Australian Society of Plastic Surgeons

ASPS Guide on Responding to the Consultation RIS

The following consultation questions have been provided (throughout the RIS) to guide feedback responses and are included on the response template.

The consultation process requests that you do not include any identifying information such as information about patients, medical practitioners or facilities in responses. However, you can refer to de-identified examples.

Feedback can be provided anonymously. If you would prefer your submission is not published, or your name included in the Decision RIS, indicate this on the response template.

Responders are not required to answer every question. This guide provides some prompts on what you could include in possible answers.

Do not cut and paste responses as this will diminish the impact of your response.

Consultation questions

Title protection and its functions

1.1 What level of qualifications and training would you generally have expected a practitioner using the title 'surgeon' to have?

A response along the lines of:

It is generally expected that all surgeons have a similar level of qualifications and training, i.e. at least five years of advanced surgical training in an AMC accredited program, during which the majority of time is focused on teaching trainees how to assess and manage patients as well as mastering surgical techniques and dealing with potential adverse events

The following could also be referred to:

- Comments you have heard from patients who have presented for a second opinion or revision surgery (possibly after seeing a 'cosmetic surgeon' whom they just presumed had completed surgical training)
- Examples of conversations with patients who have consulted you and are surprised that 'not all "cosmetic surgeons" are surgically trained.
- Comments you have heard from other medical practitioners, who have not been aware of the disparity, and any conversations as an example.

1.2 Prior to reading this RIS did you believe that cosmetic surgery is regulated in the same way as other surgery?

A response along the lines of:

As a specialist plastic surgeon, I have been aware of the inconsistency in the way in which cosmetic surgery is regulated and have been frustrated by this for some time.

The following could also be referred to:

- Comments raising concern about how confusing this is for patients. In Australia, patients expect that health services are regulated appropriately and ensure that only those who have completed AMC (Australian Medical Council) accredited surgical training are able to claim they are a 'surgeon'.
- Any comments from patients about their lack of awareness and include any examples.
- Any comments from other medical practitioners who have not been aware of the difference and provide some more specific examples including any concerns raised.

1.3 Does current regulation help you understand the differences between the regulation of cosmetic and other surgery?

A response along the lines of:

As a specialist plastic surgeon, I understand that there is no AHPRA recognised specialty of 'cosmetic surgery' and that there is a wide variety of practitioners that call themselves 'cosmetic surgeons'. The public does not generally understand how medical practitioners are regulated. Patients assume and trust that doctors providing specialist services are appropriately trained to provide the services they are advertising. The Australian Society of Plastic Surgeons (ASPS), my professional society, has allocated significant resources including a media campaign to improve the public's understanding.

Other medical practitioners may not understand that the regulation of cosmetic surgery (or lack thereof) is different. It takes substantial reading to realise that 'cosmetic surgery' is not a distinct sub-specialty and that there is no accredited specialist training program that only trains in 'cosmetic surgery'. However cosmetic surgery is an integral part of plastic surgery training. The techniques learnt during plastic surgery training are essential requirements to performing cosmetic procedures safely and effectively with a low risk of complications.

1.4 Do you think the risks, potential harms or level of adverse outcomes associated with cosmetic surgery are higher than for other areas of medical practice? If so, what is the basis for this view?

A response which draws on some of the bullet pints provided:

The potential harms and level of adverse outcomes associated with cosmetic surgery may be higher, because cosmetic surgery:

- can be performed by a medical practitioner who may not be adequately trained in surgery (and procedural sedation).
- patients may select a medical practitioner who may be performing procedures outside their level of competence (patients do not necessarily obtain a referral from a GP)
- can be performed in private facilities which may not have the capacity to manage surgical patients postoperatively or may not employ staff with the capability to monitor and care for surgical patients
- small private facilities may not have transparent quality assurance mechanisms in place (i.e. audit, peer review)
- private, independent medical practitioners are not accountable to credentialing committees or a team of colleagues (as they are when performing procedures in a hospital)
- some unscrupulous 'cosmetic surgeons' have gravitated toward delivering these services due to the profits they can make and a 'business model' prevails.

Cosmetic surgery is not a recognised specialty under the National Law

2.1 Prior to reading this RIS were you aware of the different training regimen for specialist surgeons as opposed to 'cosmetic surgeons'?

