The ACCS was established to fill this vacuum. It is a multi-disciplinary body consisting of general surgeons, plastic surgeons, dermatologists, ear nose and throat surgeons, ophthalmologists and other doctors who were already specialising in cosmetic surgery. It was the successor to the Australian Association of Cosmetic Surgery, which was formed in 1992. The College has a medical faculty which accredits cosmetic physicians and a surgical faculty which accredits cosmetic surgeons.

The overriding aim of the College is easily summarised: *“Raising standards... protecting patients”*.

Unlike some other colleges and societies representing doctors providing cosmetic procedures, the ACCS does not seek a monopoly and is keen to



work cooperatively with other craft groups and the regulatory authorities in order to raise standards.

The College has demonstrated a willingness to work co-operatively with regulators and other groups and has a track record of actions which confirm a commitment to its philosophy of raising standards and protecting patients.

The ACCS has already been recognised by various bodies as representing the specialty: The ACCS has provided submissions to the NSW Medical Board and the Victorian Medical Board regarding Advertising Guidelines. Queensland Health regularly consults with ACCS on appropriate matters in its jurisdiction. Radiation Health Queensland has invited submissions on implementation of its programme in accreditation. The Medical Council of New Zealand has invited input into its *Draft Statement on Cosmetic Practice*. Internationally, the ACCS is recognised as an authority in Cosmetic Medical Practice and regularly consults with health and professional bodies in Asia. The TGA has also asked its members to provide assistance in product trials. The ACCS was recently consulted by the Queensland Government on its legislation, *Restriction on use of cosmetic surgery for children and another measure amendment bill 2008*.

In its 10-year history the ACCS has achieved a great deal in this special area of medical practice and has rightfully earned its status as a leader in education and promoting safe practice.

- ***capable of defining, promoting, maintaining and improving standards of medical practice to ensure high quality health care and capable of engaging stakeholders, including health consumers, in setting standards***

ACCS has a public profile which allows it to be seen by the community at large as a responsible body helping to define and promote high standards of patient care. In this way ACCS strives to raise standards and thus to enhance protection for patients.



Through its Secretariat, ACCS provides a public resource to help patients identify doctors who may be skilled at a particular procedure appropriate to their requirements. The Procedure Specific Registers maintained by the College indicate to the community, which of its doctors are skilled at different procedures. The ACCS recognises that not all physicians are necessarily experienced at all procedures. A place on one of the ACCS registers indicates that a doctor has performed that particular procedure at least 50 times; in the case of Lipoplasty, at least 100 times.

The ACCS has been instrumental in developing a new National Standard for Cosmetic Practice. This pro-active process allows all providers of cosmetic medical services to establish a benchmark for practice standards.

- ***with guidelines and procedures for determining who will be Foundation Fellows/Members of the body (NB the level of knowledge, skills and competence of Foundation Fellows/Members should be no lower than those who will complete its training programme)***

Foundation Fellows were all critically assessed by a Board of Censors whose knowledge, skills and competence were well demonstrated in clinical practice and were in excess of that demanded of those completing the training programme.

Foundation Fellows are required as are all Fellows to complete a mandatory annual CME and Recertification programme.



ACCS Grandfathered Fellows

	Name	Other Fellowship or Diploma
FACCS	Colin Moore	FRCS, FRACS
FACCS	Muhammed Alam	FRCS, ISHRS
FACCS	Angelo Di Marco	FRACS
FACCS	Alan Evans	FCS(SA), FRCS(Ed.), FRACS
FACCS	Daniel Fleming	MB ChB MRCGP DipRACOG FACCS MBA
FACCS	John Flynn	Dip.RACOG, FRACGP, Dip.P.Derm.(UK)
FACCS	Bruce Fox	FRACGP, FANZCA, FFARACS
FACCS	Daryl Hodgkinson	FRCS(C), FACS, Dip.ABPS
FACCS	David Kitchen	FRACO, FRACS
FACCS	Daniel Lanzer	FACD
FACCS	Peter Martin	FRACO, FRACS
FACCS	George Mayson	BCABLS, AACs, ASLS, SSA
FACCS	William Pouw	FRCS
FACCS	Anoop Rastogi	FIACS, FEACS
FACCS	Eng-Peng Tan	FRCS. Ed., FRACS
FACCS	Richard Reid	FACS, FRCOG, FACOG, FRANZCOG, FAAAAM
FACCS	Paul Rosenberg	FRCS, FRCS(Ed)
FACCS	Peter Vickers	FRACDS, FRCS, FDSRCS, Maxillofacial Plas. Surg.
FACCS	James Walter	FACD
FACCS	Cynthia Weinstein	FACD, FRACP
FACCS	Ian Young	MSc(LON), FFDRCS(Ire), Oral & Max. Surg.
FACCS	Michael Zacharia	FRACS, FAAFPS
FACCS	Longin Zurek	DPD, Dip.IBCS
FACCS	Robert Reed	RACS, AACs, ILS



- ***with appropriate processes for determining the standard of education, training and experience of medical practitioners trained in the discipline overseas***

The ACCS has a Board of Censors tasked to maintain standards of practice and training. Trainees undergo regular clinical assessments from their trainers and are required to undergo written and oral examinations in each year of their course.

It has been the practice of ACCS to engage the American Board of Cosmetic Surgery (ABCS) to proctor and grade an examination for all trainees in the final year of their course. This concept is used as a means of external validation of our training programme. Some doctors, by virtue of training received and recognised outside the ACCS programme are sometimes permitted to sit the examination process. All doctors who have undergone the College specific programme have passed the ABCS examination.

Specifically for doctors trained overseas, an examination of practice log books and DVDs of actual operations may be used to allow the doctor to sit the examinations of the ACCS. Surgery visits by members of the Board of Censors may be implemented as well. Some doctors may be required to undertake further cosmetic specific training. The ACCS maintains training posts in Hong Kong, Shanghai and Seoul.

No claim on ability to practice in Australia is expressed or implied by attaining Fellowship of the ACCS. The College recognises that registration to practice in Australia for overseas trained doctors resides with the AMC and its established criteria.



(b) that the specific body of knowledge and skills is sufficiently complex or extensive to require a comprehensive and distinct training programme

The core of knowledge for cosmetic medical practice encompasses surgical anatomy, physiology, consultation guidelines, ethical practice, and understanding cultural and ethnic differences.

Lipoplasty, which includes fat transfer, requires an understanding of the surgical anatomy of the areas involved in liposuction and the physiology of fat deposition and micro anatomy of adipose tissue. Fat transfer to the face requires a thorough appreciation of facial anatomy. The handling of donor fat and its retrieval from preferred donor site is a prime issue requiring training and competence in tissue handling. Consideration of the nature of the instrumentation used in liposuction (hollow cannulas), a thorough understanding of sterilisation requirements, national standards of infection control and appropriate knowledge of antibiotic usage is required.

Liposuction is often carried out under a form of anaesthesia termed 'Tumescent' anaesthesia. This requires the operator to have an understanding of anaesthetics and the pharmacology of anaesthetic agents and local anaesthetics such as lignocaine. The metabolic course of anaesthetic agents and the relationship of hepatic clearance and the cytochrome P450 mechanism is essential.

Injectable dermal fillers, facial injectable implants for facial reconstruction and contouring as well as Botulinum injections for appearance modification are similarly core components of a cosmetic practice.

The suite of surgical procedures includes Face Lift procedures, Brow Lifts, Blepharoplasty, breast augmentation, abdominoplasty, face and body implants. Each of these procedures has their own requirements in respect of surgical anatomy and physiology. The consultation process to develop an understanding of the patient's desires and the appropriateness of these is a clear priority.

The clinician needs to be able to contextualise the patient's requirements and assess what may be appropriate and achievable. This pursuit requires an



appreciation of psychology and basic psychiatric medicine. Body Dysmorphic Disorder is a particular condition which needs to be identified and considered. Anxiety neurosis and obsessive compulsive disorders must be considered by the clinician.

Clinical skill and surgical dexterity and operative judgment and planning are progressively assessed throughout the training programme. Registrar evaluation forms which are completed at the end of each rotation. Elements in this progressive assessment include skills such as consultation, information assessment and developing a medical plan. Also, it is critically assessed as to whether the candidate is developing skills in surgical technique, handling of tissue and infection control.

Laser and Light based therapies are key elements of cosmetic practice. An absolute requirement for competent laser and light therapy is a thorough understanding of light physics and basic optics. Photo thermal applications and photochemical, photo acoustic and photo mechanical modes of action of laser and other light sources require a thorough understanding. ACCS training programmes include specific training opportunities in the training curriculum.

Injectable dermal fillers, facial injectable implants for facial reconstruction and contouring as well as Botulinum injections for appearance modification are similarly core components of a cosmetic practice. The nature of injectable products must be studied and appreciated. The variety of products available is vast and the differences in product design, function and application are similarly broad. Interactions and reactions occur and require a complete understanding of management protocols.

Additionally, a competent cosmetic medical or surgical practitioner is required to possess a thorough understanding of the consultation process in particular to gauge from the patient their realistic requests and to impart realistic and achievable expectations of outcome. During the consultation process certain issues must be considered, not the least of which is “does the patient have a realistic expectation of the potential outcome”.

The clinician must be able to receive the patients input and desires for their procedures whether surgical or non surgical. This information must be assessed and discussion must take place as to what might be achievable and realistic. Alternatives to the planned treatment must be considered including



the option of no treatment. An assessment of the patients overall state of physical and mental status must be made.

The doctor must be aware of the holistic nature of the care entrusted to him or her by the patient. Basic understanding of human psychology – in particular, anxieties, peer pressure and the possibilities of Body Dysmorphic Disorder and the influence of supportive circle of family and carers – is required.

A supportive post operative environment needs to be ensured and understanding carers educated about their role. The clinician needs to be able to ensure appropriate medical/surgical post-operative care. The patients physical situation must be determined; state of general health, any ongoing illness and /or treatments of any disorders such as diabetes, cardiac or respiratory disease, collagen disorders and a plethora of other conditions or circumstance which may impinge on the outcome of the planned procedure, use of medication or smoking. The cosmetic clinician must have a thorough understanding of general medicine.



(c) that there is a programme of education, training and assessment that will enable practitioners to:

- undertake unsupervised comprehensive, safe and high quality medical practice in the relevant specialty, including in the general roles and competencies that apply to all professional medical practice***
- demonstrate the requisite knowledge, skills and professional attributes through exposure to a broad range of clinical experience and training in the relevant specialty***
- provide leadership in the complex health care environment, working collaboratively with patients and their families and the range of health professionals and administrators***
- demonstrate a knowledge and understanding of the issues associated with the delivery of safe, high quality and cost effective health care within the Australian health system***

Curriculum and examinations for attaining Fellowship

ACCS has already developed a training curriculum and this has been implemented and refined over a period of eight years. Training practices have been identified to which trainees are attached. Their progress is continually assessed and Reports are regularly lodged with the Board of Censors via the College Secretariat.

Trainees are presented with a comprehensive array of workshop learning opportunities as well as structured programmes for particular sub-specialties such as lipoplasty and Cosmetic Medicine.

Credentiailling process guidelines

The College Board of Censors must assess candidates by a standardised set of credentiailling guidelines. The guidelines progress stepwise from basic training to appropriate specific procedural training, to clinical experience including the tabling of a clinical log showing the required minimum number of cases (see below).



ACCS Advanced Surgical Training

Criteria for attaining Fellowship of Faculty of Surgery (FACCS)

A training course judged appropriate by the Credentialing Committee for an individual, taking into account the candidate's basic training and experience, e.g. FRACS, plus specific liposuction course and a log of procedures.

Applicants may gain entry through one of the five following categories:

1. Completion of a suitable level of basic surgical training (see definition below)
2. Hold an FRACS or equivalent surgical qualification
3. A specialist Dermatologist with suitable surgical experience as reviewed by the board of censors
4. A specialist Ophthalmologist, ENT surgeon or Facio-maxillary surgeon
5. Others by special consideration at the discretion of the board of censors in exceptional circumstances

Definition of Basic surgical training

Five years post graduate with completion of the FRACS basic surgical training programme or five years post graduate with three years of predominately surgical training including one year at the registrar level or equivalent in either surgery or Obstetrics and Gynaecology.

Completion of basic surgical science requirements

The candidate must have passed the ACCS basic surgical science examination. Alternatively, the candidate must have passed the FRACS part I written exam or equivalent such as the MRCS. To be considered for equivalency an examination must include, as a minimum, anatomy, physiology and pathology components.

Provision of log books

All candidates would be required to submit their personal log books to the board of censors for review.

The information in these log books should contain the following information: the date, consultant, operation, level of operating i.e. from assistant (A) to working in theatre independently with no consultant present (S3) and outcome of the case.



These log books are to be accepted by the board of censors and surgical dean as satisfactory prior to the candidate being granted an interview.

Attainment of advanced life support skills

The candidate must have satisfactorily completed and EMST or ALS course.

In addition, candidates from all the categories above must supply the following prior to entry into the advanced programme.

1. Provision of contact details for three surgical referees for verbal references.
2. A letter of good standing from the relevant medical board.
3. A current indemnity policy certificate.

