The review group additional information, as follows:

Under Criterion 1 (c) - Provide references relating to a comprehensive and developing body of international research and scholarly literature to support evidence-based clinical practice; references demonstrating a significant representation within academic medicine; a list of comparable countries where cosmetic medical practice is formally recognised as a medical specialty and the definitions in use in those jurisdictions.

Answer:

Please note the bibliography of research and scholarly literature provided at Appendix 33 of the College's Application. The College provides a supplemental list of research and scholarly literature attached hereto at Appendix 1.

In addition to the examples of representation within academic medicine provided in the College's Application, additional examples are attached at Appendix 2.

The specialty is practiced extensively throughout the world and indeed the ACCS's annual conference reflects this fact: delegates with extensive experience and notoriety in cosmetic medical practice and from disciplines such as dermatology, surgery, general practice and plastic and reconstructive surgery attend from countries throughout the world (see e.g. list of ACCS and other international and national conference attendees for the College's 2010 conference provided at Appendix 3).

As noted in the Application, the specialty of cosmetic medical practice is not yet recognised as a distinct specialty in a comparable country (under terms and conditions roughly equivalent in all respects to the definition used by the College in its application or meeting the terms and conditions set forth by the AMC process). Indeed, as the sub-committee will be aware, comparable countries employ distinct and disparate processes, regulated via a variety of federal and state and provincial jurisdictions and different authorities to "recognise" a medical specialty.

Some Plastic and Reconstructive surgeons lay claim to Cosmetic Surgery (even including Cosmetic Medicine) as part of that specialty. Indeed, the British Association of Plastic Surgeons (BAPS) only very recently rebranded itself the British Association

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of Plastic, Reconstructive and *Aesthetic* Surgeons (BAPRAS) while at the same time acknowledging a need to "evolve" their training to match the new name. And although, as noted in the College's Application, a number of governmental organizations acknowledge the College and the expertise of the members of the proposed new specialty, it is not formally recognised as a medical specialty.

In the United States, medical specialties are not recognised as such by a governmental authority. There are some 70 independent medical boards representing specialties and subspecialties. Each state medical board in turn will recognise medical specialties generally if they are recognised by the American Board of Medical Specialties and their specialty board members are allowed to advertise as such. The overwhelming majority of states do not restrict cosmetic surgeons who are board certified by the American Board of Cosmetic Surgery from advertising as 'board certified.'[1]

The specialty of Cosmetic Surgery is recognised by the American Medical Association's list of self-designated practice specialties.[2] The College has provided a copy of the current certification requirements of the ABCS at Appendix 4.

In the United Kingdom, cosmetic surgery (or aesthetic, as it is also referred to) does not appear on the government's General Medical Register (GMC), although it is clearly recognised as a distinct area of medical practice requiring different relevant training and experience in order to achieve suitable recognised competency. The UK Department of Health notes:

> *Surgeons from a number of surgical specialities perform cosmetic operations allied to their main specialty. The qualifications listed below show that a surgeon is highly qualified and experienced in their chosen surgical specialty**, but it may not indicate that they have received any special training in cosmetic surgery, or that they have experience in doing cosmetic surgery or the particular procedure you are considering.***[3]

[1] A summary of US state medical board advertising restrictions are provided at Appendix 5.
[2] The American Board of Cosmetic Surgery: http://www.americanboardcosmeticsurgery.org/Certifications-Requirements/ama-listing.html (accessed December 2009).
[3] Department of Health (UK): http://www.dh.gov.uk/en/Publichealth/CosmeticSurgery/DH_4124199 (accessed December 2009). It has been shown in the US, for example, that hospitals determining clinical privileges based on incomplete and inaccurate information regarding the education, training, experience and proven competence of the doctors performing cosmetic surgery, place cosmetic surgery patients at risk. In considering a surgeon's request for hospital privileges, some hospitals are of the view that board certification in plastic surgery is prima facie sufficient qualification to perform

Although the ACCS is well aware of the difficulties doctors, patients, regulators and allied health professionals confront in trying to judge the training and experience of Australian cosmetic medical and surgical practitioners,[4] the UK Department of Health warning is also a telling disclosure: as Andrew Burd, Chief and Professor, Division of Plastic, Reconstructive and Aesthetic Surgery, Prince of Wales Hospital, Hong Kong has written recently that "Reconstructive Plastic Surgery is very different from Cosmetic Plastic Surgery." And though he argued it is a branch of Plastic and Reconstructive Surgery (most specialties were part of at least one existing specialty), he noted that "Cosmetic Surgery is, in its own right… extremely demanding".[5]

Professor Burd listed the following procedures which he considers cosmetic, noting the "list is by no means exclusive and new procedures and strategies are being added on a regular basis. The major concern is to ensure the safety and efficacy of such procedures."

