The Australasian College of Cosmetic Surgery

Raising Standards, Protecting Patients

12 February 2009

Dr Robin Mortimer
Chair
Recognition of Medical Specialties Advisory Committee
Australian Medical Council
PO Box 4810
Kingston ACT 2604

Dear Dr Mortimer

Re: Application by the Australasian College of Cosmetic Surgery to the Australian Medical Council for recognition of Cosmetic Medical Practice as a Specialty

Thank you for your letter of 12 January 2009 requesting additional information for the Economic Sub-committee of the Recognition of Medical Specialties Advisory Committee (RoMSAC).

We note that some of the Sub-committee's questions pertain to data which, unfortunately, is not available. The College and its economic consultants, Econtech, encountered this challenge during the preparation of the submission and the economic analysis prepared for the submission.

In the absence of such information and in line with the AMC's Full Application Aid, the College has sought to make carefully reasoned arguments in its submission and herein in answer to the Sub-committee's supplemental questions.

The Economic Sub-committee seeks additional information, as follows.

1. **Does the ACCS anticipate that recognition of a specialty of cosmetic medical practice would lead to changes to its membership numbers that may not have occurred without recognition?**

ACCS response to question 1:

If recognition occurs, more than one group or college may then seek accreditation of its qualification in the specialty of Cosmetic Medical Practice. Those organisations whose qualifications are subsequently assessed by the AMC to meet the requisite standard could expect to attract more doctors to their training programmes because of the desirability of having a recognised qualification in cosmetic medicine or surgery.

Without recognition, the status quo will remain where doctors who wish to practice in this field will do so anyway, unencumbered by the need, or even the possibility of, undergoing specific accredited cosmetic specialist training. In fact, recognition may reduce the total number of doctors who move into this area from their primary specialty as the presence of specialists specifically in cosmetic practice will make it harder for the non cosmetic specialist to meet patients' selection criteria.

Recognition of the specialty may thus increase the membership of the ACCS (if its qualification is subsequently itself recognised) but is unlikely to have a detrimental effect on the overall medical workforce compared with the current situation.

2. If so, does the ACCS have information on the predicted magnitude of any such changes over a defined period of time?

ACCS response to question 2:

The College is uncertain about the quantum, if any, of such an increase as a result of recognition. The ACCS does not anticipate a substantial increase in the number of procedures performed or of the total numbers of practitioners performing those procedures. However, it is anticipated that recognition of the Specialty and the potential subsequent recognition of training programmes against an agreed standard would lead to some practitioners exiting the field rather than incur the cost, time and effort to become accredited. Others may choose to narrow their practices within subspecialties in which they already have a proven competency.[1]

3. The Sub-committee seeks more detailed information on the typical clinical profile (volume and type of clinical work) of a practitioner in the fields of Cosmetic Medical Practice and Cosmetic Surgical Practice.

[1] The American Society for Aesthetic Plastic Surgery has recently stated that its research has shown that the cosmetic surgery market has reached maturity and that "only aesthetic medicine has the potential for much growth". International Society of Aesthetic Plastic Surgery Newsletter, September 2008.

ACCS response to question 3:

There is considerable variation of clinical profile from one type of practitioner to the next. In the area of cosmetic surgery, there are a number of practitioners who undertake cosmetic surgery on a part time basis – e.g. a plastic and reconstructive surgeon may have a portion of his or her practice devoted to this type of work, though there are some plastic surgeons that have a majority or even all of their practices devoted to Cosmetic Surgery. Equally, some plastic surgeons do not do cosmetic surgery at all.

The typical full time Cosmetic Surgeon, properly so called, may sub-specialise in only one or two areas, e.g. cosmetic surgery of the breast or face or liposuction. Alternatively, he or she may offer a wide range of cosmetic medical and surgical procedures. In this respect, the specialty is no different to any other where, for example, the orthopaedic surgeon may sub-specialise in knee surgery or be more generalised. Most practitioners offering cosmetic surgical procedures would also offer at least some cosmetic medical services typically injectable treatments.[2] Recognising that cosmetic practice is different to Plastic and Reconstructive Surgery, the French Society of Plastic Surgeons is now introducing courses for plastic surgeons in Cosmetic Medicine culminating in a new cosmetic medicine specific exam so that "the plastic surgeon becomes the main player in any thing that concerns beauty by applying the same rigor for adjuvant treatments as for complex surgery".[3]

Cosmetic surgeons spend their time either consulting pre and post operative patients or operating in theatre.

Cosmetic physicians specialise in treatments which do not usually require an operating theatre. Therefore, the majority of their time is spent in their own rooms consulting and performing procedures. These include injectable treatments, laser and other light based therapies, chemical peels and some minor surgical procedures. Some cosmetic physicians sub-specialise in hair transplantation but generally sub-specialisation is less common among cosmetic physicians than it is with cosmetic surgeons.