The Surgical Programme

The ACCS registrar training programme provides two years of advanced training in cosmetic surgery. It has a number of consistent parts:

1. 18 months minimum – Australian rotation;
2. Up to 6 months - Overseas training in ACCS, European or USA accredited;
3. Training posts;
4. The production of a clinical research paper or review article for;
5. Peer review publication in each year of course;
6. College academic syllabus;
7. College Fellowship examinations: written and oral components;
8. Surgical log book; and
9. Registrar evaluation reports.



Australian rotation

The Australian component comprises rotations based in NSW, VIC, SA and QLD. Rotations consist of a minimum of three months duration and involve attachment to at least four cosmetic surgeons who are responsible for the registrar's clinical training.

Registrars are required to complete a minimum of:

1. 25 hours clinical attendance each week (e.g. operating sessions, pre-op and post-op clinics) which are registered in their clinical log book (minimum 1100 hours per year);
2. 10 hours of academic time (the time estimated to complete the academic syllabus); and
3. Attendance at a minimum of 6 major procedures per week (minimum of 250 per year) recorded in their surgical log book.

Registrars are also responsible for running the Journal Club which is part of the College CME programme.

Overseas Training

Consists of either:

- ACCS / American Academy of Joint Fellowship;
- ACCS / European Academy of Joint Fellowship; or
- Other posts as accredited by the College.

Examinations

Written and Viva Voce as determined by the College from time to time.



Alternative pathways

Offered to cosmetic surgical applicants holding pre-existing qualifications and experience.

Applicants must have at least one of the following:

- Appropriate two year Fellowship from the American Academy of Cosmetic Surgery;
- Appropriate two year Fellowship from the European Academy of Cosmetic Surgery; or
- The Board of Censors has discretion to assess individual cases which do not fall into the above categories. It is expected that this discretion will be exercised on a limited basis.

Written confirmation from pre-existing credentialing organisation, logs books with experience (subject to audit) will be required. A form of examination deemed appropriate by the Board of Censors will be administered.

It is expected that this discretion will be exercised in limited circumstances.

Criteria for attaining Fellowship of Faculty of Medicine (FFMACCS)

1. The trainee must be at least five years post graduate and a fully registered practising medical practitioner. The trainee must have attained either FRACGP or VR status, three years dermatology training, Diploma of Practical Dermatology (Wales), other diplomas etc relating to skin cancer or skin disease as deemed appropriate by the College.
2. The trainee must satisfactorily complete 18 month - 2 years of advanced training programme approved by the College. The programme will include:
 - a) 3 month terms with preceptors approved by Censors;
 - b) Minimum 4 different preceptors during the training period.
3. The trainee must attend a full range of College-run workshops.
4. The registrar must be assessed as competent and proficient in practising cosmetic medicine and its procedures.
5. The registrar must show evidence of self directed learning. This will include:



- a) Completing a minimum of 2 scientific papers in cosmetic medicine which will be presented at the College annual conference and submitted for publication;
 - b) Participate in College approved educational courses, events, conferences that will meet the needs of the registrar.
6. Registrar must pass the College written examinations. When the registrar has passed the written examinations then he/she must pass the oral viva short case examinations.
7. The registrar must maintain a Log Book showing cases observed as well as cases performed under supervision. This is to be submitted to the state Censor each year.

Notes:

1. Extension of this training period may be approved by the college
2. Censors in special circumstances but not normally beyond total of 4 years.
3. Up to 4 months of elective special skills post may be included in the programme with approval by the Censors.
4. One of the criteria for award of the Fellowship is that registrar must be assessed as competent in cosmetic medicine. The programme has implemented a system of continuous assessments towards this goal. During the course of the training each preceptor will submit assessments to the Censors.

(d) that there is a programme of continuing professional development that assists participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine

Continuing medical education and recertification programme

The Australasian College of Cosmetic Surgery requires that Fellows complete an annual recertification programme as evidence that they are keeping up to date in their specialty and are continually elevating the quality of care they provide to patients.



Participation in this programme is compulsory for all Fellows if they wish to maintain their accreditation with the College. At the end of each calendar year, each Fellow will be sent a Recertification Data Form which must be completed and returned to the College by the due date.

Fellows who meet the minimum standard will be sent an annual Certificate of Professional Standards.

Every year there will be a random audit of returns of Fellows for one of the proceeding years. Fellows will be selected at random and asked to provide documentation to support the information supplied for their recertification.

Definition

The Continuing Medical Education and Recertification Programme is the process conducted by the Australasian College of Cosmetic Surgery which requires Fellows to demonstrate that they have maintained proper professional standards of knowledge and performance for the period under review.

The Goal

The goal of the Programme is to enable Fellows to contribute to the overriding aim of the College – “Raising standards, Protecting Patients”.

The Programme

There are five facets to the Continuing Medical Education and Recertification Programme. Each of these facets is required to be satisfied in order for a biennial Certificate of Professional Standards to be issued to the Fellow of the College. These are:

1. Patient Audit and Peer Review.
2. Credentialing at a hospital which is accredited by the Australian Council for Health Care Standards, or is a licensed hospital or day surgery centre.
3. Evidence of medical indemnity insurance.
4. Evidence of medical registration.



5. Continuing Medical Education

Definition:

Continuing Medical Education consists of those educational activities undertaken after qualifying as a Fellow of the College, which serve to increase, maintain and develop the knowledge and skills needed to provide more effective and safer patient care.

There are four categories of activities:

Category I – Hospital and Committee Meetings

This includes attendance at any of the following meetings:

- (a) Specialty Unit Meeting.
- (b) Clinical Outcome Meeting including grand rounds.
- (c) Any hospital committee involved with clinical care of patients.

The total minimum requirement for Category I is 10 hours active involvement per year.

Category II – Scientific Meetings (1 day = 8 hours)

This includes attendance at any internationally accredited meeting involving cosmetic surgical/medical activities.

The total minimum requirement for Category II is 30 hours per annum.

Category III – Self-Education Activities

These include the following:

- (a) Internet activities related to clinical practice.
- (b) Surgical journals, tapes, videos, etc.
- (c) Arranged visits to special units.
- (d) Preparation for and participation in self-assessment tests.
- (e) Acquisition of new skills related to cosmetic surgical practice.



Category IV – Other Activities

These include the following:

- (a) Acting as a referee for journal article.
- (b) Publication in a refereed journal or presentation at an accredited scientific meeting. Allow 6 hours for each different presentation and 10 hours for each journal article.
- (c) Undertaking tertiary level courses related to clinical care of patients. Participation is equivalent to 20 hours per unit.
- (d) Teaching activities to under-graduates, post-graduates and peers.
- (e) Review of overall practice by peers other than audit activities.
- (f) Participation in organised research related to clinical practice.

The requirements for Categories III and IV are a total of 40 hours.

Surgical/Medical Audit

Surgical/Medical audit is a regular, documented critical analysis of the outcomes of patient care which must be subjected to peer review and which is then used to further enhance clinical practice.

The results of the audit should be presented at a clinical meeting designed to discuss clinical outcomes. This constitutes the peer review of the audit.

Summary of the Requirements of the Recertification Programme

- (a) Engage in a total of 80 hours of continuing medical education per annum.
- (b) Conduct an audit of some aspect of the Fellow's clinical practice related to cosmetic surgery/medicine.
- (c) Arrange a peer review of that audit.
- (d) Engage in audit activities for at least 5 hours per annum (in addition to activities referred to in (b) and (c) above).
- (e) Be credentialed at hospital that is accredited by the Australian Council on Health Care Standards or that is licensed.
- (f) If requested, Fellows are required to supply documentation to support the information they provided for their annual recertification.

Note: The CME programme is in the process of review at this time.



(e) that the professional body can demonstrate experience in all or some of the following:

- health policy development***
- health promotion and advocacy***
- research facilitation***
- the development and dissemination of the discipline's evidence base***
- the education of other medical and health professionals***
- engagement with health consumers***



Since its inception the ACCS has been at the forefront of policy development and health promotion and advocacy in the field of cosmetic medical practice, both unilaterally and in cooperation with other related professional organisations, governmental and regulatory bodies and through its member base.

Following the publication of the 1999 NSW report on cosmetic surgery, the College engaged with government, academia, medical colleges, professional bodies and academics to set up the Cosmetic Surgery Credentialing Council, which was recommendation of the report. Although the Credentialing Council could not be sustained (due to disagreement among its members), the ACCS has gone on to implement many of the report's recommendations and other initiatives.

The College:

- Has developed a formal training programme in cosmetic surgery, which requires two years of intense study and practical tuition and also requires a minimum of five years post graduate experience, three of which must be in recognised surgery positions before commencing the cosmetic surgery programme. This is the only cosmetic surgery-specific training programme in Australia and is also the only programme that requires comprehensive written and oral examinations in cosmetic surgery.
- Is recognised in legislation in Queensland as the appropriate peer group to be consulted when any doctor applies for hospital operating rights in cosmetic surgery.
- Has among its members some of the most experienced practitioners of cosmetic surgery and medicine in Australia.
- Instituted mandatory continuing medical education (CME) and annual recertification specific to cosmetic surgery, which includes a clinical audit.
- Established a medical faculty and associated training and qualifications to cater for cosmetic physicians (non surgical doctors) who specialise in non-invasive cosmetic procedures.



- Developed new accreditation benchmarks for Fellows in special areas such as Lipoplasty (diploma) and Cosmetic Laser Medicine (diploma).
- Established procedure specific registers to enable the public to be informed accurately about which doctors are experienced in different procedures. Only qualified College Fellows can be listed on one of the registers and then only after having performed the specific procedure at least 50 times (100 times for some registers).
- Requires its members to disclose how many times they have performed an invasive procedure before if this is less than 100 times.
- Created education programmes for GPs, for example suture courses, workshops at GPCE (RACGP conference) to deliver suture and wound management education as well as introduction courses in laser practice and cosmetic medicine.
- Developed Diploma courses in Cosmetic Medicine and Diploma of Cosmetic Nursing.
- Instituted an Advertising Code which is specific to cosmetic practice and provided a template for regulatory reform of advertising protocols in various Australian jurisdictions.
- Developed guidelines for informed consent which have a specific relevance to cosmetic practice and which have also provided a template for regulatory bodies.
- Instigated a series of stakeholder round table discussion groups and production of White Papers⁵¹ on a variety of topics of essential interest in the field of cosmetic medical practice. The first Roundtable was attended by state departments of health, medical boards, the ACCC, other specialist medical colleges and representative bodies such as the ASPS, medical indemnity groups and nursing organisations.⁵²

⁵¹ Attached at Appendix 5 and 5(2).

⁵² The deliberations and recommendations which formed the ACCS's March 2008 Roundtable, and included in part in its White Paper, appeared to have influenced the SA Health Minister's paper to the July 2008 Australian Health Ministers Conference, which led to the review process announced in the conference communiqué. *Supra* note 15.



- Established a track record of co-operative interaction with peer groups and other agencies for example the RACGP, Cosmetic Physicians Society of Australasia, Australian Academy of Facial Plastic Surgeons, Facio Maxillary Surgeons association.
- Provided expert advice and assistance to regulatory bodies, Therapeutic Goods Administration (TGA), Health Departments and Medical Boards in New South Wales, Victoria and Queensland, Health Quality Care Commission (Qld), and the ACCC.
- Developed medical indemnity insurance categories to genuinely reflect practice profiles and developed a cosmetic surgery specific risk reduction programme with the insurer, MIGA.
- Achieved representation on the medical advisory panels of major medical indemnity insurers.
- Introduced a Patient Satisfaction Survey instrument, managed and monitored by an independent organisation UltraFeedback, which also supplies services to the Victoria Department of Health. The ACCS members were the first to introduce external, independent audits of patient satisfaction in cosmetic surgery through Roy Morgan Research.
- Inaugurated the ACCS *Insights* programme, a College-wide survey of practice profile and demographics designed to give as accurate as possible information as to the actual scale and variety of cosmetic practice in Australia.
- Developed a mechanism for indentifying underperforming members and organising re-training.
- Developed an effective mechanism for self-regulation and disciplining of members through a Board of Censors and Ethics Committee. Some members have been removed from College registers and two removed from the College.



The Australasian College of Cosmetic Surgery

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- Established a conference programme and now hosts the largest cosmetic surgery and medicine conference in Australia (more than 500 attendees in 2008) and administers a series of wide ranging seminars and workshops.
- Established an International profile with a presence in Hong Kong, Singapore, Indonesia, Korea, China and New Zealand. The ACCS is a respected provider of education and training in cosmetic surgery and cosmetic medicine throughout Asia.
- Launched a professional journal, *Australasian Journal of Cosmetic Surgery*, now in its fourth year of publication.



Criterion IV: That the recognition of the medical specialty would be a wise use of health resources. To satisfy this criterion, a case must be made addressing the following:

(a) that recognition of the proposed specialty is of public health significance as defined by the following:

(i) a significant burden of disease, incidence, prevalence or impact on the community relevant to the proposed specialty coupled with a demonstrated capacity of members of the proposed specialty to influence this at a population level

(ii) evidence of significant professional and consumer support for the recognition of the medical specialty in the community

By definition Cosmetic Medical Practice does not address the burden of disease. The proposed specialty is concerned with *“operations, procedures and other treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient’s appearance or self-esteem”*.

