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

Response Template – Organisations and Individual Practitioners

Required fields	Required organisational responses
Organisation/Practitioner Name	Royal Australian College of General Practitioners (RACGP)
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
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 - RACGP 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?	Any medical doctor who has an MBBS or equivalent recognised qualification leading to medical registration, who is a member of a postgraduate college, and has a predominantly surgical practice and /or Fellowship of the Royal Australasian College of Surgeons or equivalent overseas qualification as determined by the Royal Australasian College of Surgeons (RACS).
1.2 Prior to reading this RIS did you believe that cosmetic surgery is regulated in the same way as other surgery?	~
1.3 Does current regulation help you understand the differences between the regulation of cosmetic and other surgery?	~
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?	The potential harms associated with cosmetic surgery are related to the degree to which the competencies held by the practitioner match the scope of practice, which needs to be regulated through training. The potential harms are lower than for other types of surgery, as the patients tend to be younger and have fewer co-morbidities than in medical surgery.

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	Cosmetic surgery procedures are substantially easier to perform than medical surgeries technically (excess skin excision, silicone implants etc) all taking place outside of body cavities. The harms are no greater than other areas of medical practice if the healthcare practitioner has appropriate training within their speciality's scope of practice.
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'?	Yes.
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?	Not applicable.
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?	While there are anecdotal cases, as cosmetical surgical procedures are not regulated it is difficult to gauge the effectiveness of the current guidelines, laws and regulations.
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?	The RACGP is aware of Ahpra's register of practitioners, however its utility in this context is limited as 'surgeon' is not a protected title and it is not clear what exactly is to be expected from the proceduralist.
Public harm and risks that arise from the current regulatory regime	
4.1 Have you experienced difficulty getting cosmetic surgical practitioners to explain professional title, the risks and rewards of surgery, and their capacity to perform a given procedure? Was this more difficult than with other surgical practitioners?	Not applicable.
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	The RACGP recognises that harms and complications can occur in any medical field. Members of the RACGP are aware of anecdotal and isolated evidence of adverse events from people practising beyond their scope, but it cannot be quantified.

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competence? Can these harms and complications be quantified?	
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?	~
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?	The administration of corporates is quite variable depending on the internal governance of the individual corporate, with some better internally regulated than others.
4.5 If corporatisation is more common in cosmetic surgery, is this is having any discernible effects on patient risk and harm?	Corporate decisions are necessarily at a distance from the doctor-patient relationship. Corporatisation may add to the risk of commercial decisions overriding safe care.
4.6 Can you provide evidence to show that financial incentives are attracting medical practitioners to the field of cosmetic surgery? If financial incentives exist, is this leading to greater risk and harm to patients?	~
4.7 Please provide any evidence you have about the volume of patients accessing cosmetic surgical procedures.	~
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.	~
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?	The GP as a steward of the healthcare system, and coordinator of care, provides a level of accountability on the part of the GP and a level of protection against a patient entering unsafe or inappropriate care. Direct access to surgical proceduralists by patients is hazardous as patients are unlikely to have the knowledge of the surgical proceduralist to make an informed decision and if it is a medical reason then, GPs can refer to a plastic surgeon.

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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?	~
4.11 Can you provide any information about whether Ahpra's public register of practitioners 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?	The RIS muddles titles with competency, which are different things.
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?	As a GP, it is possible to check practitioner qualifications and experience; and talk to other referees.
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?	~
Options and cost-benefit analyses	
6.1 Do you support maintaining the status quo (Option 1)? Please explain why.	The RACGP supports introducing changes that will increase patient safety and care. In previous responses on this issue, we have advocated for increased public education and increased regulation around cosmetic surgery, including seeking clarity in the use of titles. There is sufficient basis to be concerned that the status quo poses particular risk of compromised patient safety, and so amendments should be considered, and this option is not supported.
6.2 Do you support implementing alternatives such as Options 2.1 or 2.2 to amending the National Law? Do you support implementing one or both? Please explain why. If this option is preferred, what reforms or initiatives would be required to realise either or both sub-option/s?	~

