Response Template – Organisations and Individual Practitioners

Consultation Regulation Impact Statement: Use of the title ‘surgeon’ by medical practitioners

OFFICIAL

This response template is for completion only by organisations and individual practitioners. Individual members of the public wishing to contribute a response must use this survey link https://cosmeticsurgeryaus.questionpro.com.au to ensure that the privacy and anonymity of consumer respondents is protected.

The Consultation Regulation Impact Statement (RIS) on medical practitioners’ use of the title ‘surgeon’ under the Health Practitioner Regulation National Law proposes various policy and legislative options to address potential issues identified with the current regulatory framework enabling use of the title.

A series of questions are included in the Consultation RIS for stakeholder response. Participants should note that it may not be possible or necessary to respond to every question provided.

For any questions regarding the Consultation RIS, please contact the NRAS Review Implementation Project Team at NRAS.Consultation@health.vic.gov.au.

Direct submissions privacy collection notice (workforce entities, other organisations and individual practitioners)

Participation in this consultation is voluntary and by providing your responses, you/your organisation will be taken to have provided consent for collection and use of the information provided. You/your organisation will also have the option of requesting that your submission remains anonymous.

The Department of Health (department) is committed to protecting your privacy. The department collects and handles the information you/your organisation provide/s in this consultation as part of a Consultation Regulation Impact Statement (RIS) process it is managing on behalf of all Australian health departments and the Australian Health Practitioner Regulation Agency (Ahpra).

When making a submission, you/your organisation will be asked to provide information about patients’ consumption of cosmetic surgical procedures. This information is not intended to compromise patient anonymity and will be used to better understand general social trends in patient access to cosmetic surgical procedures and patient outcomes.

Your/your organisation's feedback, including qualitative and quantitative data provided, will inform government decisions about regulation of the title 'surgeon' under the Health Practitioner Regulation National Law and contribute to the development of a Decision RIS for public release. It may, for example, lead to changes in the law that restrict which medical practitioners will be entitled to use that title.

The consultation requests information relating to cosmetic and/or other surgery and does not ask organisations to provide any identifying information about patients, practitioners or facilities. You/organisations are asked not to include such information in your/their answers.

Respondents should not include any identifying information such as information about patients, medical practitioners or facilities in responses, as reservations or concerns about the treatment patients may have received from a particular medical practitioner, or about a medical practitioner's conduct should be reported directly in a notification to Ahpra, or a health complaints commission or similar entity in the relevant state or territory.

Your/your organisation's feedback will be collected, analysed and interpreted by the National Registration and Accreditation Scheme Review Implementation Project Team (NRAS project team) on behalf of health ministers. It may also be disclosed to health ministers and the health departments of other states and territories for this purpose.

The NRAS project team will not publish an organisation's submission if that organisation requests that it remains anonymous but it may publish anonymised information provided by organisations in the Decision RIS. Your organisation may be identified in the Decision RIS, unless your organisation advises it wishes to remain anonymous. Where your organisation does not request to remain anonymous, your organisation's submission may be published by health ministers. Your feedback may be shared with other government entities, both in Victoria and other Australian jurisdictions.

Completion of submissions by organisations is voluntary. There are no consequences for non-completion or for providing submissions which address all or some of the questions presented.

For more information on the department's privacy collection practices, please refer to the department's privacy policy or visit our website on https://www.health.vic.gov.au/privacy.

The NRAS project team supervising the consultation can be contacted by emailing NRAS.Consultation@health.vic.gov.au or you may contact the department's Information Sharing and Privacy team by emailing privacy@health.vic.gov.au. You can request that changes be made to information you have been provided by contacting us using the above details.