As such, Cosmetic Medical Practice addresses, almost entirely, aspects of physical appearance that are not rooted in disease processes or as a result of injury. Though, as noted in Criteria III (e) above, since the ACCS’s inception and over the course of the development of the specialty, advances in technique, technology, education and the raising of standards have contributed to improved care and established frameworks for improved patient outcomes.

The most common procedures performed by cosmetic surgeons are breast augmentation, lipoplasty and abdominoplasty. The most common cosmetic medical procedures are BOTOX® dermal filler injections and laser treatments.

As noted in the Executive Summary of this application and below in sub-criterion IV (b), there is a lack of current comprehensive data about the exact numbers of procedures carried out by providers of cosmetic medical procedures and the amount spent annually by Australians.



This is due in part to the fact that cosmetic surgical and medical procedures are almost entirely delivered outside of the Medicare system and provided by a diverse range of practitioners, and the Commonwealth and States have not as a matter of course collected this information. To the ACCS's knowledge, neither the ASPS nor RACS have published such data.

The practice of cosmetic medicine and surgery has grown substantially over the last decade and is anticipated to continue to do so both internationally and within Australia.

The last in-depth analysis of the specialty carried out in Australia was *The Cosmetic Surgery Report*, prepared in 1999 for the NSW Minister for Health.⁵³ The report estimated that in 1999 there were approximately 350 doctors with a substantial practice in cosmetic surgical procedures in Australia and about 150 doctors and 50 nurses providing cosmetic medicine. At the time of the report, the industry was estimated to be performing around 50,000 surgical procedures per year and as many as 200,000 non-surgical cosmetic medical procedures per year.

More contemporary estimates by the ACCS put the current annual expenditure figure for breast augmentation and liposuction alone to be approximately \$130 million. The President of the Cosmetic Physicians Society of Australia (CPSA), Dr Mary Dingley, has provided an estimate of 30 per cent growth non-invasive and minimally invasive procedures over the last two years and anticipated another 10 per cent or more growth over the next year.⁵⁴

These figures are consistent with growth in demand for cosmetic procedures in other countries such as the US and UK as noted in the Executive Summary and below in Criteria IV (b).

As in the case of healthcare in general, population growth, demographic change leading to a higher proportion of older persons (those more likely to seek cosmetic procedures) in the population, rising levels of wealth, further advances in technology and relative price changes will likely continue to drive the growth in demand for cosmetic services into the future.

⁵³ The Cosmetic Surgery Report: Report to the NSW Minister for Health (1999).

⁵⁴ "Aussies outspend Americans on plastic surgery", ABC News (online).

www.abc.net.au/news/stories/2008/03/13/2188273.htm



Not surprisingly, there is strong support among the ACCS's multidisciplinary membership for recognition of Cosmetic Medical Practice. There is also support among other medical colleges and practitioners.

At a recent ACCS roundtable, held in June 2008, the Royal Australian College of General Practitioners (RACGP) NSW and ACT State Manager read the following prepared statement:

"The RACGP is often invited to comment on recognition of a new medical specialty and we're certainly not adverse to considering the Australasian College of Cosmetic Surgery's AMC application because we can see that the ACCS could work in very easily with the Faculty of Special Interests the RACGP is forming.

"This Faculty will form Chapters in areas of specific clinical interest that will not be restricted to GPs or GP groups, and will be open to membership from other medical groups... Ultimately a Chapter could offer a Fellowship in the specific interest, which could be adopted by the various Colleges participating. So it is something we're interested in discussing and we're open to the application for specialty recognition."⁵⁵

Other key industry stakeholders such as medical indemnity organisations have also expressed support for recognition of Cosmetic Medical Practice. MIGA's Underwriting Manager, Maurie Corsini, made the following statement at the ACCS's July 2008 roundtable:

"From the patient perspective, a recognised qualification for doctors working in the field of cosmetic medicine and surgery has merit, as it provides the patient with a level of certainty in relation to the qualifications of the doctor they have selected for the cosmetic procedure they require. We think a recognised cosmetic and surgery specialty is a logical way forward.

⁵⁵ ACCS Roundtable, June 2006, *Supra* note 5, 5(2).



“Logic tells us the better position for the patient who requires cosmetic medicine / surgery is that they can be confident they are seeing doctors that have undertaken a recognised set of standards in training and obtained recognised cosmetic and surgery specialty qualifications versus non recognised qualifications in this field of practice. From an insurer’s point of view it would also make underwriting cosmetic risks simpler because at present doctors who approach us for insurance for cosmetic work may have either varying cosmetic qualifications or may not necessarily have recognisable qualifications in the field of practice. Our ability to refuse cover to such doctors is limited. Therefore we would absolutely support an outcome where standardised and recognised cosmetic and surgery specialty qualifications were the norm.”

The Australian community already recognises the existence of cosmetic surgery and medicine. This is evidenced by the existence of cosmetic practices and the increasing utilisation of cosmetic procedures by the general public. Numerous popular publications regularly carry features on “Cosmetic Surgery” or “Aesthetic Plastic Surgery”. Some examples are *Women’s Day*, *Vogue*, *New Idea* and *Who Weekly*. Australian Cosmetic Surgery Magazine is devoted entirely to the subject of Cosmetic Medical Practice. *Bella Beauty* magazine is another publication but directed more to an industry professional audience.

The nationwide phone directory Yellow Pages by Sensis introduced a new category of Cosmetic Surgery in 2005. A look at this section will reveal numerous advertisements by cosmetic practitioners and plastic surgeons. This is further testimony to the public recognition and acceptance of Cosmetic Medical Practice.

The Galaxy Poll⁵⁶ on consumer attitudes to cosmetic surgery has been referenced earlier and this poll clearly shows that the Australian community not only recognise cosmetic surgery as a distinct specialty but overwhelmingly

⁵⁶ Galaxy Poll on consumer attitudes to cosmetic surgery, July 2007. Appendix 2. Methodology: The study was conducted on the Galaxy Omnibus on the weekend of 27-29 July 2007. The sample was 848 Australians aged 18-64, distributed throughout Australia. Interviews were conducted using CATI (computer assisted telephone interviewing) with telephone numbers randomly selected from electronic White Pages. Age, gender and region quotas were applied to the sample and the data was weighted by age, gender and region to reflect the latest ABS population estimates.



demand a process whereby they can easily determine who is and who is not properly qualified to perform cosmetic procedures.

Cosmetic Surgery Report by Galaxy Research 2007 Main Findings:

The vast majority (96 per cent) of Australians aged 18-64 years believe cosmetic surgery should be recognised as a specialty with training and qualifications approved by appropriate medical authorities (81 per cent strongly agree, 15 per cent slightly agree, cf. 3 per cent disagree). Women (85 per cent) are more likely than men (77 per cent) to strongly agree with this statement.

Again, almost all (93 per cent) Australians believe people have the right to choose to have cosmetic surgery to enhance their appearance (54 per cent strongly agree, 38 per cent slightly agree, 6 per cent disagree). Australians aged 18-24 years (95 per cent agree) and 25-34 years (97 per cent agree) are more likely to hold this view than those aged 50-64 agree (89 per cent agree).

Almost unanimously, 97 per cent of Australians believe that doctors should have to pass an exam and get a 'licence' specifically in cosmetic surgery before they are allowed to practise in it (88 per cent strongly agree, 9 per cent slightly agree 2 per cent disagree). This view is held consistently by Australians, regardless of gender, age, area income or education.

Overall, 95 per cent of Australians believe patients having a cosmetic surgery procedure have a right to know how many times the doctor has previously performed that procedure (76 per cent strongly agree, 19 per cent slightly agree, 4 per cent disagree). Women (97 per cent) are slightly more likely than men (93 per cent) to hold this belief.

Almost universally, 98 per cent of Australians believe patients have the right to know if the doctor performing their cosmetic surgery procedure is trained specifically in cosmetic surgery (87 per cent strongly agree, 11 per cent slightly agree, 1 per cent disagree). This view is held consistently by Australians, regardless of gender, age, area income or education.



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(b) that the resource utilisation for both public and private sector health care providers and consumers is justified on the basis of the benefits to the community of the recognition of the specialty



For this section, (b), of Criterion IV, the ACCS has engaged the services of Econtech in order to provide economic analysis of the likely impacts of recognition of Cosmetic Medical Practice as a medical specialty. That report, attached to the application at the conclusion of Criterion IV as Appendix 1, and forms an integral part of the College's answer to Criterion IV (b).

The College has summarised Econtech's report here, and based on the analysis provided by Econtech, discusses the benefits that would arise as a result of recognition of Cosmetic Medical Practice and, in more detail with practical examples, the adverse economic and other consequences of the *status quo*, specifically:

- Patients are confused because of the lack of a recognised cosmetic specialty;
- Hindrance or prevention of qualified cosmetic practitioners from obtaining hospital privileges; and
- Interference with training and Continuing Medical Education.

Econtech has analysed three economic effects of recognising Cosmetic Medical Practice.

First, consumers of cosmetic procedures would receive an appropriate quality of service from a recognised practitioner. There is an information asymmetry which exists between cosmetic surgery practitioners and consumers, since consumers have limited methods to determine if their practitioner is appropriately trained and qualified specifically in Cosmetic Medical Practice. Recognition will allow consumers to make more informed choices about the practitioner with whom they consult and reduce the opportunity for this information asymmetry to be exploited as the ACCS will demonstrate below.

Second, plastic surgeons and other surgeons trained by RACS receive a competitive advantage over other providers, because RACS is the only AMC-recognised surgical training college. This recognition, although not in cosmetic



surgery, is presented to consumers as if it was and creates an unjustified competitive advantage.⁵⁷

Non RACS practitioners are often denied hospital privileges because the committees which grant such operating rights are dominated by RACS members and rely on their advice. In some cases, as will be shown, hospitals are intimidated in order to acquiesce to demands by plastic surgeons through threats of primary or third party boycotts and other anticompetitive and monopolistic tactics.

The ACCC has recently removed some of the competitive advantage of RACS by making the College's training programme subject to the *Trade Practices Act 1974*. Hence it follows that listing cosmetic surgery and allowing the ACCS and others to apply to be a Government recognised training body, would be consistent with ensuring cosmetic surgery is subject to competitive disciplines, ensuring standards are not only maintained but improved and avoiding the quasi monopoly which currently exists.

Third, listing would not involve the use of taxpayer Medicare funding. The provision of services within the scope of Cosmetic Medical Practice is almost entirely outside the scope of the MBS and as such, has no direct implication into the cost of provision of medical care in Australia. In fact, because cosmetic procedures are subject to GST, they contribute to Government revenue. Also, by enabling consumers to make a choice of a provider who has reached a recognised cosmetic surgery specific accreditation benchmark, listing would reduce the cosmetic surgery's impact on the Government budget through reduced tax payer funded corrective surgery and complaints costs from poor cosmetic surgery.

Cosmetic medical and surgical procedures are performed by a variety of different providers, some of whom are not necessarily trained in the specific cosmetic procedure they may be providing to consumers.

57 The ASPS website states, for example, that "ASPS member surgeons are trained in plastic surgery both cosmetic and reconstructive procedures which encompasses both cosmetic and reconstructive procedures." and "have completed all the Surgical Education and Training requirements in the specialty of plastic surgery". <http://www.plasticsurgery.org.au/default.asp?itemid=303> Also see, e.g., ASPS's own statement which appears on the ACCC website, which states: "plastic surgeons are fully trained in a range of procedures from reconstructive to cosmetic". www.accc.gov.au/content/index.phtml/itemId/288933/fromItemId/815972/quickLinkId/815429/whichType/org (accessed September 2008).



Thus far no assessment of cosmetic surgical and cosmetic medical training has been made because no mechanism currently exists for organisations providing training and qualifications in this field to be assessed by the AMC.

Listing Cosmetic Medical Practice as a specialty on the AMC's List of Australian Recognised Medical Specialties will provide a mechanism for Colleges and other organisations to submit their training programmes for assessment.

Recognition would allow consumers to appropriately value the service they are receiving from their Cosmetic Medical practitioner and ensure that they are not being taken advantage of on price or quality. Patients will be better protected by being able to identify those providers who have been specifically trained and examined in the specialty and obtain such services from a variety of healthcare facilities. Thus the government would ensure that no artificial barriers exist which may hinder Cosmetic Medical Practice from competing efficiently with other goods and services in the economy for consumer dollars, while raising the level of protection for Australians. This would be independent of whether or not the College already had AMC accreditation in another specialty.

Discussion by the ACCS

Background

Since its inception, the ACCS has sought to work cooperatively with governmental and industry stakeholders in order to raise standards and improve patient safety – the aim of the College.

In many instances, the College's cooperation has been reciprocated. As a result, innovations and improvements have been introduced in a variety of areas related to Cosmetic Medical Practice in Australia. Examples of these efforts have been presented in Criteria II and III.

Unfortunately, over the same period of time the ACCS and its members have expended a great deal of effort correcting what is in the opinion of the ACCS orchestrated attempts to attack the College, its members, the proposed



specialty,⁵⁸ the many myths, misleading and manifestly inaccurate statements that have been promulgated by RACS, the ASPS and some of its membership, when the College's educational resources could be put to more positive use.