A response along the lines of:

As a specialist plastic surgeon I am aware that RACS and the Royal Australian College of Dental Surgeons are the only accredited specialist medical colleges to deliver specialist surgical training. What do we say about eyes and O/G. The Royal Australian and New Zealand College of Ophthalmologists are responsible for training in eye surgery and the Royal Australian College of Obstetricians and Gynaecologists is responsible for training in those specialities. These surgeons perform procedures within the scope of their surgical training.

The following could also be referred to:

- Conversations with patients who have referred to you as their 'cosmetic surgeon', not knowing the difference
- Conversations or correspondence with other medical practitioners who may have used the term 'specialist cosmetic surgeon' in error

A response could further draw on some of the bullet points provided below:

- Often the public are not aware of what the title means; they trust that medical practice is being regulated appropriately.

- Consumers and some medical practitioners would not be aware that there are only 11 specialist surgical titles
- GPs seldom use the full title when referring to surgeons … GPs may say "I'm referring you to an orthopaedic surgeon", not "I'm referring you to a specialist orthopaedic surgeon". So, when a patient sees the title 'cosmetic surgeon', they are not alerted that there is any difference because the term "specialist" does not precede it
- Many consumers (and some medical practitioners) may assume there is a field of specialist practice of 'cosmetic surgery' and the title is 'cosmetic surgeon'. They assume they are 'allowed' to use this title.
- The National Law emphasises what practitioners call themselves rather than the types of procedures they perform.
- In addition to title, it would be safer if only certain practitioners, who are trained appropriately, are able to advertise and perform specific procedures.

2.2 If you were unaware of this difference and have engaged a cosmetic surgical practitioner, would this knowledge have influenced your choice of practitioner? If you have not engaged a cosmetic surgical practitioner, would this knowledge impact your choice?

No suggested response. Is this a question for our members or for the general public ie. consumers?

Other elements in the regulatory framework for the performance of surgical procedures

3.1 Are current guidelines, laws and regulations effectively deterring patient harm that may arise from practitioners performing cosmetic surgical procedures outside their level of competency?

A response along the lines of:

General
Current guidelines, laws and regulations are inadequate.

Some of the following bullet points may be helpful inclusions in a response:

- Firstly, which practitioners are competent to perform specific procedures needs to be determined. (eg. Is a maxillofacial surgeon trained to perform breast surgery?)
- Current regulation in relation to both practitioner conduct and advertising is reactive rather than proactive. Substandard practice, misconduct or non-adherence to guidelines (including that which results in patient harm or an adverse events) must occur, followed by a complaint or notification, before any action is taken. In some instances, numerous complaints must be made by multiple complainants before any action is taken.
- In more commercially driven medical specialties or health professions it would seem appropriate for AHPRA to undertake checks or audits of practitioners to confirm they are indeed following guidelines. This does not necessarily require a significant additional workload. An efficient system, whereby the possibility that a practitioner would be reviewed, together with a suitable penalty which would act as a deterrent, could improve compliance.
- The financial incentive for a practitioner to perform cosmetic procedures beyond their level of competence, together with the elective nature of the surgery (no need for a referral and no tracking of procedures performed due to claims not being submitted to Medicare), vulnerable patients and performance of procedures in facilities which the practitioner owns, creates a 'perfect storm' and the opportunity for inappropriate practice to thrive.

- Guidelines and Codes of Conduct are admissible in proceedings under the National Law but the threshold for proceedings to commence seems to be very high.

Advertising

- Any regulatory action is reactive rather than proactive.
- A quick search of the advertising of cosmetic surgeons will reveal factually correct, but misleading claims about qualifications and experience. Cosmetic surgeons refer to their 'surgical training' which every postgraduate medical student has completed. Potential patients are not aware that the surgical rotations completed during PGY 1&2 are not equivalent to specialist surgical training.
- AHPRA's risk-based approach requires further explanation. How is risk to the community more broadly quantified (negative mental health outcomes as opposed to individual physical patient harm)?
- There are numerous examples of advertising by 'cosmetic surgeons' which may technically adhere to advertising guidelines but demonstrate a lack of medical professionalism. There is evidence which shows that sexualised images in cosmetic surgery advertising targeted at young women is detrimental to mental health, yet there is no legislation in Australia (as there now is overseas) to prevent it.
- Current financial penalties are not a deterrent for advertising compliance given the profits made by businesses that are commercially driven. The proposal to increase penalties for advertising offenses is overdue but still unlikely to make an impact. Loss of registration for an extended period would be more of a deterrent, as it restricts the practitioners' ability to derive their usual income.
- AHPRA appears to be struggling to regulate according to current advertising guidelines – it is unclear how AHPRA could manage a more nuanced approach to testimonials after the prohibition on testimonials is removed.

