Australasian Society of Maxillofacial Surgeons

02 October 2008

To : Dr John Flynn
CEO Australasian College of Cosmetic Surgery

RE: Recognizing the speciality of "Cosmetic Surgery"

Dear John,

I would like to add my comments in your proposal for recognition of the speciality of cosmetic surgery by the Australian Medical Council.

Oral and maxillofacial surgeons undertake a number of significant aesthetic procedures such as orthognathic surgery and genioplasty which is almost exclusively taught by our speciality. Other cosmetic procedures and skills have to be gained on an ad hoc basis.

There is an increasing trend for oral and maxillofacial surgeons who are doubly qualified i.e have dental and medical primary degrees to undertake facial as well as general cosmetic surgery here as well as in the USA and Europe. In the USA maxillofacial surgeons undertake the American Board of Cosmetic Surgery exam after taking additional fellowship training with the American Academy of Cosmetic Surgery. There is the increasing realisation that if we wish to practice in this field then formal didactic training must be undertaken with a recognized exit examination that is formally recognized in order that there is no disparity between the two forms of practice i.e cosmetic surgery and oral and maxillofacial surgery. If one side of my practice is of one standard with recognized training and accreditation and the other arm is not because "there did not exist in Australian law a reasonable pathway to obtain such a qualification", then there is a huge disparity within that practice .Our patients are therefore not receiving the same assurances about levels of training depending on whether they are a maxillofacial or a cosmetics patient "through no fault of the clinician".

There therefore must be recognized a speciality to be known as "Cosmetic Surgery" with recognized training pathways to standardise training and protect patients.

Advising our members to undertake a further fellowship in Plastic surgery is not a viable option because there is extensive overlap with maxillofacial training with subsequent redundancy of training. There is also no adequate training in cosmetic surgery within the plastics program as the training in plastics takes place in the public hospital system where no cosmetic surgery is carried out.

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I would therefore hotly contest the assumption that plastic surgery training provides the necessary skills in a formal program. These skills are acquired by plastic surgeons on an ad hoc basis after a plastics fellowship in the majority of cases. If I were confident that adequate training in cosmetic surgery is provided through the plastics route then we might have recommended a further plastics fellowship to our members.

This is why I strongly believe that a program such as the ACCS cosmetic surgical training program is ideally placed to formally establish these skills and to identify and be recognized as a cosmetic surgeon. Surgical mentors within the ACCS are without doubt the leaders in the field as unlike plastic surgeons they only practice cosmetic surgery on a full time basis. They therefore can assure trainees that they will be exposed to a sufficient volume of cosmetic surgery cases. This could not happen in a plastic surgery program.

Plastic surgeons cannot continue to claim that cosmetic surgery is their sole responsibility. It is plainly untrue to state such a fact. They cannot blindly assert that all other practitioners are unsafe. There has been a long precedence of plastic surgeons claiming that some surgical procedures can only be carried out by plastic surgeons. For instance they have a history of claiming that oral and maxillofacial procedures are within their sole remit and time and time again in Australia, the USA and Europe this has been successfully challenged. In fact today in the UK 70% of all oropharyngeal malignancy is managed by oral and maxillofacial surgeons despite a 50 year history of claims by the plastic surgeons that this surgery was within their sole remit. We have had numerous instances where a procedure for instance: orthognathic surgery has been developed by oral and maxillofacial surgeons who then taught these procedures to plastic surgeons in a collegiate and welcoming fashion only to have them attempt to hijack the procedures as within their sole remit. There are many other examples i.e hand surgery which is shared by orthopaedics and plastics. Medical boards cannot continue to be duped by these self interested claims.

In my opinion plastic surgery and cosmetic surgery are different specialities and should therefore be recognized as such. Once the speciality of "Cosmetic Surgery " is formally recognized by the AMC we as a society would like to cooperate with ACCS and other bodies including plastic surgeons if they will come to the table, to add input to a training pathway for cosmetic surgeons with a recognized exit examination. I note that ACCS faculty already includes plastic surgeons showing that the co-operative framework already exists.

The recognition of this new speciality in my opinion is long overdue and is the only way forward to protect and inform cosmetic surgery patients. The AMC must recognize the requirement, be unpartisan and move with the changing climate and increasing numbers of patients involved. To fail to do so will, I predict, only cause more divisions as market forces will prevail.

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Surgeries will be increasingly performed in an unregulated environment and mistakes will be made .The AMC will not be able to distance itself when, not if, this occurs. The AMC must also recognize that is a legal impossibility to enable only one group i.e the plastic surgeons to make cosmetic surgery their province alone.

Yours Sincerely,

Dr John S. Mc Hugh

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