Arm Lift	Eyelid Surgery
Body Contouring	Facelift
Body Lift	Facial Implants
Botox & Tissue Fillers	Hair Replacement
Breast Augmentation	Liposuction
Breast Lift	Nose Surgery
Brow Lift	Skin Rejuvenation & Resurfacing

cosmetic surgery. However, according to some literature, cosmetic surgery patients choosing their surgeon based solely on the surgeon's underlying board certification are being harmed. Several studies, including the twelve summarised in the College's Application ("Cosmetic surgery and patient safety: relevant US studies," Appendix 18 of College's Application), found significantly higher rates of morbidity, mortality and malpractice claims among board certified plastic surgeons over all other medical specialties performing certain cosmetic procedures.

[4] The UK's Joint Royal Colleges of Physicians Training Board has applied for and the Secretary of State for Health has recognised the new specialty of Acute Internal Medicine. Although many had assumed that there is a specialty of acute medicine in the UK, none existed. It was part of general internal medicine. The ACCS notes the analogous situation that existed and the case put by the Secretary of State for Health to the Parliament: "There is a need for doctors, employers, commissioners and most of all patients to be clear that the doctor employed and dealing with acute medical problems has a specialty in that discipline… Presently there is a mismatch between what is best for patients and service in terms of clarity, both in terms of skills and in qualification…". Explanatory memorandum to the general and specialist medical practice (education, training and qualifications) amendment order 2009 no.1846 (UK).
http://www.opsi.gov.uk/si/si2009/em/uksiem_20091846_en.pdf

[5] The Hong Kong Medical Diary, Vol 13, No 7, July 2008:
http://www.fmshk.org/database/articles/3mb6.pdf (accessed August 2009).

Chemical Peel & Dermabrasion	Thigh Lift
Chin Surgery	Tummy Tuck
Ear Surgery	

The College provided in its Application a list of definitions in use in other jurisdictions, including in the UK and the United States.

Under Criterion I (d)

- Provide information on the number and qualifications of practitioners who can be demonstrated to sustain vocational training and assessment and continuing professional development for the proposed specialty.

Answer:

Qualifications of practitioners to sustain vocational training are provided at Appendix 6.

Under Criterion II (a)

- Provide examples of how cosmetic medical practice, both within and via the College, through demonstrated leadership in the medical community, has contributed in Australia to: increased effectiveness of health care and which health outcome measures have been used in this analysis; increased appropriateness of health care and the established standards on which this assessment is based; and increased safety through significant reduction of harm in Australian healthcare, including a description of how the impact is measured and the indicators used to support the analysis.

Answer:

As noted in the Application, the College has established and developed formal specific training programmes in cosmetic medicine and surgery. So far as the College is aware, they remain the only training programmes in Australia which lead to fellowship level accredited qualifications in the proposed specialty. Information about the training programme is provided in the Application. Additional information is provided in this response below and Appendices12-17 and discussed again in more detail in response to the review group's questions below under Criterion III.

The College has also instituted mandatory continuing medical education (CME), which includes recertification and examination as part of that process. All Fellows of the College including Foundation Fellows must complete CME and recertification, which is presented in the Application in some detail and discussed below under responses to Criterion III. To date, the College has trained approx 43 in the Fellowship programme and provided additional training to over 150 practitioners through its workshop programme and diploma courses.

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).

The College's leadership is recognised by a wide range of government agencies concerned with health policy, and other health care related organisations including medico indemnity groups such as MIGA, to provide formal and informal advice and expertise. The College and/or its members have provided expert advice and

assistance to regulatory bodies including the Therapeutic Goods Administration (TGA), health departments and medical boards in New South Wales, Victoria and Queensland, the Health Quality Care Commission (Qld) and the ACCC. The College's CEO, Dr John Flynn, has recently been asked by the Victorian Coroner to provide an expert opinion to the Inquiry into the death of a young woman following liposuction. The South Australian Coroner has also requested that Dr Flynn provide similar advice there in another inquest.