The ACCS and its membership have the greatest respect for the specialty of Plastic and Reconstructive Surgery and do not wish to impugn the professional reputation of plastic surgeons, some of whom have supported the College and maintain excellent working relationships with cosmetic surgeons and physicians. The ACCS will continue to offer to cooperate on issues of common concern. As recently as this year the ACCS was pleased to welcome the CEO of ASPS, Gaye Phillips, to an ACCS-hosted stakeholder roundtable discussion where one of the issues discussed was the recognition of a new cosmetic specialty.⁵⁹

However, it remains the case that offers by the ACCS and its membership to cooperate in order to raise standards and increase patient safety are too often met with hostility and condescension to the point of undermining quality of care.⁶⁰

RACS and the ASPS sometimes argue that only its plastic and reconstructive Fellows should be allowed to perform cosmetic surgical and medical procedures.⁶¹ On other occasions, the ASPS has acknowledged other surgeons, provided they are Fellows of the RACS, should be allowed to compete. On yet other occasions the ASPS has admitted the right of non-FRACS cosmetic surgeons to provide cosmetic procedures.⁶² The current President of the ASPS, Dr Howard Webster, has called for a ban on cosmetic

58 See e.g. Memorandum from Richard Barnett, President, ASPS, to ASPS members, dated 20 October 1998, requesting information "about patients who may have had a bad experience with a Cosmetic Surgeon". Appendix 10.

59 The White Paper from this roundtable is included as Appendix 5.

60 See e.g. RACS Surgical News in which, following the release of the 1999 NSW Cosmetic Surgery report, the president of RACS is quoted as stating that non-RACS "surgeons are a source of great annoyance to the society". "Win for plastic surgeons", Surgical News, October 1999, p. 12.

61 Email correspondence between Dr Daniel Fleming and Dr Mark McGovern, 25 August to 25 September 2008. Appendix 11.

62 See e.g. Interview of ASPS Council member and spokesman, Dr Peter Callan, on Darwin ABC Radio. 29 September 2008. See also e.g. letter from former RACS president, Dr Randall Sach to solicitors for the Australian Association of Cosmetic Surgery (the forerunner to the ACCS): "I would like to provide you and your clients with an assurance that it is not suggested by this Society that persons other than qualified plastic surgeons are not able to competently perform cosmetic surgery." 22 January 1996. Appendix 12.



surgical procedures being performed by “non-surgeons” by which he means all non RACS practitioners regardless of their competence.⁶³ Although when questioned about this by the President of the ACCS, Dr Webster says he was misquoted, and does recognise ACCS cosmetic surgeons’ right to offer their services to patients. These and other examples demonstrate in part how the lack of recognition of a specialty incorporating cosmetic surgery and medicine causes confusion.

The RACS and the ASPS have stated, however, there is no need for a new specialty encompassing cosmetic surgery and medicine because it is already part of plastic and reconstructive surgery.⁶⁴ The arguments that this is not so are evidenced elsewhere in this submission but, even if it were true, since cosmetic procedures are performed by practitioners from a wide range of backgrounds, this is not a valid argument against recognition of a new specialty. Recognition will simply create a level playing field and allow **all** practitioners, including RACS and ASPS surgeons, to submit their cosmetic qualifications for independent assessment by the AMC. Without the new specialty this cannot occur. It is contradictory therefore for RACS and the ASPS to argue there is no need for a new specialty on the one hand while on the other criticise the ACCS for not submitting its qualifications for independent verification by the AMC.

Under the current regime, there are at least three areas where the College has identified monopolistic and anti-competitive behaviour which has a detrimental impact on patient choice and care as well as create sub-optimal economic consequences due to healthcare market distortions.

1. Patients are confused because of the lack of a recognised cosmetic specialty

The College agrees with the view expressed by the ACCC that consumers should be able to receive accurate and relevant information in order to make informed decisions in their dealings with medical professionals:

⁶³ “The Australian Society of Plastic Surgeons (ASPS) has called for a ban on cosmetic surgery on teenagers”, News-Medical.Net, 30 September 2008. www.news-medical.net/?id=41741 (Accessed September 2008).

⁶⁴ Peter Callan, ABC Radio Darwin. *Supra* note 63. Also, Gaye Phillips, CEO, ASPS quoted in ACCS Roundtable, 26 June 2008. Appendix 5.



“Professionals, like others, should be able to prosper on the merit of their products or services without fearing that competitors will gain an unfair competitive advantage from incomplete, inaccurate or misleading representations. Consumers and patients have a right to accurate and truthful information from business about their purchases. This is particularly pertinent in relation to health and medical services.

“However, the ACCC also recognises that some consumers of health products and services may be vulnerable... due to information asymmetries that exist between a lay-person and a medical practitioner, to misleading or exaggerated claims made in advertisements.

“Clearly it is important that consumers of cosmetic services are able to receive accurate, appropriately detailed information about services provided by doctors.”⁶⁵

However, the lack of AMC accreditation for any cosmetic medical or surgical qualification is used repeatedly by RACS and the ASPS to try to persuade patients that their safety will be placed at risk if they do not choose an FRACS plastic and reconstructive surgeon for their procedure.⁶⁶ The insurance claims data and other evidence which shows this not to be true is included in Criterion II of this Application.

The lack of recognition of the specialty and therefore the lack of the necessary framework to apply for accreditation by the ACCS or any other qualifications in cosmetic surgery and medicine, allows RACS and the ASPS to describe Fellows of the ACCS as “GPs”. The generic use of this term is specifically used to denigrate the training and competence of College members and by comparison reinforce the “specialist” credentials of RACS and therefore ASPS surgeons. That they too are not accredited specifically in cosmetic medicine or surgery is never revealed.

⁶⁵ ACCC comments on proposed revision of advertising guidelines [by the Medical Practitioners Board of Victoria], 2007. www.accc.gov.au/content/index.phtml/itemId/796393/fromItemId/7126 (Accessed December 2007)

⁶⁶ After the death of a Liposuction patient, Lauren James, in Melbourne in 2007 after receiving treatment from an FRACS plastic surgeon, Dr Norman Olbourne said on behalf of RACS that doctors performing cosmetic surgery should be FRACS in order to protect patients. Melbourne Herald Sun, 28 January 2007, www.news.com.au/heraldsun/story/0,21985,21128898-24331,00.html (Accessed May 2008).



In recent years, as it has faced competitive pressures and as the specialty of cosmetic medical practice has evolved, the ASPS, to which RACS has now devolved responsibility for its plastic and reconstructive surgical training, has attempted to improve the cosmetic elements of its course. It has a comprehensive written curriculum in cosmetic procedures but as the 1998 letter from the then Chairman of the Board of Plastic and Reconstructive Surgery at RACS, Dr Jim Katsaros states, in reality subspecialty cosmetic training is obtained **after** the award of the FRACS qualification, is not obtained by all plastic surgeons, is arranged privately and is not supervised by RACS.

“Candidates who have completed the Part 2 FRACS and wish to obtain further sub-specialty training then proceed to fellowships in designated areas such as cosmetic surgery. Currently these fellowships are available in Sydney, Melbourne and Adelaide and are arranged personally by those surgeons. The Board does not supervise post-graduate fellowships which also exist overseas.”⁶⁷

That this remains the case in 2008 was confirmed in a recent ABC Radio interview by ASPS Council member Dr Peter Callan:

*“All plastic surgeons in their training are knowledgeable and capable of doing cosmetic training, by the end of their training **and fellowship training after that.**” (emphasis added)⁶⁸*

Nevertheless, the ASPS informed patients in 1998 as in 2008 that the letters FRACS after a plastic surgeon’s name was an assurance that the surgeon was “fully trained in the field of Plastic and Reconstructive **and Cosmetic Surgery Procedures** by the Royal Australasian College of Surgeons (or its equivalent)” (emphasis added).⁶⁹ Despite these assurances, one well known plastic surgeon, a professor and former ASPS Board member responsible for the training of plastic surgeons has stated that he disagreed with the Society’s view, as he saw it as **“a monopoly held by them on cosmetic surgery”**...

He further stated:

67 Correspondence from DR James Katsaros, Chairman, Board of Plastic and Reconstructive Surgery, Royal Australasian College of Surgeons, 1 July 1998. Appendix 26.

68 Peter Callan, ABC Radio Darwin. *Supra* note 63.

69 Yellow Pages.



I was on the Board of the [ASPS] with respect to the training program and organising training and there was not one skerrick of time given to cosmetic surgery. And I thought is was rather hypocritical and I left them.⁷⁰

This unusually candid revelation is entirely consistent with the statements of Drs Katsaros and Callan referenced above. Those Australian plastic surgeons who have received formal training in cosmetic surgery obtained it privately, voluntarily and after qualifying as specialists in plastic and reconstructive surgery.

Even in 2008 only a tiny proportion of the ASPS-approved training posts are in cosmetic surgery. The ASPS and RACS have consistently refused to provide an anonymous random sample of the operation log books which all their trainees are required to keep. This would reveal how much training and exposure to cosmetic procedures a typical FRACS plastic and reconstructive surgeon has in fact received at the completion of their RACS programme and their admission as specialists.⁷¹

In October 2008, responding to the findings of the Galaxy survey of public opinion,⁷² the ACCS made it compulsory for its members to disclose to patients at the time of the initial consultation how many times they had performed the procedure under consideration before if this was less than 100 times. Despite the fact that the ASPS itself recognises on its website the number of times a practitioner has performed the procedure before is one important factor of which patients should ask about, it dismissed placing the onus of disclosure onto the doctor as a “publicity stunt”.⁷³ Such a mandatory disclosure would better inform patients too intimidated to ask but would also result in RACS plastic surgeons revealing the extent of their cosmetic experience.

Without recognised cosmetic surgery and cosmetic medical qualifications consumers are left confused about what qualifications actually mean. This

⁷⁰ Professor Peter Haertsch, Interview, Channel Nine, July 2008.

⁷¹ See e.g. Correspondence between the ACCS and RACS, 25 October 2005, 1 May 2006. Appendix 13.

⁷² Galaxy survey. Appendix 2.

⁷³ “Cosmetic surgery rules cop flak”, The Age, 4 October 2008, www.theage.com.au/national/cosmetic-surgery-rules-cop-flak-20081003-4tkk.html (Accessed October 2008).



confusion is exacerbated by misstatements by those who seek an economic advantage.

The most common theme of these misstatements is that only RACS trained doctors who are ASPS members are capable of performing cosmetic surgical procedures. Another is that they are comprehensively trained in all the specific procedures that comprise Cosmetic Medical Practice.

The inference to this misstatement is that cosmetic surgeons, by virtue of the fact that they have not received an FRACS are not properly trained to perform cosmetic surgical procedures, when, in fact, the qualification FACCS provides much greater exposure to cosmetic surgery than FRACS.

For example, the ASPS website contains the statement: “The best way to know your surgeon is fully trained and qualified is to choose an ASPS Member Surgeon.”⁷⁴ The implication, following a discussion of cosmetic surgery, is that ASPS member surgeons are, solely by virtue of their FRACS qualification, “fully trained” to perform cosmetic surgery. This statement is manifestly untrue as is revealed by the statements of RACS and ASPS and the international evidence.

The ACCS is aware that RACS Fellowship training now provides some exposure to aesthetic procedures, but it is not “comprehensive” nor is it sufficient to qualify an FRACS surgeon in cosmetic surgery and medicine without further training.

This situation is not unique to Australia. In the UK, for example:

In common with many other areas of surgical practice there is currently no formal basis for procedure-based training of surgeons in cosmetic surgery in the UK. The NHS funds pure cosmetic surgery procedures for individual patients only in exceptional cases, so trainee surgeons do not have the same opportunities to become fully trained in cosmetic surgery as part of their specialist training in the NHS. Trainees do, however, learn the basic surgical principles related to many of these procedures as they are integral to the Curriculum in many surgical specialties. However opportunities to train in the

⁷⁴ ASPS website: www.plasticsurgery.melbournebusiness.com.au/default.asp?itemid=270 (Accessed August 2008).



*specific procedures are limited, particularly for facial rejuvenation surgery. The training available in this area consists principally of assisting NHS consultants or fully accredited independent practitioners in their private practice. This is undertaken during their normal 'NHS' attachment to a consultant or as a separately identified attachment or fellowship. Some surgical registrars who have a heavy NHS workload have experienced difficulties in obtaining such opportunities. This has been recognised and there is now a commitment from all concerned with the training of surgeons to develop a recognised training programme, based on competency assessment that will result in procedure, or area specific, accreditation in all aspects of cosmetic surgery.*⁷⁵

The ACCS has led the way in this model of procedure-specific accreditation for cosmetic procedures. In addition to its qualifications, the ACCS has, for many years, provided an extra level of disclosure and protection for patients through its procedure specific registers.

It is not surprising then that, as noted in the Executive Summary, the UK department of health has also recently made consumers aware of the fact that though a surgeon or other practitioner may have a qualification in a related specialty ***including in Plastic and Reconstructive Surgery***, their core qualification ***"may not indicate that they have received any special training in cosmetic surgery, or that they have experience in doing cosmetic surgery or [in a] particular procedure"*** (emphasis added).⁷⁶

75 Composite Paper on Cosmetic Surgery Training, Assessment and Funding the Cosmetic Surgery Inter Speciality Committee (CSIC), The Senate of Surgery of Great Britain & Ireland, April 2007.