3.2 Prior to reading this RIS were you aware of AHPRA's register of practitioners, and if so, have you found its information useful to help you make informed decisions about choosing a proceduralist? What additional information do you think it should include?

A response could include:

As a specialist plastic surgeon, I am aware of AHPRA's register of practitioners.

To look at the register: https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx

The following could also be referred to:

- If you have used the register or not to look up other medical practitioners
- If the information contained in the register is helpful to make informed decisions about choosing proceduralists

Also:

- Qualifications may be better placed under the first sub-heading of 'Registration Details' rather than the last 'sub-heading of 'Personal Details'
- For consumers, unless they know what type of training leads to the qualification listed, it is unlikely to provide adequate information as to whether the practitioner is suitably trained without more detailed information of how to interpret the information on the register.
- There could be a note which explains that the register only includes any conditions, undertakings or reprimands that are current or perceived to be important information. It does not contain any history. The category name should change to 'Current conditions', 'Current reprimands' etc.
- The best predictor of future behaviour is previous behaviour. Previous conditions, undertakings or reprimands should not be removed from the register. Include any

examples of practitioner behaviour you know of, and conditions, undertakings or reprimands which have been removed when the practitioner's practise was still cause for concern.

- The name a practitioner uses in their practice and in any advertising (i.e. the name by which their patients refer to them or their practising name) should be included in addition to the practitioner's legal name on the register. It seems inconceivable that the register is accessible to keep public and other informed about medical practitioners' registration, yet practitioners who are most likely to want to use a different 'practising name' to avoid identification on the register (due to conditions and the like), can do so.

Public harm and risks that arise from the current regulatory regime

4.1 Have you experienced difficulty getting cosmetic surgical practitioners to explain professional title, the risks and rewards of surgery, and their capacity to perform a given procedure? Was this more difficult than with other surgical practitioners?

A response could include:

- Any examples of creative ways in which 'cosmetic surgeons' have explained their qualifications (without including the name of the practitioner)
- Any examples of correspondence that former patients of 'cosmetic surgeons' may have shared with you that demonstrates an inability to explain risks associated with procedures
- Any examples of talking with 'cosmetic surgeons' about how they perform a given procedure (which raised your concern about their capacity to perform a procedure)

And how these examples contrast with similar explanations by specialist surgeons.

4.2 Do you have any evidence of harms or complications resulting from procedures performed by practitioners who do not have advanced surgical training, or who are practising outside their scope of competence? Can these harms and complications be quantified?

A response could include:

- Any de-identified examples of patients presenting for revision surgery after undergoing cosmetic surgery by a practitioner who has not had FRACS surgical training.
- A reference to the costs of reparative surgery for consumers, which may be much greater than the costs associated with the original procedure.
- The long term post-operative adverse outcomes for these patients and the impacts on their mental health and overall wellbeing
- It may be helpful to quantify how many presentations of various harms and complications you see each year.

4.3 Do you have any evidence of harms arising from cosmetic surgeries that are the result of unethical or substandard practices or unethical conduct?

Include any de-identified examples of patient harm related to unethical or substandard practices or unethical conduct by practitioners who refer to themselves as cosmetic surgeons.

4.4 Can you provide information about the relationship between corporatisation and cosmetic surgery? If a relationship exists, is this more common in cosmetic surgery than in other surgical fields?

No suggested response. This has already been documented in the RIS.

4.5 If corporatisation is more common in cosmetic surgery, is this is having any discernible effects on patient risk and harm?

No suggested response.

4.6 Can you provide evidence to show that financial incentives are attracting medical practitioners to the field of cosmetic surgery? If financial incentives exist, is this leading to greater risk and harm to patients?