These activities are discussed further and examples provided below at response to Criterion III. Additional examples are provided in the College's Application.

The ACCS has established a national and international conference programme and now hosts the largest cosmetic medical practice conference in Australia (more than 500 will attend in 2010 from Asia, Canada, Europe and the United States). The conferences -- through papers, plenary sessions and smaller group workshops – provide College members and practitioners from other recognised medical specialty fields such as Dermatology, Plastic and Reconstructive Surgery and Opthalomology to learn and share the latest innovations in technology, technique and pharmacy. Over the years, thousands of doctors from these and other recognised specialties and others have benefited from the College's conference programme, and have applied those benefits toward better care of their patients. The 2010 Conference draft programme is attached at Appendix 3.

Each year's conference includes topics which address the effectiveness, appropriateness and safety of care provided by practitioners of the proposed specialty.

This year's conference attendees will also hear speakers from the Therapeutic Goods Administration and the Australian Competition and Consumer Commission discuss standards.

College members also routinely travel to participate in conferences, seminars and workshops throughout the world in order to advance their proficiency and knowledge (which they use in their practices to raise standards of care and achieve better outcomes) as well as to contribute to the ongoing development of the area of cosmetic medical practice. Additional examples of international conferences attended by College members is attached at Appendix 7.

Launched a professional journal, now in its fifth year of publication, *Australasian Journal of Cosmetic Surgery*, recently re-titled the *Journal of Cosmetic Surgery and Medicine* because it has outgrown its regional base and is now circulated in the UK, Europe and soon to be the USA. The new title also reflects the broad church which is Cosmetic Medical Practice.[6]

Since the lodging of its Full Application, the College has also developed a Code of Practice, which was formally Authorised as being in the public benefit by the ACCC on 18 June 2008 after extensive public and peer consultation.[7] A copy of the Code of Practice is attached at Appendix 8.

The Code provides patients with greater protection and it will require all College members to meet exemplary standards – higher in some areas than that required by state medical boards and other regulatory regimes – in advertising and other promotional conduct, informed consent guidelines, monitoring of the code and an extensive governance regime.

The College has and will continue to conduct annual independent compliance audits and report to the ACCC on the operations of the code and on the outcomes of audits. In its first six-monthly audit, the College found that substantial compliance and significant improvement with the key areas of testimonials, inducements, before and after photographs and use of superlatives. No members were found to be providing finance facilities or credit or receiving a commission for such services. The majority of members whose practice websites and advertising were found to be in breach of the Code are now in compliance or have made efforts to comply with the Code.

In one case, a member has indicated that they will leave the College rather than remediate the breaches that have been brought to their attention. While that College is disappointed that a practitioner has 'self-selected' to leave the College rather than raise their standards, the College is of the view that this is a public benefit. The practitioner will no longer be able to represent themselves as a member of the College to the public or in compliance with the College's standards.

While the College was not bound to seek ACCC Authorisation, the process of Authorisation led to improvements in the Code, and will ultimately we believe, will lift

[6] Examples attached at Appendix 10.
[7] Additional information about voluntary codes of conduct and ACCC Authorisation may be found here: http://www.accc.gov.au/content/index.phtml/itemId/783116 .

standards of care through greater disclosure and better informed consent. Authorisation of the Code also ensures that the College can enforce its provisions notwithstanding the *Trade Practices Act 1974*.

As a condition of Authorisation, the College developed a patient information brochure, “Things you should know” (Attached at Appendix 9). The brochure, to be provided by College members to their patients, is intended to assist patients when considering a cosmetic procedure. It encourages them to consider carefully their options, to seek a second opinion and to ask questions of their doctor. It also provides information should they wish to file a complaint against a doctor with the College or state medical board or health care complaints commission.

The College has set up a formal process and complaints panel to consider complaints under the Code and to discipline members in the event of a breach of the Code is established.

As noted in its Application the College has also demonstrated its leadership through other initiatives such as its programme of Roundtables. The purpose of the Roundtable programme is to bring together a number of key health care stakeholders representing various disciplines, medical associations, government and universities for open discussions on issues relevant to the practice area.