76 (UK) Department of Health, 2008 www.dh.gov.uk/en/Publichealth/CosmeticSurgery/DH_4124199 (Accessed May 2008). The UK Expert Group on the Regulation of Cosmetic Surgery report noted, "As there is no specialty for cosmetic surgery to which doctors can be registered, doctors can practice outside the area of competence for which they are registered". The report considered the situation "unsatisfactory because it is virtually impossible for a person seeking cosmetic surgery to understand or evaluate the precise qualifications and supervisory framework in which their surgeon is practicing". The report recommended that specialist colleges "evolve" education and training programs. Expert Group on the Regulation of Cosmetic Surgery, *Supra* note 2, p. 6. Recognition of the specialty in Australia will provide the necessary framework so that organisations here can apply to have their training schemes properly assessed against appropriate AMC criteria.



Plastic and reconstructive surgeons then are not necessarily trained as cosmetic surgeons. An ASPS membership or FRACS does not necessarily indicate *per se* that a surgeon is qualified or sufficiently experienced in cosmetic procedures.

The public is unlikely to appreciate this fact and may be further confused when the ASPS website goes on to state that, “many health care providers are now performing cosmetic procedures, but that doesn’t mean they’re all qualified to perform plastic surgery. ASPS Member Surgeons are trained in plastic surgery which encompasses both cosmetic and reconstructive procedures”.⁷⁷

While the opening premise is undoubtedly true – i.e. that “many health care providers are now performing cosmetic procedures, but that doesn’t mean they’re all qualified to perform plastic surgery” – the statement is deliberately confusing to the consumer by conflating cosmetic with plastic. Cosmetic surgeons do not hold themselves out to be plastic surgeons.

The ACCS is not suggesting all ASPS plastic surgeons are not competent or unsafe in cosmetic procedures. This is patently not true. Some of the best cosmetic surgeons in Australia are ASPS plastic surgeons and some are FACCS cosmetic surgeons. The former have become experts in cosmetic practice because of training and experience after their FRACS qualification and not all plastic surgeons obtain this or even want to obtain this.⁷⁸ Plastic and reconstructive surgical training provides a sound base on which to build these further skills but there are other ways of training doctors to acquire these competencies, one of which is the ACCS programme. In the case of the College’s surgical qualification, this requires a core surgical background and training prior to advanced cosmetic surgery-specific training and assessment.⁷⁹ The recognition of Cosmetic Medical Practice as a new specialty is a necessary step to allow cosmetic surgical and medical qualifications to be assessed by the AMC and therefore patients to access practitioners whose cosmetic qualifications have been independently accredited.

⁷⁷ ASPS website.

⁷⁸ Peter Callan interview ABC Radio Darwin, *Supra* note 63.

⁷⁹ See ACCS surgical entry criteria provided in Criteria III.



The need for recognition of a cosmetic surgical specialty to protect patients was emphasised by Ron Paterson, the New Zealand Health and Disability Commissioner, during the review process of cosmetic practice in that country:

"I understand from Dr Fleming (President of the ACCS) that doctors who are certified by the ACCS have undergone three years of basic surgical training, followed by two years in an advanced surgical training programme in cosmetic procedures. You will recall I commented on the need for these types of cosmetic sub specialty training programmes in my 22 March 2007 submission."⁸⁰

He concluded by supporting the need for suitable interim accreditation arrangements "until there is a recognised scope of practice for cosmetic surgery in New Zealand". The ACCS has commenced the application process with the New Zealand Medical Council for such recognition.

Privately the ASPS admits that many of its public statements are made to "protect its brand" which is inextricably linked to the monopolistic position it currently enjoys through its agreement with RACS, the only AMC accredited provider of surgical training. While the ASPS has the right to protect its brand, its ability to engage in anti-competitive practices and disseminate what the ACCS believes to be misleading information about its competitors is, in the College's view, facilitated by the lack of recognition of Cosmetic Medical Practice.

It is to be hoped that RACS and the ASPS will support the recognition of the new specialty and therefore a framework in which they and other organisations will be able to submit their cosmetic training for assessment by the AMC. However, given their previous statements and the structural advantages RACS and the ASPS will continue to enjoy so long as cosmetic medicine and surgery remain unrecognised, the ACCS cannot be optimistic about this:

"The whole reason for the existence of the Australian College of Cosmetic Surgeons is so that these guys can award themselves a higher degree and some sort of legitimacy without getting their college properly accredited," [ASPS

⁸⁰ Letter from Ron Patterson, New Zealand Health and Disability Commissioner, 8 October 2007. *Supra* note 44.



*president] Dr [Howard] Webster, says. "They are spinning very hard and we think it's all bullsh*t."⁸¹*

The College has considered very carefully whether or not to include some of the material and the source documents contained in the Appendices. It takes no pleasure in doing so. It has been included because the College believes the AMC needs to be aware of the wider context in which any objections are made, by or on behalf of RACS and the ASPS, to the recognition of the specialty of Cosmetic Medical Practice.

The ACCS is of the opinion that there is a longstanding, ongoing, organised campaign by plastic surgery colleges and societies around the world, supported by many but not all of their members, which has been replicated in Australia. The College is of the view that the primary purpose of these activities is not to protect patients as is claimed (though this ostensible reason is often given, the College believes these activities have the opposite effect by confusing patients), but to protect the economic interests of plastic surgeons.

Tactics include ensuring non-plastic surgeons of proven competence are denied credentialing for cosmetic surgery operating privileges in hospitals, denigrating non-plastic surgeons who perform cosmetic surgery, sabotaging training programmes and attempting to enforce third party boycotts of academic conferences organised by non-plastic surgeon organisations. It is regrettable, but necessary for the AMC to see the evidence so it may make come to a fully informed decision having made up its own mind about the motivation behind some of the objections it may receive.

It is also important that the AMC appreciate that these views and activities are neither spontaneous nor isolated. There is a well documented history of reports of RACS and ASPS member surgeons engaging in activities to protect their economic interests.⁸² These activities have attracted the attention of the ACCC. In some instances their anti-competitive behaviour has been directed at their own members; in others, toward other members of the medical fraternity, including cosmetic surgeons.

81 Dr Howard Webster, President, ASPS. The Age, 12 March 2007, www.theage.com.au/news/national/doctors-duel-over-accreditation-for-nips-tucks-and-lifts/2007/03/11/1173548021838.html (Accessed May 2008). Appendix 29.

82 See, e.g. ACCC, October 2003, p. viii. Also "ACCC tells doctors they are not above the law", The Australian, 26 September 2008, www.theaustralian.news.com.au/story/0,20867,22031466-23289,00.html (Accessed May 2008).



The best source of evidence of this well orchestrated campaign to protect their financial interests is the plastic and reconstructive surgeons themselves.

For example, Dr Foad Nahai, President of the International Society of Aesthetic Plastic Surgery (ISAPS), outlined these views and tactics at ISAPS's 2008 conference held in Melbourne.⁸³

In his speech to the conference titled, 'The sky is the limit', Dr Nahai began by stating that unlike other medical specialties, plastic surgeons were 'lucky' because there was a "boom" in cosmetic surgery and medicine. He continued:

"We should be rejoicing. But why are we not?"

"We are being bypassed. We are becoming irrelevant."

"Competition....Everyone wants to be in cosmetic medicine and surgery"

"Who is going to help us?.. No one is going to help us we have to help ourselves."

His solution was:

"Control facilities where cosmetic surgery is performed. Define the skills and training required to perform different cosmetic surgery procedures."

As will be shown, the definition of the "skills and training required" is having a qualification in plastic and reconstructive surgery and this is indeed used to "control facilities where cosmetic surgery is performed."

These tactics and others are now being promoted by ISAPS's 'Specialty Promotion Committee,' which Dr Nahai credits with building alliances internationally to "**position... plastic surgeons at the centre of the cosmetic universe**" while keeping others out. This "universe" includes both cosmetic surgery and cosmetic medicine – they have created a separate injectable "Task Force" to attempt to control less invasive procedures.

⁸³ "The sky is the limit", Dr Foad Nahai, President, International Society of Aesthetic Plastic Surgeons, speech delivered to the 2008 ISAPS Conference, Melbourne, February 2008.



Dr Nahai congratulated Dr Bryan Mendelsohn, a Melbourne plastic surgeon and member of the ASPS for his “wisdom” in appointing the Chair of the Promotion Committee, “to deal with exactly the issues I am talking about today.”

Dr Nahai makes no attempt to hide the tactic of controlling operating facilities. This same tactic has been, and still is, used by Australian plastic surgeons.

2. Hindering or preventing qualified practitioners from obtaining hospital privileges

The Australian Council for Safety and Quality in Healthcare “Standard for Credentialing and Defining the Scope of Clinical Practice” 2004 requires that credentialing committees:

“ensure that the threshold credentials are based on objective criteria about the necessary period and character of training and experience, rather than the possession of specific endorsements or accreditation by named professional colleges, associations, or societies;” (emphasis added)

This requirement is routinely ignored when non-plastic surgeons, especially FACCS qualified doctors apply for credentialing in cosmetic surgery. In matters of cosmetic surgery, hospital medical advisory committees are indeed “controlled” by RACS/ASPS plastic surgeons who refuse to credential any practitioners who are not in RACS. Despite the requirement of the ACSQH, hospitals are often persuaded that due to the lack of an AMC recognised qualification, the practitioner cannot possibly be competent.

Sometimes implied threats of boycotting are used. Such cases are notoriously difficult to prove as the activities are usually not committed to paper. Sometimes, however, evidence does emerge, which in the College’s opinion demonstrates these tactics. The letter from Drs Doyle and Hertess, both ASPS plastic surgeons, to Darwin Private Hospital is a case in point.⁸⁴ Dr Michael Zacharia, whom they sought to exclude from providing cosmetic surgery at the hospital, is an FRACS in Ear, Nose and Throat Surgery, an FACCS and a past President of the ACCS.

⁸⁴ Letter from Drs Mark Doyle and Isolde Hertess to Dr Michael Zacharia, 8 August 1997. Appendix 14.



Dr Daryl Hodgkinson MB BS (Hons) FRCS(C) FACS FACCS, also a past president of the ACCS and its current Dean of Surgery, is another example. Dr Hodgkinson is recognised by the Health Insurance Commission as a specialist in Plastic and Reconstructive Surgery, but was still denied hospital operating credentialing privileges by RACS and ASPS surgeons. His letter to Dr John Quinn, Executive Director for Surgical Affairs at RACS details his experiences.⁸⁵

RACS often justifies its monopolistic behavior on the basis it will recognise “equivalent” qualifications. Dr Hugh Bartholomeusz, a former Queensland President of the ASPS wrote in Private Hospital magazine in October 2006:

“There is an open and transparent process that the College of Surgeons has for accrediting people’s credentials. As far as the College is concerned they can be scrutinised by the College by this process, and if the College feels they are appropriately qualified they will grant them an FRACS.”⁸⁶

Dr Hodgkinson’s letter details just how open and transparent this process is when plastic and reconstructive surgery is involved.

The comments of Dr Hodgkinson’s QC, Mr C A Sweeney, who represented him at his appeal at RACS, are very revealing:

“the appeal was a travesty, a charade the only purpose of which was to give the impression to outsiders that there was a legitimate and impartial appeals process when there was in truth nothing of the sort.”

and

“A private club which conducted its affairs in this manner would be sanctioned by the courts. It is a disgraceful state of affairs that a College invested with the public responsibility of

⁸⁵ Letter from cosmetic plastic surgeon Dr Darryl Hodgkinson MB BS (Hons) FRCS (C) FACS FACCS to Dr John M Quinn, Executive Director for Surgical Affairs, Royal Australasian College of Surgeons, 29 January 2007 with memorandum from CA Sweeney QC, Dixon Chambers, 3 March 2008. Appendix 15.

⁸⁶ “Call for GP check in private hospitals”, Private Hospital Magazine, October 2006, p. 24. Appendix 16.



conferring surgical degrees should consider itself able to do so with impunity.”⁸⁷

In October 2006, Dr Bartholomeusz, the plastic surgeon referred to above, was removed from Logan Surgery Centre’s Medical Advisory Board. His alleged behaviour as a RACS appointee is detailed in the letter sent to him by the hospital and annexed in Appendix 17.⁸⁸

Specifically, the clinic formed a view that Dr Bartholomeusz had allowed his RACS representation to interfere in his duties to the clinic in his capacity as a member of the credentialing committee, had breached the privacy of the committee’s proceedings by discussing them with the media⁸⁹ and had implied that the clinic would be boycotted by RACS surgeons if it did not support his stand on a number of applicants with non-RACS affiliation.

In demanding Dr Bartholomeusz’s resignation, the clinic stated:

“We feel that your appointment to our committee was to serve some form of political agenda and we deeply resent being a part of this action.”⁹⁰

In *Private Hospital* magazine, Dr Bartholomeusz, speaking as the immediate past president of the Queensland State Committee of RACS, called for a retrospective removal of operating privileges of non RACS practitioners, including Fellows of the ACCS (all of whom he generically labeled “GPs”), not on the basis of competence, but on the basis that they did not have the only AMC recognised surgical qualification - FRACS.⁹¹

It is important to remember it has been shown that in Australia, to date, there is no difference in the frequency of adverse outcomes between those

87 Letter and enclosed documents, Hodgkinson, *Supra* note 86.

88 Letter from Dr PD Elliot, Director, Logan Skin Clinic and Sister JE Koboroff, CEO/Practice Manager, 28 August 2006. Appendix 17.