Required fields	Required organisational responses
Organisation/Practitioner Name	Royal Australasian College of Surgeons (RACS)
Would you/your organisation like to remain anonymous in the Decision RIS for public release in the event data from the below responses is included? (Delete whichever is not applicable)	No

Required fields	Required organisational responses
Do you/does your organisation consent for its submission to be published online on release of the Decision RIS? (Delete whichever is not applicable)	Yes
Do you/does your organisation consent for collection and use of the information provided in this submission? (Delete whichever is not applicable)	I agree

Consultation RIS organisational responses

Consultation RIS questions	Organisational responses
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?	X
1.2 Prior to reading this RIS did you believe that cosmetic surgery is regulated in the same way as other surgery?	X
1.3 Does current regulation help you understand the differences between the regulation of cosmetic and other surgery?	X
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?	X

Consultation RIS questions	Organisational responses
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’?	X
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?	X
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?	X
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?	X
Public harm and risks that arise from the current regulatory regime	
4.1 Have you experienced difficulty getting cosmetic surgical	X

Consultation RIS questions	Organisational responses
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?	
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?	X
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?	X
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?	X
4.5 If corporatisation is more common in cosmetic surgery, is this is having any discernible effects on patient risk and harm?	X
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	X

Consultation RIS questions	Organisational responses
greater risk and harm to patients?	
4.7 Please provide any evidence you have about the volume of patients accessing cosmetic surgical procedures.	X
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.	X
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?	X
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?	X
4.11 Can you provide any information about whether Ahpra's public register of practitioners	X

Consultation RIS questions	Organisational responses
helps to address any identified cosmetic surgery regulatory issues?	
Available data: quantitative and qualitative	
5.1 Are the issues relating to title restriction accurately outlined in this RIS?	X
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?	X
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?	X
Options and cost-benefit analyses	
6.1 Do you support maintaining the status quo (Option 1)? Please explain why.	RACS does not support maintaining the status quo. The costs of the status quo are well outlined in the Consultation RIS. With RACS' focus on patient safety RACS would consider maintaining the status quo due to the 'benefits' outlined in the Consultation RIS - most of which are narrowly financial - to be verging on the unethical.
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	On balance, RACS does not support option 2.1 as a stand-alone action. Communicating to the public - in order to convey the meaning and significance of titles, and to raise safety awareness regarding cosmetic procedures – is good in principle. However as touched on in the Consultation RIS, in practice effective health campaigns are very difficult. Effectively conveying information about titling (without legislative change) would be particularly difficult because titling regulation is very complex. Trying to explain which titles are restricted or protected, and which are not, and which titles may be used in a way that is in breach of the law by some practitioners but not others, would be practically

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required to realise either or both sub-option/s?	impossible via a post on social media, or other public communications campaign, which would also have to be sustained and frequently repeated. A benefit of the approach advocated for by RACS is that it would make communicating who is allowed to use the title 'surgeon' a lot simpler. Were RACS' position agreed to by the Health Council, RACS would recommend an information campaign in this instance, as such a campaign is more likely to be practicable and successful. RACS does not support option 2.2. RACS is concerned that increasing provider liability for non-economic damages would be a step towards a US-style culture of litigiousness in healthcare, which Australians would not want to see imported into this country. As outlined in the 'costs' section of the Consultation RIS RACS is concerned that such changes would result in increases to the cost of professional indemnity insurance for medical practitioners, with the flow on effect of increased costs to patients.
6.3 Do you support strengthening existing mechanisms in the National Scheme (Option 3)? Please explain why.	While there is likely to be some value to be found in strengthening existing mechanisms, RACS does not support option 3 as a *primary* means of achieving reform and protecting patients. What exactly 'strengthening existing mechanisms' would mean is somewhat unclear, and could mean a great many things, some of which may in some way further the aims of the National Law, and some which may not. RACS notes that the concurrent 'Independent Review of the Regulation of Health Practitioners in Cosmetic Surgery' includes several areas for investigation within its terms of reference which may be considered as 'strengthening existing mechanisms', such as updates to codes of conduct, AHPRA investigation protocols and AHPRA risk assessments, amongst others. Whatever it means in practice, what 'strengthening existing mechanisms' will *not* do is prevent practitioners from advertising themselves to the public as surgeons when they do not have the guarantee of very high education and training standards that completion of an AMC accredited program in a surgical discipline brings. For many years, RACS and other stakeholders have argued that this needs to change. The time for making minor alterations to codes of conduct, AHPRA investigation protocols or AHPRA risk assessments, and claiming that these changes will solve the issue is past. Now is the time to act rather than wait for more surgical patients to suffer harm, having incorrectly assumed that the person carrying out the procedure had completed accredited surgical training.
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	*What a 'surgeon' is, for the Royal Australasian College of Surgeons* Becoming a surgeon is more than just being able to perform surgery or a particular surgical skill. Fellows of RACS and other similar surgical colleges around the world have long since moved on from just being technicians that perform surgery, to now being clinicians that care for patients through their healthcare journey. As an example a surgeon doesn't simply "cut ", but rather comprehensively cares for the whole patient; from the diagnosis, to counselling, advice, development of a treatment plan that may – or may not involve a surgical procedure, ensuring that alternatives to a proposed