No suggested response.

4.7 Please provide any evidence you have about the volume of patients accessing cosmetic surgical procedures.

No suggested response. A response could include average number of patients per year and proportion that are requesting cosmetic surgery, though an individual member's data is not very useful.

4.8 Can you provide evidence that demonstrates any broader costs of post-operative outcomes of cosmetic surgeries on the health system and the broader economy? This includes any data that quantifies the cost to the public health system of revision surgeries for consumers who have suffered poor outcomes from cosmetic procedures.

No suggested response.

4.9 Are you aware of adverse impacts to cosmetic surgery patients due to there being no requirements to involve a GP in referrals? Does this have material effects on the quality of care being provided by cosmetic surgical proceduralists? If so, how this might reasonably be demonstrated?

A response could include:

- De-identified examples of patients who have made poor choices in relation to their cosmetic surgery due to the lack of understanding of titles, were lured by clever advertising and did not consult their GP.
- Deidentified examples of patients who then had issues with subsequent post-procedural care such as many post-operative visits back to the 'cosmetic surgeon', additional operations or being left disfigured and feeling they should not consult other doctors.

4.10 Can you provide any evidence demonstrating the effectiveness or ineffectiveness of the National Law's advertising provisions, particularly in relation to the cosmetic surgery industry?

A response could include:

- Any examples of significant poor practice or detrimental outcomes that were not detected or investigated by AHPRA until numerous patients were harmed.
- Deidentified examples of 'cosmetic surgeons' who have not been deterred by the currently regulatory scheme, in relation to advertising.
- Any examples of your dealings with AHPRA in relation to advertising and if your advertising has been unnecessarily scrutinised in comparison to other advertising which is blatantly non-compliant but no action is taken.

4.11 Can you provide any information about whether AHPRA'S public register of practitioners helps to address any identified cosmetic surgery regulatory issues?

No suggested response.

Available data: quantitative and qualitative

5.1 Are the issues relating to title restriction accurately outlined in this RIS?

5.2 How do you currently satisfy yourself that your practitioner is qualified to perform their desired surgery, cosmetic or otherwise? How did you satisfy yourself that a practitioner was qualified prior to reading this RIS?

No suggested response.

5.3 Does this RIS accurately describe surgical procedures (cosmetic or otherwise) performed by practitioners, the types of specialists and other registered practitioners that perform them and the accepted parameters of practice for these practitioners?

No suggested response.

Options and cost-benefit analyses

The policy options for consideration are thoroughly discussed in the RIS from p.56-85. You may want to read through this section to prepare a more nuanced response.

6.1 Do you support maintaining the status quo (Option 1)? Please explain why.

A response along the lines of:

I do not support maintaining the status quo. As outlined in response to previous questions, the current National Law, regulations and guidelines are not effective in protecting patients from harm and the adverse effects of surgery performed by 'cosmetic surgeons' who are not adequately trained.

It is clear from the information detailed in the RIS that existing measures are inadequate. Additional costs associated with implementing changes and checking compliance with new standards or guidelines must be incurred to ensure patient safety. Such costs could be offset by a reduction in the current costs borne by the public health system from complications of cosmetic surgery procedures.

6.2 Do you support implementing alternatives such as Options 2.1 or 2.2 to amending the National Law? Do you support implementing one or both? Please explain why. If this option is preferred, what reforms or initiatives would be required to realise either or both sub-option/s?

A response along the lines of:

Option 2.1 is supported, however, NOT as an alternative to amending the National Law. Option 2.2 is not supported.

Option 2.1- Public information campaigns

There needs to be greater public awareness about medical practitioner titles and qualifications. It is expected that patients who would like to have cosmetic surgery will do so with a fully trained specialist surgeon.

The costs associated with these measures will likely be offset by the costs associated with ameliorating adverse outcomes from surgeries performed by 'cosmetic surgeons' who are inadequately trained.

Option 2.2 – Increased provider liability for non-economic damages

While patients who have suffered physical and mental harm from surgical procedures in particular situations should receive adequate compensation, a clear directive on which surgical practitioners can perform specific procedures needs to be developed.