89 Media release, “Check first”, Royal Australasian College of Surgeons, 28 July 2006. Appendix 18, and “Call for GP check in private hospitals”, *Private Hospital Magazine*, October 2006, p. 24. Appendix 16.

90 Letter from Dr PD Elliot and Sister JE Koboroff, *Supra* note 89.

91 *Private Hospital magazine*, *Supra* note 90.



ASPS/RACS plastic surgeons who choose to practice cosmetic surgery and ACCS Fellows.⁹²

A contemporaneous press release issued by RACS the day after he had refused to follow the National Standards on credentialing to be followed stated:

*“GP’s do not have the experience or skill to operate on patients unless it is done under a local anaesthetic,” said College representative Dr Hugh Bartholomeusz.*⁹³

This unequivocal yet un-evidenced declaration, in a RACS authorised media release, that it should have a monopoly on all surgery unless performed under a local anaesthetic, is relevant when considering objections RACS may have to the recognition of a new specialty over which RACS will not have exclusive control.

In radio interviews Dr Bartholomeusz gave following the RACS media release, he misrepresented the new regulations concerning credentialing which were under development by Queensland Health Department. This attempt to “control facilities where cosmetic surgery is performed” caused the authorities in Queensland to enact changes to ensure it would not happen again.

In April 2008, the Queensland Department of Health approved updated regulations concerning "Credentialing and Defining the Scope of Clinical Practice" of medical practitioners in Queensland. This policy document includes a specific reference to cosmetic surgery credentialing and recognises that a nominee of the Australasian College of Cosmetic Surgery is the

92 See insurance claims data provided in Criteria II. However, according to US studies, cosmetic surgery patients choosing their physician based solely on the physician’s underlying board certification are being harmed. Several studies, including the 12 summarised in Appendix 18, found significantly higher rates of morbidity, mortality and malpractice claims among board certified plastic surgeons over all other medical specialties performing certain cosmetic procedures.

93 Media release, “Check first”, Royal Australasian College of Surgeons, 28 July 2006 and “Call for GP check in private hospitals, Private Hospital Magazine, October 2006, p. 24. *Supra* note 90.



relevant peer which must be consulted when any medical practitioner applies for credentialing in cosmetic surgical procedures.⁹⁴

Another example is provided by the withdrawal of operating privileges of Dr Colin Moore FRACS FACCS, also a past President of the ACCS. The third party forcing tactics concerning plastic surgeons and their anesthetists are described in the correspondence in Appendix.⁹⁵

In the context of dealing with competition, there have been other instances where spokespersons for the ASPS have made misrepresentations or misstatements.

In March 2001, Sunshine Coast plastic surgeon Dr Mark McGovern, speaking on behalf of the ASPS, issued a media release in which he stated that “unqualified doctors should not practice cosmetic surgery or medicine” and that “plastic surgeons alone have comprehensive training and qualifications”.⁹⁶ Dr McGovern alleged that Phillip Cleaton, the Director of Operations of a Brisbane private hospital, was “understandably concerned” about non-plastic surgeons performing cosmetic procedures and “had taken the highly unusual decision to refer the matter to the Medical Board of Queensland for their opinion!”.⁹⁷ According to a sworn affidavit by Phillip Cleaton, Dr McGovern had misrepresented the facts.

In his affidavit, Mr Cleaton stated that not only was the statement untrue, but he was “entirely satisfied with the standards of all doctors performing cosmetic surgery at that hospital. The vast majority of cosmetic surgery at the hospital was performed by cosmetic surgeons and not by plastic surgeons. There has not been a single incident to cause concern...”.⁹⁸

The disadvantage to affected practitioners of this tactic of “control facilities where cosmetic surgery is performed” is obvious. Patients are also disadvantaged. They have a right to choose the cosmetic or plastic surgeon

94 Credentialing and the Scope of Clinical Practice Appx 2: Model Terms of Reference, Queensland Health, April 2008.

95 Letter from Dr Colin Moore to Dr Daniel Fleming, 15 August 2006 and attached correspondence from: Dr JF Arbuckle, Medical Director, Anglo Scottish Medical Services Pty Ltd, 5 November 1997 and 5 February 1999; Michael Cass, 11 March 1998. Appendix 19.

96 Media Release, Sunshine Coast Plastic & Cosmetic Clinic, 5 March 2001. Appendix 20.

97 Media release, Sunshine Coast Plastic & Cosmetic Clinic. Ibid..

98 Affidavit of Phillip Cleaton, 23 September 2001. Appendix 21.



they believe is most appropriate for their procedure. They also have a right to expect that surgeons and his or her patients to have equal access to accredited private hospital operating facilities based on training, experience and competence in that cosmetic surgical procedure, as is required by the National Standard. As has been shown, the absence of a recognised cosmetic specialty frequently results in patients being denied this right.

3. *Interfering with Training and Continuing Medical Education*

There have also been instances of RACS/ASPS plastic surgeons interfering or preventing other, non-plastic surgeons, from participating in training or CME. In December 2007, the current president of ASPS, Dr Howard Webster, was in contact with *The Daily Telegraph* and made several inaccurate, unfounded statements and imputations regarding the College's liposuction training workshops. These workshops form an important part of the training of ACCS registrars and also are an integral part of the course of study which leads to the ACCS Diploma in Lipoplasty.

The College was particularly disappointed by this event, because ASPS had only recently approached the College for discussions to work cooperatively together in order to advance public health outcomes and cease its attacks in the media.

After expressing its concerns to the ASPS, the College's solicitors received a letter from ASPS's solicitors stating, among other things:

"We note that the relationship between our respective clients has been undergoing a significant improvement in recent months with an enhanced degree of cooperation and understanding being established..."

"Our clients regret this incident, look forward to putting this matter behind them and continuing to develop an enhanced relationship with your client in 2008."⁹⁹

The ACCS was pleased to note the apparent change in attitude exhibited by the ASPS following this incident; *The Daily Telegraph* story was withdrawn and another story, based on it, to appear on Network Nine's *A Current Affair*,

⁹⁹ Letter from Swaab Solicitors on behalf of the ASPS, 20 December 2007..



was cancelled after expensive legal action by the College. Although the ASPS “brand was protected” it came at a cost to the considerable reputational damage done to the College its training programme, while consumer confidence and understanding was undermined.

In 2006, Dr Luiz Toledo, a renowned plastic and cosmetic surgeon had agreed to attend the ACCS annual academic conference. He received a letter from a senior Australian plastic surgeon urging him to boycott the meeting because it was organised by the ACCS and not plastic surgeons.¹⁰⁰

This protectionist behavior has been replicated recently with similar attempts being made to convince Dr Constantin Stan, a world expert in breast augmentation surgery, to withdraw his acceptance to speak at the ACCS 10th Anniversary Conference in 2009.¹⁰¹

RACS, in its monopoly position as the only accredited provider of surgical training in Australia, has sought to prevent the training of an ACCS surgical registrar. The letters from Drs Rosenberg¹⁰² and Attalla¹⁰³ describe this in detail. Such activities have the effect of interfering with a competing organisation from being able to provide proper training in cosmetic surgery and thus reach the standards likely to be required by the AMC for training programmes applying for recognition. An analysis of these letters, combined with other statements and actions, has led the College to form the view that the lack of AMC accreditation is again the pretext on which this behavior is justified.

The extent to which the different specialties within RACS cooperate in these tactics is revealed in a letter written in September 2006 by the then RACS President, Dr Russell Stitz.¹⁰⁴ Dr Stitz described how he had successfully forced the organising committee of the 7th Australasian Day Surgery Conference to withdraw an invitation to Mr Mark Gilheany, President of the Australasian College of Podiatric Surgeons by threatening to refuse to speak if Mr Gilheany was allowed to do so. Although this particular act was to protect

100 Darryl Hodgkinson. *Supra* note 86.

101 Letter from Dr Constantin Stan to Dr Daniel Fleming, 29 September 2008. Appendix 22.

102 Letter from Mr Paul Rosenberg MB BS FRCS FRCS FRCS (Ed) FACCS to the AMC, 29 September 2008. Appendix 23.

103 Letter from Dr Mark Attalla to Dr Daniel Fleming, 3 July 2008. Appendix 24.

104 Correspondence from Dr Russell Stitz, President, Royal Australasian College of Surgeons, 21 September 2006. Appendix 25.



the interests of orthopaedic surgeons and had nothing to do with plastic, reconstructive or cosmetic surgery, Dr Stitz felt the need to copy the letter to all RACS plastic surgeons.

The ACCS recognises that this propensity is not relegated to RACS and ASPS. The 2005 AHWOC-ACCC Review of Australian specialist medical colleges noted:

The self regulatory framework in the specialist medical profession does mean that professional bodies such as specialist medical colleges have a dual role—one as a standard setter for the profession in education and accreditation and another as an advocate of the interests of the profession. Colleges could be subject to criticism that they are unduly restrictive when situations develop where the interests of the colleges and consumers and the general public (and therefore governments) are not aligned, and the college's focus is on the interests of its members.¹⁰⁵

ACCC Chairman Graeme Samuel also noted:

More than in virtually any other sector, regulation of health care provision, including professional self-regulation, has robbed consumers of sovereignty. Introducing competition means providing consumers with greater freedom to choose between different services and different service delivery mechanisms.¹⁰⁶

In the absence of a recognised specialty of Cosmetic Medical practice, consumers are left confused about what qualifications actually mean. This confusion is exacerbated by misstatements by those who seek an economic advantage.

¹⁰⁵ Report to Australian Health Ministers: Review of Australian specialist medical colleges, Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee, Commonwealth of Australia, July 2005, p. 10.

¹⁰⁶ "Introducing competition in the public delivery of health care services", presentation by Graeme Samuel, to World Bank Human Development Week, Washington DC 29 February 2000, p. 10.



Recognition of the specialty of Cosmetic Medical Practice will not by itself eliminate these activities; they occur among RACS surgeons. In 2007, for example, the ACCC brought successful court actions against two Adelaide cardiothoracic surgeons for among other things making an arrangement to hinder or prevent other specialist surgeons from attaining hospital privileges.¹⁰⁷

However, recognition will allow less scope for practices which are self-evidently monopolistic and anticompetitive and the promulgation of misinformation and, therefore, confusion about training and standards. This, and the ability of patients to identify practitioners whose qualifications in cosmetic surgery and medicine have been formally assessed by the AMC, and access their services at hospitals, will benefit patients and allow them to make more informed decisions about their care. Such outcomes could only raise standards and improve patient safety.

¹⁰⁷ ACCC media release, "Court penalises surgeons \$110,000 for moves to prevent competition, 5 July 2007. See also letter from Dr Hodgkinson. *Supra* note 86.



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***ECONOMIC ANALYSIS OF COSMETIC MEDICAL PRACTICE
BEING LISTED ON THE AUSTRALASIAN MEDICAL COUNCIL'S***

LIST OF AUSTRALIAN RECOGNISED MEDICAL SPECIALTIES

This report was prepared for
The Australasian College of Cosmetic Surgery
by Econtech Pty Ltd

13 June 2008

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Executive Summary

1. The cosmetic surgery industry is rapidly expanding both within Australia and abroad. Cosmetic surgery and medicine are performed by many different medical professionals, some of which are not necessarily trained in the specific cosmetic procedure they may be providing. The Government body responsible for assessing the quality of the Colleges which provide medical and surgical training is the Australian Medical Council (AMC). Thus far no assessment of cosmetic surgical and cosmetic medical training has been made because no mechanism currently exists for organisations providing training and qualifications in this field to be assessed by the AMC.
2. Having Cosmetic Medical Practice listed as a specialty on the AMC's List of Australian Recognised Medical Specialties will provide a mechanism for Colleges and other organisations to submit their training programmes for assessment.
3. This report analyses three economic effects of listing.
4. The first is consumers would receive an appropriate quality of service from a recognised practitioner. Currently an information asymmetry exists between cosmetic surgery practitioners and consumers, since consumers have limited methods to determine if their practitioner is safe and that is appropriately trained and qualified specifically in Cosmetic Medical Practice. Listing will allow consumers to make more informed choices about the practitioner with whom they consult.
5. The second is consumers would receive a fair price for this quality of service. Currently plastic surgeons and other surgeons trained by the Royal Australian College of Surgeons (RACS) receive a competitive advantage over other providers, because RACS is the only AMC recognised surgical training College. This "recognition", although not in cosmetic surgery, is presented to consumers as if it was and creates an unjustified competitive advantage. Non RACS providers of unquestioned competence are often denied access to licensed operating facilities because the committees which grant such operating rights are dominated by RACS members and rely on their advice.
6. The ACCC has recently removed some of the competitive advantage of RACS by making the College's training programme subject to the *Trade Practices Act 1974*. Hence it follows that listing Cosmetic Medical Practice and allowing the ACCS and others to apply to be a Government recognised training body, would be consistent with ensuring cosmetic medicine and surgery is subject to competitive disciplines, ensuring standards are not only maintained but improved and avoiding the quasi monopoly which currently exists.
7. The third is that listing would not involve the use of taxpayer Medicare funding. Cosmetic procedures do not attract a Medicare rebate. In fact, because they are subject to GST, they contribute to Government revenue. Also, by enabling consumers to make a choice of a provider who has reached a recognised Cosmetic Medical Practice specific accreditation benchmark, listing would reduce cosmetic medicine and surgery's impact on the Government budget through reduced tax payer funded corrective surgery and complaints costs from poor cosmetic practice.