Topics covered in past ACCS Roundtables (which were provided in the College’s Application) included:

- Clarification for the community of titles, qualifications and memberships used in cosmetic surgery advertising.

- Addressing the increasing use of commission or bonus rewarded “sales consultants” or “advisors” to perform the first face to face consultation instead of the doctor. Patients are rarely informed that the advisor may have a vested financial interest in the patient proceeding to surgery.

- Clear guidelines form the profession concerning the provision of cosmetic surgery to patients under the age of 18.

- Exploration of the roles and responsibilities of doctors with respect to the delegation and administration of S4 medicine in the cosmetic context with particular reference to botulinum toxin (Botox, Dysport).

- Clarification of the current industry regulations and consumer issues surrounding the financing of cosmetic procedures.

While the College cannot reliably measure the increase in appropriateness, effectiveness and safety in the delivery of health care which may be directly attributable to the College's demonstrated leadership in the medical community through these key activities, it is reasonable to accept that they would contributive. Indeed, the existence or absence of these activities though not a proxy measure for performance outcomes are necessary for their achievement.

In its Application, the College provided data from MIGA and other sources such as health care complaints commissions concerning claims (pp. 53-57), which provide one proxy in terms of harm reduction. The MIGA claims analysis showed that claims had not grown. Indeed, when considered against the background of substantial increases in cosmetic medical procedures over the past decade, the number of claims has declined as a ratio of procedures performed.

Under Criterion ii (b)

- Describe College policies and programmemes which promote the equality of access to cosmetic medical services across geography, culture and socioeconomic status in Australia.

Answer:

Note: Criterion II (b) Application asks: **that specialisation is not adversely affecting the quality of healthcare in Australia, and will not in the future, by promoting: inequitable access to health care as defined by socioeconomic status, geography or culture.**

The College does not believe that specialisation will adversely affect the quality of healthcare in Australia by promoting inequitable access to health care as defined by socioeconomic status, geography or culture.

Moreover, the *World Medical Association Declaration on the Rights of the Patient* states that, "The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decision".[8] The status quo restricts patient self-determination in a number of ways (e.g. higher costs, manipulation of information asymmetries and contribution to inefficiencies in training and health care resource allocations), as noted in response to Criterion IV of the College's Application and below, which will be lessoned by recognition of cosmetic medical practice.

The College is committed to equality in the workplace and advancing diversity within the proposed specialty. Indeed, a quick perusal of the names on the College's Council and fellowship directory or the attendees of the College's annual conference, make it clear that the College membership is made up of doctors who are from diverse socio-economic backgrounds, cultures, nationalities and races. Like other areas of medicine, this diversity reflects the communities in which the College's members practice, which in turn signifies to patients that they are welcome.

The College's Code of Practice also serves an extremely important role in assisting those who may either be less advantaged or more vulnerable due to their socio-

[8] World Medical Association Declaration on the Rights of the Patient <http://www.wma.net/en/30publications/10policies/l4/index.html> (accessed 04 November 2009).

economic background. First, it sends a clear reinforcing message to College members about their duties to properly inform and not mislead or encourage inappropriate procedures. Second, it informs patients about their rights to ask for and receive information about their doctor and the procedures they may be contemplating.

The College's distance learning modules that form a part of its diploma courses also assist regional GPs, for example, who have a history of procedural expertise, in up-skilling and offer additional appropriate services, which may help support their practice.

Cosmetic medical practices tend to be located near population centres (rather than in rural areas, reflecting the local demand for a private elective health service and, like other health services, the need for supporting infrastructure and services. However, cosmetic medical practice is performed in a diverse range of geographic and socioeconomic areas throughout Australia in all states and territories – from exclusive Double Bay and Toorak to ethnically diverse suburbs such as Lakemba and Parramatta to regional centres such as Coffs Harbour and Shepparton.

Under Criterion II (c)

- Provide evidence of how services in cosmetic medical practice enhance the quality and/or efficiency of health care beyond that provided by practice within existing recognised specialties, including in the handling of adverse reactions and complaints.

Answer:

Relevant, specific training as outlined below and in the College's Application.

While some medical colleges offer limited elective cosmetic modules as part of their training, at present, the ACCS is the only existing medical college that offers dedicated specific comprehensive training in Cosmetic Medical Practice. Cosmetic surgeons practice in the proposed specialty on a full time basis, versus practitioners in other specialties who may only provide cosmetic services on a part-time or intermittent basis.