The College suggests it might be helpful for Sub-committee members to meet a number of cosmetic physicians and surgeons in order to gain a fuller understanding of the typical scope of practice of each area of the proposed specialty. The College would be happy to arrange such meetings.

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2 It is estimated in the US that only 12 per cent of the cosmetic procedures ASPS Plastic Surgeons will be surgical while 88 per cent will be non-surgical by 2015. Medical News Today, 28 June 2008 www.medicalnewstoday.com/articles/112583.php (Accessed June 2008).
3 ISAPS Newsletter, *supra* note 1.

4. **Does the ACCS anticipate changes to volume and type of clinical work by individual fellows occurring as a result of recognition as a specialty? If so, please outline the likely changes.**

   ACCS response to question 4:

   Cosmetic Medical Practice has been undergoing substantial change over the past decade, through greater specialisation, technology and improved techniques. Patients have led the demand for less invasive procedures and/or techniques which reduce recovery times. These macro trends are expected to continue in the years ahead. Within that context, the ACCS does not anticipate substantial changes to the volume or type of work by individual fellows occurring as a result of recognition of the specialty.

5. **Does the ACCS have additional data that can be provided to the RoMSAC in relation to changes that may occur as a result of recognition as a specialty, such as:**

   a. patient referral patterns
   b. medical workforce (for instance, shifts from general practice to cosmetic medicine)
   c. any other changes that may affect the cost or efficiency of services?

ACCS response to question 5:

a. The ACCS does not have additional data. However, the College would observe that Cosmetic Surgery and Medicine is generally a self-referral service for most patients. Referral by GPs and other specialists are not the norm but are more likely in the event of late complications when the original practitioner may no longer be available. As noted in the College's submission throughout, recognition of the specialty of Cosmetic Medical Practice and subsequent recognition of training programmes will provide better information to consumers. It is likely that recognition will have the same benefit for referring physicians. It would be difficult, however, to predict in advance what impact recognition would have on patient referral patterns except to say that the College would anticipate that it would encourage physicians to refer patients seeking cosmetic procedures to practitioners who have completed relevant specific training in cosmetic medicine or surgery.

b. The ACCS does not anticipate any substantial impact on the Australian medical workforce. As noted in the College's submission (p. 49), the number of practitioners providing Cosmetic Surgery and Medicine is a relatively small subset of the medical workforce. Shifts have already occurred with plastic and reconstructive surgeons, general surgeons, ENT surgeons, ophthalmologists,

maxilla facial surgeons, gynaecologists, dermatologists and others choosing to focus on cosmetic work.

Recognition is unlikely to trigger more GPs or anyone else shifting to cosmetic practice. Indeed, recognition is likely to have the opposite influence – i.e. discourage the less committed from transferring – by placing a greater training and qualification hurdle to overcome in order to achieve a relevant specialist qualification. Thus recognition itself is unlikely to be to the detriment of the broader medical workforce resource.

As noted in the College's submission, a number of states and territories have reported shortages of qualified plastic and reconstructive surgeons. The then NSW Minister for Health stated that there was a "critical shortage of plastic surgeons within the public health system".[4] The Queensland Minister for Health has also stated:

> Increased demand for life-saving emergency surgery plus a shortage of specialist doctors forced larger numbers of Queensland patients to wait longer than recommended for their elective surgery during the three months to 1 January 2006…
>
> This situation has been exacerbated by a shortage of senior staff specialists and anaesthetists plus the inability of private Visiting Medical Officer (VMO) specialists to cover spare or available elective surgery sessions.
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> In fact, the majority of long wait Category 1 and 2 elective surgery patients are in the specialties of Neurosurgery, Orthopaedics, Urology and Plastic and Reconstructive Surgery.
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> These are highly specialised services that are primarily provided by private sector VMOs who have had limited capacity to increase their public hospital sessions". [5]

Similarly, the ACT Minister for Health identified Plastic and Reconstructive Surgery as a specialty within the ACT facing pressure due to "intense national and international competition for doctors".[6]

One of the reasons for this is that currently, because there is no recognition of a cosmetic specialty, doctors wishing to practice *solely* in cosmetic surgery must undergo training in another recognised specialty if they wish to avoid the competitive disadvantages detailed in the ACCS submission. Often they choose

[4] The Hon Morris Iemma MP, NSW Minister for Health, Media Release, 1 June 2005.
[5] The Hon Stephen Robertson MP, Queensland Minister for Health, Media Release, 8 February 2006.
[6] The Hon Katy Gallagher MLA, ACT Minister for Health, Media Release, 21 May 2008.

plastic and reconstructive surgery as this is perceived as the closest to cosmetic surgery. Thus the Australian tax payer subsidises the training in the public hospital system of a doctor who has no intention of practicing plastic and reconstructive surgery once he or she has obtained their specialist qualification.