Required legislative change across all jurisdictions will be extremely difficult to achieve and is unrealistic. Considerable costs would be associated with this option, to no avail.

A possible impact would be increased professional indemnity insurance fees across the medical profession. One possible solution would be to increase the medical indemnity fees for non surgically trained practitioners or to legislate to allow medical indemnity insurers to deny cover for procedures performed that outside a doctor's scope of practice.

6.3 Do you support strengthening existing mechanisms in the National Scheme (Option 3)? Please explain why.

A response along the lines of:

Option 3 is not supported. Current law, regulations and guidelines are not effective and there is no firm proposal of what change would occur and how it could make a significant difference. The suggestion of strengthening existing mechanisms so the public understands titles, regulations and advertising provisions of the National Law appears to be similar to option 2.1 – education campaigns.

The current predicament is largely a result of administrative controls not working. A greater understanding of how current regulatory measures work will not assist in reducing patient harm. A more proactive approach by AHPRA is required.

Change at an administrative level may appear easier and quicker to implement but is unlikely to achieve the goal of reducing patient harm.

6.4 Do you support restricting the title 'surgeon' under the National Law (Option 4)? Please explain why. If option 4 is preferred, which medical practitioners should be eligible to use the title 'surgeon', and why should option 4.1 or 4.2 be preferred?

A response along the lines of:

Option 4.1 is supported.

The title of 'surgeon' should be restricted to practitioners who have completed at least five years of AMC accredited specialist surgical training, similar to other titles being restricted to those who have completed the requisite specialist training program.

The regulatory burden on some medical practitioners who may need to complete training to achieve the appropriate qualification and then use the title of 'surgeon' is acknowledged.

However, the estimation is based on a practitioner with no prior training or experience. With a move to more competency based surgical training programs, recognition of prior learning and experience and workplace-based assessment to ensure competence allow practitioners to complete training programs in a shorter time (and therefore incur less cost), if they are indeed competent when they commence training.

Medical practitioners who decide to undergo additional training, as all medical practitioners do to improve and maintain their competence, will benefit personally and their patients will also benefit from a highly skilled practitioner. The overall level of performance by surgeons will increase.

However surgical training must be delivered by highly competent surgeons who have themselves achieved specialist surgeon recognition (by the RACS and AMC)

Substantial change is required given the media attention on this issue. Options 1-3 are unlikely to be effective. Consumers need to be confident that the health system will keep them safe. If there is no change, the reputation of regulatory bodies and the medical profession as a whole will suffer. Patients need to be able to trust that anyone who advertises themselves as a surgeon, is suitably qualified to perform surgery. Public confidence in the medical profession is vital to continue self-regulation.

Cosmetic surgery performed solely by fully qualified surgeons will lead to fewer severe preventable adverse events, increased patient satisfaction and fewer legal disputes between patients and practitioners.

Other titles such as 'surgical practitioner' could be considered for medical practitioners who may have had limited training in specific surgical/procedural skills. Allowing medical practitioner such as general practitioners and dermatologists to also use the title of 'surgeon' will perpetuate confusion. While such practitioners may start to use other terms to market themselves, few have the weight of 'surgeon' and would prompt patients to question why such practitioners are calling themselves a proceduralist and not a surgeon. Public education on the change to titling is also required.

Possible more importantly, medical practitioners who offer cosmetic procedures which do not attract a Medicare rebate (commercially driven) should be identified as a group so that AHPRA can proactively regulate this subset of practitioners, especially in relation to advertising.

6.5 Will restricting the title 'surgeon' prevent medical practitioners who cannot use that title from using other titles that imply they are expert providers of cosmetic surgical services?

A response along the lines of:

Most likely. A more responsive approach from AHPRA is required to address such potential outcomes, through a proactive approach to compliance with advertising guidelines. Patients may not notice such misleading title claims and waiting for complaints to be submitted and action to be taken has been ineffective to date to deal with such issues.

6.6 What other impacts will restricting the title 'surgeon' have on surgical specialists and other medical practitioners, including those who obtained their qualifications overseas?

No suggested response.

6.7 Is it likely that cosmetic surgery consumption patterns will change because of title restriction (whether option 4.1 or 4.2)? In what way? Will they be changed by options 2 and 3? In what way?