As a result, it is reasonable to state that, generally, those cosmetic surgeons are more proficient and up-to-date. On average they will see more cosmetic patients and have more experience dealing with issues which are unique to cosmetic practice – e.g. counseling, diagnosing Body Dysmorphic Syndrome or anticipating and treating potential complications.

As noted in its Application, in 2006, the College completed a five-year survey of its fellows' performance of liposuction, which found no mortalities in 27,000 cases. It is a record which compares favourably to a 1999 survey conducted by the ASPS (US), which reported a mortality rate of one in every 5,224 (or 19 per 100,000) liposuction patients among Plastic and Reconstructive Surgeons. The ASPS stated then that the relatively high mortality rate "may be due to an increase in unqualified *plastic surgeons* performing liposuction during that period".[9]

9 As a result of this finding, there was strong pressure to "re-educate" plastic surgeons about risk reduction in lipoplasty procedures. Several measures were identified as ways to increase patient safety. CE Hughes, Reduction of lipoplasty risks and mortality: An ASAPS survey. Aesth Plast Surg 2001;21:120-127.

While it commendable that ASPS undertook the study and recommended corrective action, it is uncertain how that organisation could have so many "undertrained" surgeons, in a basic though potentially life-threatening procedure, in its ranks while at the same time profess that ASPS membership was an assurance of full training in cosmetic procedures.

The College uses this example reluctantly. Members of the ACCS have the greatest respect for members of the specialty of Plastic and Reconstructive Surgery, some of whom are, colleagues, Fellows and educators in the College and friends.

But not only does that example provide sobering evidence, it demonstrates the consequences resulting from a lack of recognition. To the time of this writing, ASPS and its members in Australia continue to assert that fellowship in their organisation (now sub-contracted by the RACS to manage plastic and reconstructive training), is evidence of being *'fully qualified'* in cosmetic surgery, when no evidence has been presented to support that claim other than recognition of Plastic and Reconstructive Surgery as a medical specialty and the further claim that cosmetic surgery is part of or a sub-specialty of that specialty.[10]

Cosmetic medical practice provides efficiencies to health care in the form of alternative specific training that does not displace public health care resources (discussed below at Criteria IV).

The College has led the way among medical colleges in implementing new complaint processes through an ACCC-authorised Code of Practice, which gives the College and Members' patients greater ability to deal effectively with complaints. The Code is not intended to supplant other forums, such as state medical boards or health care complaints bodies.

[10] See e.g. discussion at page 93 of College's Application.

Under Criterion III

- Provide evidence of how the College has defined, promoted, maintained and improved standards of medical practice to ensure high quality health care. Include a description of how the impact is measured and the indicators used to support the analysis.
- Describe in detail the College processes for standard setting and stakeholder engagement, including health consumers.
- Describe the College's policies and processes for assessing the knowledge, skills and competence of Foundation Fellows and Members.
- Describe the College policies and processes for determining the standards of education, training and experience of overseas trained medical practitioners.
- Provide copies of the policies and guidelines of the College Board of Censors.
- Describe the College Programmemes of education, training and assessment in both the cosmetic surgery and medicine streams and provide specific examples of how those programmemes meet sub-criteria (b), (c), and (d). Provide examples of the written and oral examinations.
- Under sub-criterion (d) provide detailed information on the ACCS mandatory continuing education and recertrification programmemes.
- If available, provide evidence of audits of education, training and assessment programmemes of the College.
- Provide documentation which demonstrates the College's experience in activities listed under sub-criterion (e).

Answer:

- *Provide evidence of how the College has defined, promoted, maintained and improved standards of medical practice to ensure high quality health care. Include a description of how the impact is measured and the indicators used to support the analysis.*

The ACCS has a well established training and accreditation programmememe in place which provides the framework necessary to administer the requirements of Cosmetic Medical Practice. None of the other existing learned colleges offer dedicated, specific formal training in Cosmetic Medical Practice. The College also sets and enforces standards for its Fellows as described in its Application and above. The College promotes the standards it has defined to its membership via a variety of communications, through its conference and seminar programme discussed elsewhere, journals and wider media.