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should option 4.1 or 4.2 be preferred?	treatment are discussed, and that if surgery is to proceed that the practitioner is the best suited and trained to perform that procedure, either by himself or herself, or as part of a wider more comprehensive team, and is able to care for the patient effectively post-operatively and deal with complications in a manner that safeguards patients. Worldwide, learned medical institutions have spent many years defining and elaborating on the essential attributes and skills that appropriately trained surgeons should acquire and master. These are now known as 'competencies' and were developed initially by the Royal College of Physicians and Surgeons of Canada and launched as the CanMEDS framework in 1996. This framework described seven roles that were considered integral in becoming a surgeon – Medical Expert, Professional, Communicator, Collaborator, Leader, Health Advocate, and Scholar. The framework was further refined in 2005, and again in 2015. Within each of these roles, there are several key concepts and enabling competencies that define the skills, attributes, and behaviours that should be present or acquired to become a safe and competent surgeon. The framework also includes the concept of 'milestones' that further define the various stages of development of these elements during training from transition into surgical training (junior residency), to transition to practice (becoming a surgeon), to advanced expertise. These concepts were adopted by many medical colleges throughout the world, including RACS, who then incorporated them into their own training processes. RACS expanded on these original seven competencies to develop the nine RACS Core Competencies in 2012. In addition to the original seven competencies, RACS added Technical Expertise and Clinical Judgement, recognising the critical necessity of these attributes to being a surgeon. In 2019 in recognition of the significance of health inequities on poor health outcomes, particularly in Indigenous communities – RACS added a tenth competency, 'cultural competence and cultural safety'. The ten competencies underpin all aspects of the specialty surgical training programs for which RACS has been accredited by the Australian Medical College (AMC) and provide a framework for the assessment of practising surgeons.[1] Each of the RACS specialty training programs take 5 or 6 years at a minimum to complete, on top of a standard medical degree. Mastering these competencies provides the physiological, ethical, psychological, pharmacological and medical expertise to safely diagnose, treat and manage surgical patients. This includes knowing the medical conditions that preclude surgery, awareness of associated conditions that will influence surgical management choices, managing appropriate referrals for complex care and performing all aspects of postoperative care including correcting complications. Thus, for RACS, to be a 'surgeon' is to have mastered these competencies. As was described above, internationally, medical colleges which train those