8. Given that listing would not involve the use of taxpayer Medicare funding, whether listing would be a wise use of health resources is not the central issue. Cosmetic Medical Practice should not be viewed as competing with health services for tax payer funds. Listing would allow consumers to appropriately value the service they are receiving from their specialist cosmetic surgeon and ensure that they are not being taken advantage of on price. Importantly, patients will be better protected by being able to identify those practitioners who have been specifically trained and examined in Cosmetic Medical Practice and reached a specialist standard recognised by the AMC. Thus the government would ensure that no artificial barriers exist which hinder cosmetic medicine and surgery from competing with other goods and services in the economy for consumer dollars, while raising the level of protection for Australians.

1. Introduction

Cosmetic Medical Practice may be defined as operations, procedures and treatments that revise or change the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise to be within the broad range of “normal” for that person. Popular cosmetic procedures include facelifts, breast augmentations, liposuction and rhinoplasty.

Cosmetic surgical and medical procedures are performed by medical professionals from various specialties and craft groups. These include plastic and reconstructive surgeons, dermatologists, ear, nose and throat surgeons, ophthalmologists, general surgeons, gynaecologists and others. Some have recognised qualifications in areas other than Cosmetic Medical Practice and some do not. The common denominator is that all of these doctors are “*cosmetic surgeons*” because they are all performing Cosmetic Medical Practice. It is important to understand that the training and experience specifically in Cosmetic Medical Practice of all of these doctors is very variable and specialist status in any of the existing specialties is no guarantee of competence in cosmetic procedure.

This was noted by “The Cosmetic Surgery Report” to the NSW Minister in 1999. Specifically, the report noted that “Specialist medical colleges and professional associations in the industry provide training and qualifications in aspects of cosmetic procedures, but they are no guarantee of competence in particular procedures. Key factors in assessing competence are training and experience, rather than membership of professional bodies, yet this is the only information available to consumers”¹⁰⁸.

The current position is that no doctor in Australia, including plastic surgeons, has had, or is even able to have, their training and qualifications in cosmetic medicine and surgery assessed by the authorities because currently no mechanism exists for this to occur. Consumers therefore are unable to identify doctors who are specialists in cosmetic procedures in the way they can identify a specialist in, for example, orthopaedic surgery. To rectify this deficiency the Australasian College of Cosmetic Surgery (ACCS) has applied to the Australian Medical Council (AMC) to have Cosmetic Medical Practice listed as a specialty on the AMC’s List of Australian Recognised Medical Specialties. Once this has occurred the ACCS and any other body could apply to become one of the Government accredited training organisations whose qualification would confer specialist status in cosmetic practitioner

Econtech has been commissioned by the ACCS to assist in the preparation of criterion 4 of the submission, specifically to determine whether recognition of Cosmetic Medical Practice would be a wise use of health resources. In particular this report provides an analysis of the economic effects of listing Cosmetic Medical Practice on the AMC’s List of Australian Recognised Medical Specialties. For hereafter this will be referred to as listing.

This report is structured as follows.

- Section 2 presents background information on the cosmetic surgery industry in Australia, the US and UK.
- Section 3 provides an analysis of the economic effects of listing.

108 The Cosmetic Surgery Report: Report to the NSW Minister for Health (1999) p22.

- Section 4 discusses whether listing is a wise use of health resources.
- Section 5 concludes.

While all care, skill and consideration has been used in the preparation of this report, the findings refer to the terms of reference of the ACCS and are designed to be used only for the specific purpose set out below. If you believe that your terms of reference are different from those set out below, or you wish to use this report or information contained within it for another purpose, please contact us.

The specific purpose of this report is to provide an economic analysis of the economic effects of listing and discussion on whether listing is a wise use of health resources.

The findings in this report are subject to unavoidable statistical variation. While all care has been taken to ensure that the statistical variation is kept to a minimum, care should be taken whenever using this information. This report only takes into account information available to Econtech up to the date of this report and so its findings may be affected by new information. Should you require clarification of any material, please contact us.

2. Background

Cosmetic medicine and surgery is a rapidly growing industry around the world. It is particularly well developed in the US. In 2007, around \$US12.5 billion dollars was spent on cosmetic procedures.¹⁰⁹ Part of this was spent on just under 2 million cosmetic procedures such as breast augmentations, facelifts, liposuction, nose reshaping, eyelid surgery and tummy tucks being the main procedures.¹¹⁰ The remainder was spent on just under 10 million minimal-invasive cosmetic procedures such as Botox injections, chemical peels and laser hair removal.¹¹¹ This represents an increase of 59 per cent since the year 2000 and 7 per cent over the previous year. The majority of the recent increases have come from the minimal-invasive category.

This trend is also replicated in the UK. The British Association of Aesthetic Plastic Surgeons (BAAPS) conducts yearly audits on the number and nature of cosmetic procedures undertaken by its members. In 2007, 32,453 surgical procedures were undertaken by its members, up 12.2 per cent from the previous year.¹¹² Further a recent report estimates that the cosmetic surgery market — which includes both surgical and non-surgical procedures — was worth £493m at the end of 2007, with annual growth rates of between 21.7% and 69% from 2003.¹¹³

The last time the industry was examined in any detail in Australia was for “The Cosmetic Surgery Report” in 1999 prepared for the NSW Minister for Health.¹¹⁴ The report estimates that in 1999 there were approximately 350 doctors with a substantial practice in cosmetic surgical procedures in Australia. However, the report also notes this is essentially a guestimate from the industry since “no data exists on who is providing cosmetic surgery, how much is being provided and where it is being provided”. The report also notes that cosmetic medicine and surgery is mostly performed by doctors with a wide range of qualifications, but dentists, nurses and beauty therapists are also represented. In terms of the number of procedures performed “The Cosmetic Surgery Report” notes that the industry claimed that it doubled in the five years up to 1999. By 1999, the industry was estimated to be performing around 50,000 procedures per year.

Although data has been scarcer and harder to obtain since that report, the trends of rapid growth are likely to have continued, consistent with international experience. Breast augmentation is one of the more popular procedures in Australia and information relating to the supply of breast implants indicates an annual usage of approximately 8,000 pairs of implants. Surveys of practitioners indicate an average total price for the procedure of breast augmentation to be about \$10,000 per case. Using this information we can estimate an annual expenditure of \$80 million.

ACCS conducted a survey of its members performing Liposuction and found a figure of 27,000 cases over an eight year time frame giving an annual performance of 3,000 cases. At

109 National Clearinghouse of Plastic Surgery Statistics, America Society of Plastic Surgeons(a).

110 National Clearinghouse of Plastic Surgery Statistics, America Society of Plastic Surgeons(b).

111 Ibid.

112 See: www.baaps.org.uk/content/view/280/62/

113 Cosmetic Surgery Market Report 2008.

114 The Cosmetic Surgery Report: Report to the NSW Minister for Health (1999).

an average of \$5,500 per case this translates into an annual expenditure of \$16.5 million. There are no available figures for Liposuction being performed by doctors outside the ACCS.

There is no reliable measure of Laser and Light based therapy procedures.

Recently, the President of the Cosmetic Physicians Society of Australia (CPSA), Dr Mary Dingley, noted that there had been growth in the non-invasive and minimally invasive treatments of about 30 per cent over the last two years and that she expected another 10 per cent or more growth over the next year.¹¹⁵

A recent book published by Dr Meredith Jones of the University of Sydney called "*Skintight: An Anatomy of Cosmetic Surgery*" also claims that cosmetic surgery is on the rise.¹¹⁶ Dr Jones also acknowledges that data is difficult to source, however through her research and interviews she claims that cosmetic surgery is rising and is being consumed by a more diverse range of consumers. This is in line with the global trend and part of a cultural change toward self-improvement through cosmetic procedures.

This indicates a growing trend in the acceptance and utilisation of cosmetic procedures both within Australia and abroad. This is being fuelled by a growing cultural shift toward self improvement, as mentioned by Dr Meredith Jones and rapid advancements in technology, particularly for non-surgical procedures.¹¹⁷ With this growth has come the growth in the number of cosmetic practitioners, not all of whom are necessarily specifically qualified to conduct such specific cosmetic procedures. Such growth in the number and nature of practitioners can, and has lead, to adverse outcomes for consumers. As such, the next section provides an economic analysis for listing to overcome these adverse the problems associated with low skilled practitioners.

115 See: [www.cosmeticphysicians.org.au/pdf/\\$300_MILLION_ON_COSMETIC_MEDICINE.pdf](http://www.cosmeticphysicians.org.au/pdf/$300_MILLION_ON_COSMETIC_MEDICINE.pdf) and www.abc.net.au/news/stories/2008/03/13/2188273.htm

116 See:

www.smh.com.au/news/health/cosmetic-surgery-the-go-for-aussies/2008/04/15/1208025129579.html

117 See Cosmetic Surgery Market Report 2007.

3. Analysis of the Economic Effects of Listing

This section provides an economic analysis for listing. It focuses on three criteria and how listing would impact on these criteria. Section 3.1 discusses how listing would impact on the quality of service provided to consumers. Section 3.2 discusses how listing would impact on the prices paid by consumers for this service. Finally, section 3.3 considers the implications for taxpayers from listing.

3.1 Quality of Service

Currently consumers of cosmetic medical procedures are unknowingly at risk of receiving a poor quality of service. This occurs because practitioners are better informed of the quality of service they provide than consumers. This information asymmetry creates an imbalance of power in transactions which can sometimes cause transactions to go awry.

Information asymmetries exist throughout the buying and selling of healthcare products. For transactions involving largely symmetric information the buyer has enough information to make a rational choice and does not need the seller to tell them what they should buy. However, in the healthcare market, information is not equally shared between buyers and sellers; instead, the seller, the medical practitioner, has far more information than the buyer, the patient. Most medical information is technically complex and so not easily understood by a layman. Further many medical procedures are not repeated on the same patient so the cost of gaining the necessary information is very high.

The existence of this information asymmetry can lead consumers of cosmetic medical procedures to make mistaken choices that can lead to adverse flow health effects. While data on the number of such instances is limited, the Cosmetic Surgery Report noted that submissions from consumers “raised complaints about lack of proper care, lack of hygiene of facilities and price. Many submissions described serious injuries from cosmetic procedures. A larger proportion had corrective surgery performed by another practitioner.”¹¹⁸ Further, unlike most goods and services, the costs of these mistaken choices are much greater and less reversible than in other cases. In the extreme example a wrong decision can lead to death. Recent reports in the media both within Australia and abroad confirm this trend.¹¹⁹

In addition, these mistaken choices can lead to reduced productivity for the economy. This loss in productivity manifests itself into absenteeism and presenteeism. Absenteeism is the lost productivity that occurs when workers do not come to work. Presenteeism is the lost productivity that occurs when employees come to work but, as a consequence of illness or other medical conditions, are not fully functioning. Absenteeism for cosmetic surgery can occur when patients are away from their place of work to receive corrective surgery and medical treatment and/or participating in litigation or complaints against certain practitioners. Absenteeism can also occur as patients spend time overcoming substandard procedures both physically and emotionally. Presenteeism occurs when patients are at work but are unable to fully function due to the physical and emotional stress related to these

118 Ibid p20.

119 See e.g. www.news.com.au/heraldsun/story/0,21985,21128898-24331,00.html, www.news-medical.net/?id=32545 and www.smh.com.au/news/opinion/theyre-so-beautiful-they-could-just-die/2007/02/02/1169919532260.html.

substandard procedures. This loss in productivity impacts on the economic output of the economy and the amount of taxation dollars that can be raised from the individual involved directly and indirectly through the loss in economic output.

To overcome this problem of information asymmetry, one method is the use of signaling. Signaling is the idea that one party can send a signal that would reveal some piece of relevant information to the other party¹²⁰. That party would then interpret the signal and adjust their purchasing behaviour accordingly. For healthcare products and services this can be simply providing information on the level and nature of training the medical practitioner has obtained. However the story does not end there in the medical profession

For consumers to trust the training information supplied by the medical practitioner, they require a benchmark for comparison. Government recognition of particular training and institutions that provide this training serves as an important benchmark setter. Government recognition, independent of the industry, provides consumers with the confidence that medical practitioners trained at the appropriate government approved institution will possess the necessary training to undertake the buyer's desired medical procedure. It is again relevant to recall the findings of "The Cosmetic Surgery Report" to the NSW Minister in 1999. Specifically, the report noted that "Specialist medical colleges and professional associations in the industry provide training and qualifications in aspects of cosmetic surgery procedures, but they are no guarantee of competence in particular procedures. Key factors in assessing competence are training and experience, rather than membership of professional bodies, yet this is the only information available to consumers"¹²¹.

For cosmetic medicine and surgery no such government signalling mechanism exists and, as such, the information asymmetry within the cosmetic medical industry remains. Any registered medical practitioner can perform cosmetic medicine and surgery. This includes plastic surgeons who may or may not have adequate training and experience in cosmetic procedures and also non-specialist practitioners who may have extensive training and experience in Cosmetic Medical Practice or none at all.¹²² The varying levels of cosmetic training and experience of different practitioners makes it generally unclear to consumers how to value the product they are receiving and to determine whether or not it is safe. As such, consumers have no reference point to determine beforehand whether they are receiving a safe quality of service at an appropriate price.