Recognition should result in a better use of health care resources as such doctors will be able to choose a recognised cosmetic surgery specific training programme which, in the case of the ACCS at least, is funded privately and therefore not an impost on the public purse. Additionally, this will free up training places in plastic and reconstructive surgery for those doctors who want to practice plastic and reconstructive surgery as opposed to cosmetic surgery. This can only help alleviate the shortages identified above and will do so at no cost to the taxpayer.

The College believes it is equally important to consider the economic impact and resource implications if the application for recognition is not accepted. Specialists in existing recognised surgical specialties have structural competitive advantages over practitioners whose qualifications have not and, without recognition, cannot be assessed for accreditation by the AMC. This is particularly true in the case of plastic and reconstructive surgeons. The evidence for this and the way in which these advantages are used by the ASPS are provided in detail in the submission in Criterion IV. It would inevitably follow from the rejection of the application for recognition that the ASPS and RACS will claim their views have been vindicated (regardless of the actual reasons for rejection) and this would lead to an exacerbation of the structural competitive advantages enjoyed by ASPS surgeons.

In consequence, plastic and reconstructive surgeons would be assisted in increasing their market share of cosmetic procedures, both medical and surgical as the French example cited above reveals. More plastic and reconstructive surgeons will spend more of their time in cosmetic practice. Doctors wishing to have a career in cosmetic practice will be more likely to feel the need to undergo plastic and reconstructive surgical training as the only way to access these advantages. Not only will the resource benefits of recognition described above not occur, the opposite will in fact occur, exacerbating the already identified shortages of plastic and reconstructive specialist available to perform plastic and reconstructive as opposed to cosmetic procedures. In short the return on the public investment into training plastic and reconstructive surgeons will likely be diminished if recognition does not occur.

c. The College is unaware of any other changes that may occur, other than those noted in its submission, as a result of recognition of Cosmetic Medical Practice.

6. It is noted that the submission argues under Criterion IV (page 90) that a benefit of the recognition of Cosmetic Medical Practice as a specialty would be to improve information asymmetry for consumers. What evidence is there that there will be a decrease in information asymmetry, and if there is, what is the evidence that better care will result? For example, will all those within the proposed specialty have the same professional skill set, or will the wide range of skill differentiation remain, thus actually increasing the potential for confusion by patients.

ACCS response to question 6:

It is axiomatic that between consumers and vendors there exist information asymmetries. The more highly specialised the vendor's services (versus a general consumer), the greater the degree of information asymmetry. It is especially relevant in medicine and particularly in Cosmetic Medical Practice because of its entirely elective and discretionary nature. The importance increases if the doctor is relatively inexperienced in the procedure. Furthermore, because cosmetic surgery is performed almost exclusively in the private sector, many surgeons will have had very little exposure to it at the time they obtain their specialist qualification or, as noted below, they will not be properly trained or qualified. Many patients do not know this.

In its submission, the ACCS maintains that recognition of the specialty of Cosmetic Medical Practice is the first, necessary, step toward improving information and standards of care for consumers. As Cosmetic Medical Practice is not currently recognised by the AMC, there is no mechanism in Australia for the formal assessment of training and qualifications in specialised areas of cosmetic surgery and cosmetic medicine. Recognition will allow that process to occur.

The ACCS shares the concern expressed by the Australian Health Ministers' Conference (AHMC) that there is a lack of consistent standards.[7] Inconsistent standards increase information asymmetries. A national standardised regulatory framework which assesses all practitioners against an AMC accreditation will provide consumers with an opportunity to assess who and who is not properly qualified to perform cosmetic medical and surgical procedures. This is currently very difficult owing to the lack of recognition and inconsistencies. Indeed, the Galaxy research included in the College's submission (Appendix 2), showed that consumers overwhelmingly (96 per cent) held the view that the specialty should be recognised with training and qualifications approved by appropriate medical authorities, some 98 per cent hold the view that consumers have a right to know if the doctor performing their procedure is trained specifically in the specialty.

[7] Australian Health Ministers' Conference Communiqué, 22 July 2008.

As the College noted in its submission and above, there are a variety of practitioners from different medical backgrounds who offer procedures that would fall under the umbrella of the specialty of Cosmetic Medical Practice. It is the College's view that a number of these practitioners either do not have the proper training and qualifications to conduct these procedures or their training and qualifications cannot easily be properly assessed, even by knowledgeable peers, due in part to the lack of a standard regulated specialty against which to make such an assessment. Consumers, with much less background knowledge, are at a greater disadvantage.