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	who undertake significant surgery aim for similar defined and elaborated attributes and skills. *Why use of the title 'surgeon' should be restricted* While the common understanding of what it means to be a 'surgeon' may not be as comprehensive as the above, the term carries weight with the public. The public at least expects those who use the title to have high standards of training and patient care, and probably expects that person to be nationally registered. Yet in Australia use of the term 'surgeon' is not restricted to particular medical practitioners who have successfully completed accredited training or met other registration standards. Around the country, numerous medical practitioners who have not completed RACS' training or other accredited high-level surgical training advertise themselves using 'surgeon' in their title. These are often in the cosmetic surgery sector. As the COAG Health Council noted in 2019, the lack of regulation of the term 'surgeon', 'can cause confusion among members of the public'. The public do not look at cosmetic surgery as "risk-taking", but some of it is. There have been numerous cases of patients suffering adverse outcomes, having undergone surgery by non-surgical specialist practitioners, for example as cited in the Consultation RIS. RACS thus believes the title 'surgeon' should be restricted, ideally to those who hold the defined and elaborated attributes and skills which are the international standard for appropriately trained surgeons, as described above. *How should the title be restricted, given the law which currently exists?* Despite this view, RACS would not at this time recommend legislating its competencies as the standards which a medical practitioner must meet to access the title, 'surgeon'. To do so would require a largescale re-engineering of the *Health Practitioner Regulation National Law* (National Law). Under the National Law access to a restricted specialty title is based on registration in a specialty with the Medical Board of Australia, rather than holding defined competencies. It is also possible that that the competencies required of surgeons may change over time. In RACS' view the key to accessing the title, as is the case for other restricted specialist medical titles, must be a qualification awarded following completion of a *relevant* accredited medical specialty program[1], and registration with the Medical Board of Australia in a relevant specialty. While the AMC's accreditation standards are not standards specific to surgery (rather they are common standards which are applied when

[1] Or if a specialist international medical graduate- successful completion of an assessment by a relevant accredited medical college.

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	assessing medical colleges from all specialties), their rigorous nature, and the rigorous processes used to apply them, mean that only medical colleges which provide training in their specialty that is of a high international standard, have their programs accredited. AMC standards are also applied to continuing professional development programs (CPD), which are a requirement for registration. *Which medical practitioners should the title be restricted to?* Aside from the surgical specialties for which RACS provides accredited training, there are three medical specialties which internationally, and in Australia involve regular, significant surgery within their scope. These three specialties are Ophthalmology, Obstetrics & Gynaecology, and Oral and Maxillofacial surgery (OMFS - this specialty is actually already classed as a surgical specialty by the Medical Board). RACS has not assessed the AMC accredited training programs and CPD of these three specialties[2] against its own ten surgical competencies. However, RACS is aware that each training program has a significant surgical focus and each has been accredited by the AMC. Like RACS' specialty training programs their training programs are 5 or 6 years in length (the OMFS program is 4 years but RACS' understands a full year of surgery in general (SIG) must be completed prior). As is the case with RACS' Fellows, to maintain their registration, those registered in these specialties must be up to date with continuing professional development programs which meet the AMC's standards. RACS understands that, as is with the case with RACS, accredited CPD for these specialties includes audit and peer review. Due to the fact that in Australia and internationally the recognised scope of these three specialties includes significant surgery, because the AMC's rigorous accreditation process ensures that only programs of a high international standard for a specialty are accredited, because of the extended period of the training programs, and because they all have high level mandatory CPD, RACS acknowledges that those who are registered in these specialties, hold the essential attributes and skills which make a surgeon. In other words, RACS accepts that medical practitioners registered in these specialties have the physiological, ethical, psychological, pharmacological and medical training and experience to safely diagnose, treat and manage surgical patients. With this background RACS' position is that patient safety must be enhanced by modifying current legal arrangements to: **Restrict use of surgeon as a title by itself and in combination with other qualifier or descriptor words to medical practitioners who have completed Australian Medical Council (AMC) accredited specialist training in the medical specialty of surgery, and are currently registered in the specialty. For clarity this does not refer to any**