Listing of Cosmetic Medical Practice as a specialty on the AMC's List of Australian Recognised Medical Specialties provides Government recognition of the appropriate training and experience required to conduct specific cosmetic procedures. This assists consumers to choose properly trained and recognised cosmetic surgeons to decrease the risk of complications. This is the same conclusion reached by the committee of authors of "The Cosmetic Surgery Report" in 1999 to the NSW health minister. The committee agreed training is a reliable measure of competence in medicine. Medical research supports the reliability of training in surgical procedures to produce good clinical outcomes and

¹²⁰ See Spence (1973) for a fuller description.

¹²¹ The Cosmetic Surgery Report: Report to the NSW Minister for Health (1999) p22.

¹²² Plastic and reconstructive surgeons differ from cosmetic surgeons in that they perform procedures to treat for example burn victims, traumatic injuries, skin cancers and developmental abnormalities. Some plastic surgeons also perform cosmetic procedures.

practitioners who know their limitations. Training provides a reliable surrogate for medical practitioners to measure competence of a peer”.

3.2 Fair Price

Listing Cosmetic Medical Practice as a new specialty also ensures that quality Cosmetic Medical Practice is provided at a fair price for consumers by providing transparency of information regarding a practitioner's Cosmetic Medical Practice qualifications. As indicated in Table 3.1, currently consumers that seek a Government recognised surgeon may only do so if they seek the services of a plastic and reconstructive surgeon or other surgeon qualified by RACS. RACS surgeons have completed Government recognised training in one of the existing surgical subspecialties. They have not, however, received Government approved training in cosmetic procedures, as at present such a category does not exist. Such surgeons may or may not have unrecognised training in Cosmetic Medical Practice and may or may not be competent in cosmetic surgical procedures. Because only RACS surgeons are Government recognised specialists they can and do distinguish themselves from non-RACS cosmetic surgeons on the basis that they are specialists and the latter are not. For example, unlike purely RACS surgeons, Fellows of the Australasian College of Cosmetic Surgery have completed formal Cosmetic Medical Practice-specific training and have been assessed by examinations in this as yet unrecognised specialty. Because the specialty is not recognised, these highly and specifically trained doctors are referred to by the ASPS and RACS as generic GPs. Consumers can validate this Government recognised training only for RACS surgeons in making their decisions about choosing a practitioner are unaware that, for the purposes of Cosmetic Medical Practice, the distinction may be, and often is, misleading RACS nor its Fellows do not inform consumers that they are not specialists in cosmetic medicine or surgery, though they may perform either. This provides plastic surgeons, and to a lesser extent other RACS surgeons, with an artificial competitive advantage over their non RACS cosmetic surgeon competitors As a consequence of this lack of transparency about the nature and relevance of the training and qualifications in Cosmetic Medical Practice, consumers are unable to make informed decisions about their choice of practitioner and what constitutes a fair price.

The Queensland Government has passed legislation which prevents RACS surgeons from using the title “cosmetic” or “aesthetic” surgeon to protect patients from being misled in this way.

The ACCC has recently removed some of the competitive advantage of RACS by revoking an authorisation that granted RACS an exemption under the *Trade Practices Act 1974* for the College's training programme. Authorisation provides immunity from court action, and is granted where the ACCC is satisfied that anti-competitive practices deliver public benefits. In June 2003, the ACCC granted authorisation to RACS for its selection, training and accreditation processes. At the time the ACCC noted that the College needed to remain substantially involved in the setting of surgical training and assessment standards, given its technical expertise. However, the ACCC was concerned about the longer-term commitment of the College to ensuring that its processes do not inappropriately impact on competition. Given this, the authorisation was subject to 21 conditions that were mostly concerned with increasing participation by stakeholders (including jurisdictions and consumers) and improving the transparency and accountability of RACS' processes.¹²³

¹²³ See “ACCC requires reform of surgeons' training programme”, www.accc.gov.au/content/index.phtml/itemId/346166/fromItemId/378016.

The effect of removing the authorisation exposes the College to the application of the Trade Practices Act in the event that the College restricts training intakes in an anti-competitive manner.¹²⁴ Given this determination, it follows that listing Cosmetic Medical Practice, and thus providing a pathway allowing the ACCS and any other professional body including RACS to apply for recognition as a Government approved training body for the new specialty would be consistent with minimising any potential anti-competitive behaviour of RACS thus addressing some of the ACCC's concerns. All training bodies would compete on a level playing field ensuring that consumers receive a fair price and the protection of being able to choose from a range of cosmetic medical practitioners who have had their training and qualifications in this field assessed by the Government. Consumers will still have the option of choosing cosmetic surgery from a practitioner not recognised by the Government and this may be cheaper. However, consumers will now be informed of where they can receive safe, Government recognised cosmetic medicine and surgery, at a fair price.

3.3 Cost to taxpayers

The ACCS application for listing would not require the use of taxpayer Medicare funds. There are two avenues in which the AMC can approve a medical specialty to be recognised. The first is recognition for the purposes of the *Health Insurance Act 1973* (Cth). Effectively, this recognition enables doctors with specific qualifications to attract a relevant Medicare benefit for services rendered. The second allows for organisations to seek recognition of a medical specialty for purposes other than the *Health Insurance Act*. In this case, applicants can have specialist medical skills and knowledge acknowledged, and to have the education and training programmes that lead to these attributes accepted as a standard for a particular area of practice.¹²⁵ It is this second avenue of approval that the ACCS is seeking to achieve.

Specifically, the AMC's guidelines for this avenue state "A successful application in such a case would lead to a listing on the AMC's *List of Australian Recognised Medical Specialties*. This enables medical specialist training providers to participate in the AMC's accreditation of specialist medical education, training and professional development programmes". This ensures that practising medical professionals are subject to a minimum basic standard in their field and that consumers can check whether they have been trained at an appropriate government recognised training institute.

Hence listing would require minimal use of government health resources, if any. Rather listing would ensure that cosmetic surgeons are able to obtain training at a government recognised training institute. In fact, not listing Cosmetic Medical Practice is currently costing taxpayers.

The first cost to the taxpayer relates to corrective surgery and medical treatment. Given that some of the surgery or other procedure performed by plastic or cosmetic surgeons is of an insufficient standard, corrective surgery is sometimes required to reverse the impact of poorly performed cosmetic procedures. Further, in severe cases, poor cosmetic practice can cause adverse health effects which require extra medical treatment. Sometimes poor cosmetic surgery can also cause death. Whilst the original cosmetic surgery would have been funded by individuals out of their own pockets, some corrective surgery and the medical

¹²⁴ See "ACCC confirms changes to surgeons immunity", www.accc.gov.au/content/index.phtml/itemId/773260 (Accessed June 2008).

¹²⁵ See AMC (2007), *The Recognition of Medical Specialties: Policy and Process*, for more information.

treatment in severe cases is performed through the public healthcare system and thus is covered by Medicare. Hence the poor performing surgeon or practitioner has indirectly cost the taxpayer funds to assist their patient. Not only does this affect the government budget, through use of taxation dollars, but also the economy since more taxes need to be raised to fund the public healthcare system. It also impacts on waiting lists for corrective surgery, placing further pressure on the public hospital system and adding to waiting lists.

The second cost to taxpayers relates to court and health care complaint commission costs. These are costs associated with individuals taking action against certain practitioners who they believe are performing at a substandard level. Each state in Australia has its own healthcare complaints commission or similar institution, where consumers can report a healthcare practitioner to the commission. Upon receipt of a complaint, the commission needs to process the complaint and make decisions regarding how far the action should be taken. In extreme cases, these complaints can end up in courts to settle issues. Further, individuals can directly take legal action against healthcare practitioners (independent of the commission) and sue for damages. All of this leads to use of tax payer dollars in some part to operate the complaints commission and the court. As such, the government budget is affected, including the economy through the raising of more taxation. Finally, court waiting lists are impacted upon, leading to the delay in resolution of some disputes, to the detriment of the parties involved.

So in fact, listing would lead to a positive budget outcome for taxpayers. Quantifying these impacts is not possible due to a lack of data on the cosmetic medicine and surgery industry. The unstructured nature of the industry makes it impossible to accurately collect independent data on the prevalence of poorly performed procedures, let alone quantifying their economic and budget impacts. As such, it is impossible to know the true impact of poor performing surgeons – plastic or cosmetic – on the economy. However, as noted in the background section, the industry is rapidly growing each year. This means that the impact of this poorly performed surgery will only be increasing over time.

The uncertainty of the magnitude of the impacts, and the fact that the industry is rapidly expanding, makes it all the more important that Cosmetic Medical Practice obtain listing. Listing would provide a minimal government recognised benchmark of the required training to perform specific cosmetic procedures. This would facilitate improvement in the training of cosmetic surgeons on the one hand, and provide consumers with information to choose appropriately qualified cosmetic surgeons on the other at a fair price. Such an outcome would reduced the number of poorly performed cosmetic procedures and reduce the cost to taxpayers.

4. A wise use of health resources

Criterion 4 of the submission asks ACCS to address whether recognition of the medical specialty (in this case Cosmetic Medical Practice) would be a wise use of health resources. Some view cosmetic procedures as a luxury good rather than a healthcare good and as such may not agree with government involvement in the industry. Cosmetic procedures are largely purchased for personal benefit rather than healthcare need. However, as indicated in Section 3.3, government involvement in the industry would not be via taxpayer subsidies through Medicare, rather it would involve government recognition of appropriate training.

Given the specific nature of this application, the question of whether recognition would be a wise use of health resources is not the central issue. Cosmetic Medical Practice largely involves commercial transactions that are subject to GST. It is largely performed outside of Medicare and is a product purchased by consumers based on their preference for such a product. This situation would continue and cosmetic surgeons and patients would not receive tax payer funded subsidies through Medicare. This is actually contrary to plastic surgeons, who receive some government subsidised training through RACS. This means that some plastic surgeons receive government subsidised training of Cosmetic Medical Practice on top of their reconstructive surgery training. ACCS is not applying to receive such a subsidy for their training as it is aware that this involves discretionary commercial transactions. Hence Cosmetic Medical Practice should not be viewed as competing with health services for taxpayer funds.

Rather, the main issue concerns consumer sovereignty in the context of a properly regulated market which increases consumer information and safety. Cosmetic Medical Practice competes with other goods and services for consumers dollars. The government is being asked to facilitate the effective operation of the Cosmetic Medical Practice market so that it can compete with other goods and services for consumer spending. Listing would allow consumers to appropriately value the service they are receiving from their cosmetic medical practitioner, to ensure that they are not being taken advantage of on price and, more importantly, safety grounds. Thus the government would ensure that no artificial barriers exists that would hinder Cosmetic Medical Practice from competing with other goods and services in the economy for consumer dollars.

5. Conclusion

This report provides an economic analysis for having Cosmetic Medical Practice listed as a specialty on the AMC's List of Australian Recognised Medical Specialties. It focuses on three key areas.

The first considers the information asymmetry that exists between practitioners and consumers. This can lead to buyers to unknowingly choose an unskilled or inadequately surgeon which increases the risks of complications from their surgery. As such, consumers cannot be confident that they will receive an appropriate quality of service. Listing would provide a level playing field where practitioners in the new specialty would have to have reached a government recognised minimum benchmark of the required training before being accredited as specialists. This would assist consumers to make more informed choices about the safety of a practitioner and the value of that practitioner's services.

The second considers how listing ensures that quality Cosmetic Medical Practice is also provided at a fair price for consumers. The report notes the competitive advantage plastic surgeons have over cosmetic surgeons, since they have access to government recognised training through RACS. However this level of training is not necessarily required for Cosmetic Medical Practice, nor is it necessarily specific for each cosmetic procedure performed. The ACCC has recently removed some of the competitive advantage of RACS by making that College's training programme subject to the *Trade Practices Act 1974*. Hence it follows that listing Cosmetic Medical Practice and allowing the ACCS and other organisations to apply to be government recognised training bodies in the new specialty, would be consistent with ensuring surgical training is subject to competitive disciplines, ensuring quality Cosmetic Medical Practice is charged a fair price.

The third considers how listing would not require use of taxpayer funding. The ACCS is not applying for Cosmetic Medical Practice to receive Medicare funding. Rather, the ACCS is applying for listing for specialist medical skills and knowledge to be acknowledged, and to have the education and training programmes that lead to these attributes accepted as a standard for a particular area of practice. Hence there would be minimal use of government health resources, if any. In fact, through improved quality of Cosmetic Medical Practice, the budget impact would actually be positive. Listing would reduce the specialty's impact on the government expenditure through reduced tax payer funded corrective surgery and complaints costs from poorly performed procedures.

Finally, the report explains since listing would not involve the use of taxpayer funding, whether listing would be a wise use of health resources is not the central issue. Given this, Cosmetic Medical Practice should not be viewed as competing with health services for tax payer funds. Listing would allow consumers to appropriately value the service they are receiving from their cosmetic surgeon, to ensure that they are not being taken advantage of on price and, more importantly, safely grounds. Thus the government would ensure that no artificial barriers exists that would hinder Cosmetic Medical Practice from competing with other goods and services in the economy for consumer dollars.

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