A response could include that it is likely that consumption patterns will change because patients may have a clearer idea of the complications of cosmetic surgery. Some patients will decide that they cannot afford it, but those patients who do have cosmetic surgery will be more assured that they will be safe, in the hands of fully trained surgeons.

6.8 Is the regulatory burden estimate provided in this RIS realistic? How likely is it that medical practitioners would embark on advanced studies solely in order to call themselves a 'surgeon'? Do you expect option 4.1 or 4.2 to heighten demand for advanced surgical qualifications? If so by what number? What evidence do you have to support this view?

No suggested response.

6.9 Should any options be implemented alongside other options, as a package? If so, please explain why this would be ideal and how any potential impediments might be overcome?

A response along the lines of:

Option 4 is preferred.

In addition, education campaigns to improve public awareness and amendments to regulations and guidelines are necessary complements to a change to the National Law.

6.10 Should Australian lawmakers be mindful of the potential for regulatory change in Australia to shift cosmetic surgery consumption to other jurisdictions abroad? What would the impacts be?

A response could include the proportion of patients you believe will engage in medical tourism to seek cosmetic surgery at a reduced cost.

There will always be some patients who do not understand the possible risks or do understand and are willing to take them.

Greater public education of the risks of medical tourism, including case studies of the cost borne by patients when they return to Australia and need revision surgery, and the health impacts of having surgery in less regulated countries, could be included in education campaigns associated with recommended changes to the National Law.

6.11 Are you concerned that a particular option might have serious, adverse and possibly unanticipated effects? Please state which option/s and unanticipated effects, and why you hold these concerns.

A response could refer to the fact that the RIS outline the costs and benefits of each option and it appears that the anticipated effects have been well considered. There is always a possibility of unintended consequences. The effect of inaction appears to be far greater.

Information the Health Council is seeking

Health ministers are concerned that use of the title 'surgeon' by medical practitioners may be confusing for the public and, more important may be creating risks and harm to the public. Ministers are particularly concerned that the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' may be associated with these risks and harm.

The Health Council is publishing this consultation RIS to help determine if current policy settings regulating use by medical practitioners of the title 'surgeon' are effective or should be augmented or changed. To help answer these questions, the Council is inviting all interested stakeholders, including members of the general public, to read the RIS and respond to the Consultation Questions.

Health ministers are particularly keen to broaden and deepen the empirical data that authorities currently hold to help inform decision-making about these Questions. Ministers appreciate the difficulty in sourcing this data but emphasise the importance of collecting and collating whatever available data exists. Ministers welcome additional data that will help substantiate the:

- total expenditure in Australia on cosmetic surgical procedures, per annum and per capita, over time
- gross number of cosmetic surgical procedures performed in Australia
- popularity of particular cosmetic surgical procedures
- incidence of public confusion is experienced more commonly or widely in relation to cosmetic as opposed to other forms of surgery
- gross number and proportion of cosmetic surgical procedures that have adverse consequences
- associations of procedure with adverse outcomes
- proportions of adverse outcomes from procedures performed by:
    - medical practitioners with advanced surgical qualifications
    - medical practitioners without advanced surgical qualifications
- gross number, and total and mean cost of reparative surgeries performed to address adverse cosmetic surgical outcomes
- total number and average cost of emergency procedures performed when a cosmetic surgical procedure must be abandoned to save the life of a patient
- trend data relating to gross number, range, severity and trends of complaints about cosmetic surgical procedures
- gross number of referrals for cosmetic surgical procedures for minors
- trend data that can demonstrate public awareness and use (including type) of the Ahpra public register of health practitioners
- gross number of cosmetic medical tourism trips by Australians.

Health ministers are more immediately concerned, however, with the practice of 'cosmetic surgery' by many different kinds of medical practitioners. This activity represents a unique problem with the scope of the title protection provisions of the National Law. Health authorities are not aware of other surgical practices where a similarly broad range of practitioners are operating, or of similar levels of public confusion about the competence and appropriate activity of other surgeons, because they are more clearly designated and regulated by the Medical Board and professional colleges. 'Cosmetic surgery' is not a designated field of specialty under the National Law and cannot therefore be regulated by the same authorities to the same degree, and to the degree expected or assumed by the public.