[2] Provided by RANZCO, RANCOG, and RACDS respectively

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	training in surgery which may take place in a primary medical education program **Exceptions to this rule may be allowed for those in the following categories, in combination with the qualifier or descriptor words as described:** • **Those who have completed AMC accredited specialist training in obstetrics and gynaecology or ophthalmology (and are currently registered in these specialties) in combination with relevant qualifier or descriptor words which accurately describe their scope of practice – e.g. gynaecologic surgeon, ophthalmic surgeon** • **General practitioners in areas of need, where other medical specialists are less accessible, and when they have attained their qualifications via AMC accredited courses which include a significant surgical component (e.g. those provided via the 'Rural Generalist Pathway'), in combination with the words 'Rural GP/General Practitioner' i.e Rural GP Surgeon / Rural General Practice Surgeon** **Additional exceptions may be made for:** • **Professions for which there is little chance that the public may be misled or deceived into believing that a person in that profession provides human healthcare services – such as tree surgery or veterinary surgery.** • **Non-medical health specialties approved by the Health Council as of January 2021 whose titles include the word surgeon, as long as the full specialist title is used** RACS' position is not about 'protecting the turf' of RACS' Fellows. Implementing RACS' position would mean all AMC accredited Specialist Surgeons, whether or not they are RACS Fellows, would be able to use the term 'surgeon'. In addition, all registered 'Specialist Obstetric Gynaecologists', and all registered 'Specialist Ophthalmologists' would be able to use the term in combination with relevant 'qualifier' or 'descriptor' words, which accurately describe their scope of practice. For example, an Ophthalmologist would be able to advertise themselves as an 'ophthalmic surgeon', a retina surgeon, or an eye surgeon. *Why has RACS taken this position?* RACS has taken this position because it is appropriate that only those registered in specialties explicitly classed as 'surgical' specialties should have *unencumbered* access to use of the term surgeon. Also see footnote note about urologists[3].

[3] NB the specialties classed as 'surgical' specialties by the MBA in its July 2018 *List of Specialties, Fields of Specialty Practice and Related Specialty Titles* document, includes the specialty of urology, which it should be noted does not have 'surgeon' as part of its restricted title. Although the specialty title 'specialist urologist does not have 'surgeon' in it, whatever decision is made by the Health Council re use of the title 'surgeon', urologists must continue to have unencumbered access to use of 'surgeon' and/or be able to call themselves "urological surgeons".

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	At the same time it is reasonable that those who have completed AMC accredited training and are up to date with CPD in other specialties which have a significant surgical component be able to use surgeon in their titles, with appropriate descriptor words indicating scope of practice. Implementing RACS' position would mean that medical practitioners who have not demonstrated their surgical expertise by completing an AMC accredited training program in surgery, ophthalmology or obstetrics and gynaecology, would be prevented from advertising themselves to the public using 'surgeon' in their titles. The accredited advanced skills surgical training provided to GPs is not comparable to AMC accredited RACS SET training. However as rural GPs play an important role in rural communities by providing accessible health services RACS' position would enable rural GPs who completed the rural generalist pathway and have undertaken AMC accredited advanced skills surgical training, to use the term in combination with the words, 'Rural GP' or 'Rural General Practitioner' – i.e, 'Rural GP Surgeon' /'Rural General Practice Surgeon' and to practice within their scope and accreditation. RACS' position would also have the effect that the title 'podiatric surgeon' is maintained, however -'RACS does not believe that the current arrangements with regards to podiatric surgery training and professional standards are optimal. The accrediting authority for podiatric surgery training is not the AMC, despite the fact that the AMC accredits all other surgical training programs. Studies have found a variety of issues with podiatric surgery training and outcomes internationally, and training and professional standards for the specialisation are not being provided by a single body as they are in medical practice. To remedy these issues RACS believes the AMC should be made the accrediting authority assessing podiatric surgery training programs, and recommends that the AOA be consulted with regard to education required to undertake surgery in this area. In the case of foot and ankle surgery the training and education required for podiatric surgeons must be at the same level as has been established for orthopaedic surgeons in relation to foot and ankle surgery.' Restricting who can use 'surgeon' in the way RACS proposes would help prevent patients from undergoing surgery under a false assumption about the standard of training of the person carrying out the surgery. Restricting who can use 'surgeon' in the way RACS proposes would also help maintain public confidence in the high standards of Australia's health system. Implementing RACS' proposal would support the main aim of the *Health Practitioner Regulation National Law* of protecting the public, by guaranteeing that only those who have been trained to a very high standard can advertise themselves to the public using the term 'surgeon'. *What 'option' then does RACS support?*