- *Describe in detail the College processes for standard setting and stakeholder engagement, including health consumers.*

The College's standard-setting and stakeholder engagement processes are set and approved by the Council (per the Constitution of the College) who are elected by Fellows of the College, and meet at least monthly.

Standards and stakeholder engagement is managed on a day-to-day basis by the executives of the College including the President, CEO and General Manager.

Important also are the Board of Censors of the College, the Ethics Committee (Some members have been removed from College registers and two removed from the College), the Deans of Surgery and Medicine, and College Preceptors and the independent Complaints Panel which enforces the Code of Practice.

Additionally, ad hoc committees and working groups are formed to develop new standards or revise existing ones (e.g. the College's CME programme). The organisation and management of the College is governed by its Constitution and By-Laws. Complaints involving breaches to the standards set forth in the Code of Practice are dealt with through the rules set forth in the Code.

There is also a Lipoplasty committee which overseas the training and the Diploma of Lipoplasty and a Cosmetic Nursing Committee.

As noted in its Application and above, the College engages with a wide variety of stakeholders including its own members, other health care providers, health ministers and opposition spokespersons, health departments, medical boards, Medico-indemnity groups, health care complaints commissions, other medical colleges and organisations in Australia and overseas. The goals of this engagement are primarily to articulate and promote the goals of the College and learn of and adopt best practice.

The College also regularly (often several times per week) fulfils print, radio and television media requests to provide expert comment on all areas of the proposed specialty: public health policy and debate, new technical and pharmaceutical developments and other issues which arise from time to time. The College can forward media clips if the review groups so desires.

- *Describe the College's policies and processes for assessing the knowledge, skills and competence of Foundation Fellows and Members.*

The College's predecessor organisation was the Australian Association of Cosmetic Surgeons which was inaugurated in 1992. This organisation was made up of practitioners in the field of cosmetic surgery and medicine at that time and formed a group of special interest doctors with particular skills and experience in this field.

Foundation Fellows were drawn from the ranks of cosmetic surgeons and cosmetic physicians in practice at the time of the College's formation, from the ranks of the Australian Association of Cosmetic Surgeons as well as from other medical disciplines. A review body was established to examine the candidates. Candidates needed to present referees and an existing body of practice in a variety of practice areas. Each candidate was assessed individually, had to supply validated log books of experience, together with examples of their work. Evidence of higher medical qualifications was assessed.

Practical evaluation of surgical skills and professional judgement was undertaken. Medico legal claims and a history of any complaints were examined. Candidates for Foundation Fellowship also had to be accredited at a fully licensed facility. This mean s that their experience and qualifications had to be considered by the Medical Advisory Board of that facility (an independent assessment of competence and skills) and therefore there was also a continuing monitoring of performance and outcomes.

The College has recently amended its CME and recertification programme, which now requires all Fellows including Foundation Fellows to undergo mandatory recertification including examination.

- *Describe the College policies and processes for determining the standards of education, training and experience of overseas trained medical practitioners.*

"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."

- *Provide copies of the policies and guidelines of the College Board of Censors.*

Policies and guidelines of the College Board of Censors attached at Appendix 11.

- *Describe the College Programmes of education, training and assessment in both the cosmetic surgery and medicine streams and provide specific examples of*

how those programmes meet sub-criteria (b), (c), and (d). Provide examples of the written and oral examinations.

Please see curricula and discussion provided in the Application (pp 72-80). Additionally, the College attaches copies of the following College handbooks which provide details of the education, training and assessment in cosmetic surgery and medicine:

1. *ACCS Cosmetic Medical Practice: Training Handbook for Cosmetic Surgery FACCS* (Appendix 12)

2. A*CCS Cosmetic Medical Practice: Training Handbook for Cosmetic Medicine FFMACCS* (Appendix 13)

3. *ACCS Cosmetic Medical Practice: Preceptor Information and Guidelines for Cosmetic Surgery Programme* (Appendix 14)

4. *ACCS Cosmetic Medical Practice: Preceptor Information and Guidelines for Cosmetic Medical Programme* (Appendix 15)

Please see attached examples of oral and written examination questions (Appendix 16-17)

- *Under sub-criterion (d) provide detailed information on the ACCS mandatory continuing education and recertrification programmes.*

Please see Application (pp 79 – 80) for the existing CME programme. The ACCS's governing Council recently revised the College's CME programme and introduced mandatory recertification with examination. The recertification will apply to all Fellows including Foundation Fellows. A new CME programme is currently being drafted and will be forwarded to the review group.