This point was noted in the submission and highlighted by the UK Department of Health, which stated that a qualification in Plastic and Reconstructive Surgery "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".[8]
Yet in Australia, for example, there appears on the Australian Competition and Consumer Commission (ACCC) website a statement placed there by the ASPS:

> Australian Society of Plastic Surgeons (ASPS) represents plastic surgeons who hold a Fellowship of the Royal Australasian College of Surgeons (FRACS). ***Plastic Surgeons are fully trained in a range of procedures from reconstructive to cosmetic***.[9]

In the College's opinion, there is not enough available evidence to conclude that this statement – i.e. that 'plastic surgeons are fully trained' – is true or any transparent mechanism in place to test it. Indeed, the ASPS has recently refused to even clarify the nature of its cosmetic training and RACS has been unable to deny its non plastic Fellows who perform cosmetic surgery, of which there are an increasing number, receive no cosmetic training and are unable to access it via RACS.[10] It is the College's opinion that the statement is misleading at the very least and provides further elaboration and evidence in Criteria IV (pp. 94-103). Such information asymmetry cannot benefit patients. Recognised benchmarks of training and assessment open to all practitioners of cosmetic surgery or cosmetic medicine, will allow them to identify practitioners who have relevant qualifications which have been assessed by an independent body, the AMC or its successor.

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[8] UK Department of Health, 2007 www.dh.gov.uk/en/Publichealth/CosmeticSUrgery/DH_4124199 (Accessed January 2009).
[9] ACCC website http://www.accc.gov.au/content/index.phtml/itemId/288933/fromItemId/815972/quickLinkId/815429/whichType/org (accessed January 2009).
[10] See e.g. correspondence between the ACCS, the ASPS and RACS regarding "Practitioner experience – disclosure to patients", 21 October to 16 December 2008 (attached as Appendix 1). The College apologises for providing so large a volume of correspondence regarding these issues. However, it has provided the full exchange of correspondence to allow the AMC to make its own judgment and to avoid any suggestion that the College has quoted correspondents out of context.

Cosmetic physicians and cosmetic surgeons do have different skill sets. Within the ACCS training programme there is some overlap with the surgical trainees being required to also pass the medical exam. This is why the submission proposes that two types of qualification are submitted for assessment if the specialty is recognised: a medical one for specialist cosmetic physicians and a surgical one for cosmetic surgeons. An existing comparison would be cardiologist and cardiothoracic surgeons or gastroenterologists and gastro-intestinal surgeons who are different with different but overlapping skill sets. There is no reason recognition should lead to a worsening of information asymmetry – quite the contrary.

7. **The Econtech Report (page 12) suggests there will be tax payer savings made as result of lower rates of corrective surgery required and fewer complaints to the Health Care Commissions. What is the evidence for this and what is the estimate of the quantity of savings?**

   ACCS response to question 7:

   There is no set of data available upon which to make an accurate assessment. Rather, the ACCS argues that recognition of Cosmetic Medical Practice, which will lead to better training and national standards for qualifications, will improve standards, reduce the number of under qualified practitioners, increase patient safety, allow equity of access to private hospitals for all competent practitioners, inform consumers and, therefore, reduce the incidence of mishap, complaints to Health Care Commissions and lower levels of corrective surgery. The ACCS cannot accurately estimate the quantity of savings, but notes any avoidance of potentially life threatening surgical mistakes for the individual concerned would be a worthwhile benefit. Certainly, not recognising the specialty will cause these benefits to remain unrealised.

8. **While appreciating that cosmetic procedures are generally not covered by the MBS, it is possible that some consultations provided by ACCS fellows which lead to cosmetic surgery or medicine services are so covered. Does ACCS have any information on the numbers of MBS consultations provided by its members in the context of their cosmetic work?**

   ACCS response to question 8:

   Work purely of a cosmetic nature forms the vast majority of the work performed by ACCS members. Some consultations and procedures are covered by the HIC. The percentage would vary enormously depending on the individual member's practice profile. For example a doctor sub-specialising in liposuction would claim very few rebates from the HIC. Another concentrating on skin rejuvenation may

have many more as he or she will inevitably be required to diagnose and treat or refer numerous skin cancers. The ACCS is attempting to extrapolate additional data from a recently conducted survey of its members in order to provide the AMC with this information. However, the ACCS may need to conduct a further survey in order to do, and will make this information available as soon as possible.

The College hopes the information provided in response to the Sub-committee's questions will be helpful in its assessment of Criteria IV. As noted above, in question 3, the College looks forward to introducing the Sub-committee to a number of practitioners who specialise in both cosmetic medicine and surgery in order to gain a fuller appreciation of typical practices.

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

Yours sincerely

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President

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Attachment: Appendix