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	RACs will leave the decision on whether 4.1 or 4.2 achieves the desired outcomes to Health Ministers and will not limit the potential of a combination of options being used to achieve the desired outcome. At the same time, RACS suggests that during future AMC accreditation processes for all speciality training programs which include a surgical component, RACS' *Surgical Competence and Performance Guide,* which details the ten surgical competences as RACS understands them, be used by assessment teams, to underpin the assessment. *A separate framework not necessary* RACS is aware of public claims that there is a 'gap' in RACS' SET programmes regarding cosmetic surgery, and hence; the need for a separate 'framework' for 'endorsing' providers of cosmetic surgery, rather than restricting access to the title 'surgeon'. The claim about cosmetic surgery is simply incorrect. In the public mind cosmetic surgery is often thought of as encompassing a discrete collection of procedures, albeit very different ones, such as breast enhancements and rhinoplasty. Yet cosmetic objectives – the restoration or enhancement of aesthetic form and texture - is an important, if not always primary, objective of all surgery. Whether a surgeon is undertaking functional surgery or tumour surgery, there is always an aesthetic component to the operation; the surgeon will always seek the best aesthetic outcome possible for the patient. Achieving the best cosmetic/aesthetic outcomes comes down to physiological, ethical, psychological, pharmacological and medical expertise as well as surgical technique and an understanding of how to handle tissue, as well as looking after the patient post-operatively. Only 5- or 6-year accredited training programs in specialties which include a significant surgical component within their scope are guaranteed by AMC accreditation to train medical practitioners to very high standards in these areas of expertise. As noted, there is always a cosmetic/aesthetic component to an operation, although there are several surgical fields for which aesthetic outcomes are usually a core objective of procedures. These include: • Plastic Surgery • Otolaryngology • Ophthalmology • General Surgery • Urology (Urological Surgery) • Gynaecology • Paediatric surgery Different fields of specialty practice training programs usually focus on different parts of the human anatomy. For example, nose surgery is obviously a focus in the training program for Otolaryngology. Rhinoplasties are often sought for cosmetic purposes. The specialty of plastic surgery is a technique and process surgical specialty with relatively broad scope. RACS' plastic SET program includes topics on many of the procedures in the

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	domain of cosmetic surgery, such as breast procedures, facial surgery, gender affirming surgery, laser surgery, injectables and body contouring surgery. Other RACS, RANZCO and RANZCOG surgical specialty training programs also cover various of these procedures, as well as other procedures for which aesthetic outcomes are a core objective. The specific claim about a cosmetic surgery training 'gap' is based on a 2017 AMC accreditation report. This report raised a concern about the exposure of RACS surgical trainees to aesthetic surgery in the Plastic and Reconstructive Surgery program. This issue was caused by the fact that, *at the time*, Commonwealth government funding to several trainee positions in private hospitals was under threat. Subsequently all but one training position secured alternative funding and no compromise to training in aesthetic surgery occurred. The concern was fully addressed and resolved, and any suggestion that the concern remains current is inaccurate. The 2021 AMC accreditation report has no mention of a gap. Also as described in detail above, aesthetic outcomes are a focus of all surgical training programs, and talk of a 'gap' somewhat overlooks this fact. However, the argument goes that, because of the claimed 'gap', a separate 'framework' to accredit (or endorse) all medically qualified providers of cosmetic surgery procedures' should be set up. Without a 'gap' there is little reason to set up a separate framework for endorsement of cosmetic surgery. A framework for endorsing cosmetic surgery practitioners which required 5 – 6 years of surgical training at the level undertaken by trainees in AMC accredited surgical programs would be little more than a duplication of an already existing, rigorous system. As has been described all surgeons who have met the standards for fellowship of RACS (as well as, RACS understands, graduates of OMFS, Ophthalmology and Obstetrics & Gynaecology accredited programs) have received rigorous, world class, AMC accredited training with a strong focus on aesthetic outcomes, with different specialties having received specific training in different procedures commonly understood as the domain of cosmetic surgery. An endorsement framework which did *not* require 5 – 6 years of surgical training at the level undertaken by trainees in AMC accredited programs for specialties with a significant surgical component, and not underpinned by the 10 core RACS competencies would be a framework with lower standards than the existing AMC accreditation system. Surgery for cosmetic/aesthetic purposes, as in all surgery, has risks, complications, and failures. A framework for endorsing those who undertake cosmetic surgery against a lower standard than is currently the case should not be an outcome that results from this consultation process.