- *If available, provide evidence of audits of education, training and assessment programmes of the College.*

Audits examples provided at Appendix 18.

- *Provide documentation which demonstrates the College's experience in activities listed under sub-criterion (e).*

Please see the following documentation examples:

1. Submission to Queensland Health re teenage surgery (Appendix 19)

2. Submission to the Medical Board of Victoria regarding advertising guidelines for registered medical practitioners (Appendix 20)

3. Programme for ACCS Annual Conference (Appendix 3)

4. ACCS Code of Practice (Appendix 8)

5. ACCS Patient Brochure, “Things you should know” (Appendix 9)

6. A copy of the College’s Journal: *Journal of Cosmetic Surgery and Medicine* (Appendix 10)

7. Description and course requirements and work for the Diploma of Cosmetic Nursing (Appendix 21)

8. Introduced a Patient Satisfaction Survey instrument, managed and monitored by an independent organisation UltraFeedback, which also supplies services to the Victoria Department of Health. (Appendix 22-23)

Under Criterion IV (a)

- Provide data which demonstrate the significant burden of disease (including incidence, prevalence or impact on the community) represented in cosmetic medical practice and the capacity of the College members to influence this burden at a population level.
- Provide further information which justifies how recognition of the specialty might deliver benefits to the community through application of resources across private and public healthcare sectors.

Answer:

Note: Criterion IV of the Application asks,

> "*that recognition of the proposed specialty is of public health significance as defined by the following: 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 (and not merely members of the College."*

The College anticipates that there will continue to be practitioners who do not belong to the College who would achieve accreditation in cosmetic medical practice – through the ACCS or other Colleges that may have their training programmes accredited in the proposed specialty -- and contribute to this overall capacity.

There is no comprehensive set of data which demonstrates the burden of disease, incidence, prevalence or impact on the community. The College has provided in its Application that data which it holds.

Although cosmetic medical practice as defined does not generally directly address disease processes associated with typical medical or surgical intervention – e.g. to treat disease or trauma, it does however address the burden of disease, incidence or impact on the community in three fundamental ways.

First, increased relevant training and specialisation applied to deliver appropriate services will result in better outcomes. 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 doctors and consumers and, therefore, reduce the incidence of inappropriate health care services, morbidity, mortality and the need and cost for corrective treatment and other impacts (e.g. lost productivity and emotional suffering).

The ACCS cannot at this time 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.

Second, as the College has argued in its Application and elsewhere in this response, recognition of the proposed specialty will provide an alternate recognised and AMC accredited training pathway for doctors who wish to focus solely on cosmetic medical practice.

Encouraging alternative training pathways to account for the rapidly changing and growing proposed specialty and competing health demands is not merely an efficiency argument (discussed below); it will free up strained publically resourced training positions which will ultimately help address the burden of disease overall.

For example, the Australian Society of Plastic Surgeons has stated that purely cosmetic practice on average accounts for 40 per cent of its more than 200 members' practice time (some members do not practice cosmetic surgery at all; some only practice in cosmetic surgery and have given up their traditional practice areas in Reconstructive Surgery).[11]

Indeed, an increasing amount of Plastic Surgeons' devotion to cosmetic practice is devoted to non-surgical procedures, a trend which is predicted to grow. In the US, it is estimated that 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.[12]

[11] "A mania for makeovers", The Australian, Feb 18 2009 http://www.theaustralian.com.au/news/health-science/a-mania-for-makeovers/story-e6frg8y6-1111118881837 .

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

Indeed, and further the World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[13] Or as one Australian plastic surgeon has put it,

> *In reality we live in a world where appearance is very important, and self-esteem is related to appearance… and cosmetic surgery has been shown to improve a patient's psychosocial wellbeing.*[14]

Although the proposed specialty typically is defined by procedures and treatments that are purely elective, these procedures and treatments sometimes address physical deformities or "imperfections" such as breast reduction or Rhinoplasty which are of a nature that are sometimes covered by Medicare, while others such as breast and face implants can be said to be restorative (i.e. treating the degenerative effects of ageing, sun exposure or HIV). Cosmetic procedures and treatments may be seen on a continuum: although they may all be seen to be elective some at one end of the continuum address physical changes as a result of ageing or disease processes, whereas others at the other end of the spectrum are undertaken purely to improve some aspect of a patient's appearance which is unrelated to disease or ageing.