Consultation RIS questions	Organisational responses
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?	Were the National Law amended to align with RACS' position, RACS would recommend that an information campaign be launched so as to educate the public about the new, and simpler, regulation of the title surgeon. In this environment the public would hopefully be more alert to the incongruity of a practitioner who advertised cosmetic surgical services, but who did not describe themselves using the term 'surgeon'. In such an environment it may be more difficult for practitioners who cannot use the title surgeon to imply they have completed accredited training.
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?	Were the title 'surgeon' restricted, to access the title, specialist medical practitioners who had obtained their qualifications overseas would need to complete a Specialist International Medical Graduate pathway as is currently the case to access the current surgical restricted titles. RACS considers this appropriate.
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?	As described in the Consultation RIS, information asymmetry between practitioner and patient is a key problem with the status quo. This reform, particularly if implemented in combination with an information campaign, may result in patients asking more questions of practitioners proposing to undertake surgery. If information campaigns focused on the new importance of the term 'surgeon', it would seem likely that patients would be particularly questioning of practitioners who did not use the title 'surgeon'. This would hopefully lead patients to gain more information about the doctor proposing to undertake cosmetic surgery and in so doing lead to reduced information asymmetry. If patients were not satisfied with the information they gained about their medical practitioner's qualifications and expertise, they would then of course have the option of seeking out another medical practitioner, if they choose – one able to advertise themselves as a surgeon.
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?	Specialist Surgery training positions are already highly sought after, with the number of training positions not being established by RACS/other medical colleges, but by health systems, with hospital training post accreditation by RACS. Were the title restricted it is conceivable that it may in a small way increase the number of people applying to training programs, but without additional decisions by health systems, the number of training posts would not increase. RACS however would support applications for increased training numbers as long as the training position provided sufficient exposure and supervision for the trainee to progress to achieving the 10 competencies required currently.
6.9 Should any options be implemented alongside other options, as a package? If so, please	As has been mentioned previously it is RACS' view that RACS' position, should be implemented as a package with option 2.1 – a major information campaign.

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explain why this would be ideal and how any potential impediments might be overcome?	As described in response to question 6.2, a benefit of the approach selected by RACS is that it would make communicating who is allowed to use the title 'surgeon' a lot simpler.
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?	When patients go abroad for surgery it seems likely that they will already be cognisant of the possibility that standards may be different than in Australia. It seems reasonable to assume that restricting access to the title surgeon in Australia will lead to a greater understanding of surgical qualifications and reinforce public confidence in the very high standards of Australia's health system. It may be that, more aware of surgical qualifications and more aware of the potential difference in standards between Australian and some other jurisdictions, some Australians who would otherwise have considered travelling abroad for surgery, will stay at home.
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.	RACS is particularly concerned about option 2.2 for the reasons outlined above in response to question 6.2. RACS is also concerned about option 3. While there may be some value from strengthening existing mechanisms in the National Scheme, RACS is concerned that easier changes - for example changes to codes of conduct, AHPRA investigation protocols or AHPRA risk assessments, may be used as a justification for not moving forward on the reform which is needed – restricting access to use of the title surgeon. For too many years this reform has been put off. Now is the time to act to ensure the safe delivery of surgical care and procedures, when clinically appropriate, to the Australian public.
Additional comments	
Please include any additional comments or identified risks that you believe should be considered by health ministers.	X

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76096-698-0 (online/PDF/Word) or (print)

Available at Medical practitioners’ use of the title surgeon under the National Law, Engage Victoria <https://engage.vic.gov.au/medical-practitioners-use-title-surgeon-under-national-law>