And as noted in the College's 12 February 2009 response to the RoMSAC, with most cosmetic surgeons being shut out of the medical mainstream due to lack of recognition, most patients are self-referred. 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.

The assistance of GPs earlier, together with a thorough patient history, is very valuable in determining whether cosmetic surgery is likely to have a positive psychosocial outcome. Unfortunately, the generally poor attitude of the Australian medical community towards cosmetic surgery has led to patients being afraid of a negative response when asking their GPs about cosmetic surgery.

It is to be hoped that recognition of the proposed new medical specialty would promote more contact between cosmetic surgeons and other medical practitioners so that the true benefits and risks of the procedures can be understood by the

[13] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

14 Macgregor FC. Social and psychological studies of plastic surgery: past, present and future. Clin Plast Surg 1982; 9: 283-288.

general medical community, who, in turn, can properly counsel their patients in a sympathetic manner as to whether cosmetic surgery is advisable.

As noted in the College's submission, a number of states and territories have reported shortages of qualified plastic and reconstructive surgeons. In its report to the Australian Health ministers' Advisory Council, the Medical Specialist Training Steering Committee noted:

> *There is growing concern in the community about the shortage of medical specialists. Additional medical school places have been created over the last few years to address this shortage, and this will further increase with the additional places announced for 2007.*
>
> *If an expansion of settings does not occur, it is likely that some existing settings will over-reach their capacity to train. Expanding the range of available training settings will assist in accommodating these graduates as they complete pre-vocational training and start specialist training.*[15]

The then NSW Minister for Health stated that there was a "critical shortage of plastic surgeons within the public health system".[16] 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.*
>
> *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*

[15] Medical Specialist Training Steering Committee, "Expanding settings for medical specialist training: a report to the Australian Health Ministers' Advisory Council". Canberra, ACT, Department of Health and Ageing, 2006. http://www.health.gov.au/internet/main/publishing.nsf/Content/work-edu-spectr-mstsc-rept-toc~work-edu-spectr-mstsc-rept-2~work-edu-spectr-mstsc-rept-2-3 (Accessed August 2009).

[16] The Hon Morris Iemma MP, NSW Minister for Health, Media Release, 1 June 2005.

Reconstructive Surgery.

These are highly specialised services that are primarily provided by private sector VMOs who have had limited capacity to increase their public hospital sessions". [17]

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".[18]

A contributing factor to these shortages is that doctors wishing to practice *solely* in cosmetic surgery must undergo training in Plastic and Reconstructive Surgery in order to avoid the competitive disadvantages detailed in the College's Application. In these cases, not only are they being publically subsidised to pursue a private vocation to a degree no other medical specialty enjoys, they are using limited training positions in the public hospital system to do so.

It is the view of the College that subsidising a doctor who has no intention of practicing in their specialty once he or she has obtained their qualification or, attracted perhaps by better financial remuneration in cosmetic practice, simply 'moves on' a few years after completing their training, is not an optimal use of limited health care resources. This is particularly so when an alternative private training pathway is available which will not adversely impact the public health care system to the same degree.

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 programmememe 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 public treasury.

The College has also argued above and in its Application that there will continue to be adverse economic impacts for health care resource allocation if the application for

[17] The Hon Stephen Robertson MP, Queensland Minister for Health, Media Release, 8 February 2006.
[18] The Hon Katy Gallagher MLA, ACT Minister for Health, Media Release, 21 May 2008.

recognition of the proposed specialty is not successful. Practitioners in existing AMC recognised surgical specialties have structural competitive advantages over practitioners whose qualifications have not and, without recognition, cannot be assessed for accreditation by the AMC.

The College does not contend that recognition is a substitute for regulation or that regulation cannot occur in the absence of recognition. Rather, recognition is a key component of the health care regulatory matrix. States, hospitals, medical boards and others use it as the basis upon which to confer prima facie legitimacy. And more critically, recognition is used as a proxy for good regulation.

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 is overwhelming and compelling and is provided in detail in the Application in Criterion IV. However, the College would be happy to provide additional examples should the review group request them.