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6.3 Do you support strengthening existing mechanisms in the National Scheme (Option 3)? Please explain why.	~
6.4 Do you support restricting the title 'surgeon' under the National Law (Option 4)? Please explain why. If option 4 is preferred, which medical practitioners should be eligible to use the title 'surgeon', and why should option 4.1 or 4.2 be preferred?	As a principle the RACGP does not support efforts to diminish the role or skills of GP specialists as a mechanism to regulate unqualified practitioners. The use of the title 'surgeon' should be dependent on certified completion of approved training and demonstrated required competencies. While this requires legislation, restricting access to this scope of practice only to those who undertake RACS training poses no advantage to patient safety. We are supportive of option 4.2 as it enables clinicians with primary specialisations of dermatology and general practice to undertake additional training that is sufficient to hold the required competencies and therefore hold the title 'surgeon'. We note the RIS clarifies that option 4.2 enables 'specialist medical practitioners who have undertaken substantial surgical training – such as dermatologists, specialist GPs, obstetricians and ophthalmologists would be able to continue to use the title 'surgeon'; and that it 'will not restrict medical practitioners' existing scope of practice, allowing practitioners to practise competently and within the scope of their qualifications and skills.' We support inclusion of the specialities of general practice, dermatology, obstetrics and gynaecology and ophthalmology, but also encourage flexibility in this approach to account for future developments in GP surgical knowledge and skills. The term "GP-Surgeon" should be allowed and protected for those in the RACGP or Australian College of Rural and Remote Medicine (ACRRM) who have completed the relevant training – Fellows of the Advanced Rural General Practice (FARGP) qualification who have completed the Surgery – Advanced Rural Skills Training (ARST) should be eligible to use the title 'surgeon' and practitioners with the FACRRM qualification who have completed the Surgery Advanced Skills Training (AST). Registrars and GPs who have completed their Surgery ARST with the RACGP will have completed a minimum of 12 months (full-time equivalent) supervised surgical training in an accredited training post. Accredited posts must be approved by the RACS and include direct supervision by a Fellow of the RACS throughout the training period. The numbers of GPs who have gained their surgical skills through fellowship with either the RACGP or ACRRM are small, but their role is often vital to providing essential services in rural communities who don't have access to a full surgical team.
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?	The protected title of surgeon enables clear communication to the public about a medical practitioners' qualifications. The RACGP suggests use of terms such as "Cosmetician" and "Dr", and not surgeons as alternatives for providers of cosmetic surgical services. Restriction of these titles alone will not be sufficient. There needs to be public education as to what these titles mean.
6.6 What other impacts will restricting the title 'surgeon' have on surgical specialists and other medical practitioners, including those who	In the event of restrictions on the use of the title 'surgeon' being introduced, and the current processes involving RACS in the assessment of overseas qualifications are followed, only suitable qualified surgeons would be admitted for practice in Australia.

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obtained their qualifications overseas?	This would be no different to the current system and therefore unlikely to have any impact on the assessment of overseas qualifications.
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?	There may be a reduction in the availability of services due to decreased supply and increased costs, but this is unlikely to impact upon the demand for services. Increased demand may lead to a growth in surgical 'holidays' overseas.
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?	~
6.9 Should any options be implemented alongside other options, as a package? If so, please explain why this would be ideal and how any potential impediments might be overcome?	The RACGP supports efforts to increase patient safety through public education, which communicates who performs surgery, what the relevant qualifications mean and how to find out the qualifications of the cosmetic service provider. Greater transparency in the publication of the complication rates of different practitioners irrespective of their qualification and titles would assist with our understanding of potential risk.
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?	~
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.	While we are supportive of option 4.2, we consider option 4.1 would impact GP proceduralists, particularly in rural areas. We recognise that groups this proposal is likely to impact include: • GP-Surgeons and other GP proceduralists (such as GP-Obstetricians and GP-Anaesthetists) • IMG Surgeons who can currently use the title without being a Fellow of RACS if APHRA approves. It is very important that these individuals and their communities are not negatively impacted, and certain surgical procedures can still be performed by appropriately trained medical practitioners, for example, GPs, rural generalists, dermatologists and obstetricians. Large parts of Australia have very limited access to surgical services and in many of these areas GPs are often the specialists available to manage patient care. GPs providing surgical services make an important contribution to comprehensive care in communities, with the potential to reduce the need for patient travel and the waiting times for surgery.

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	In addition, patients can have their specialised care delivered by a medical practitioner with whom they have an established and trusted therapeutic relationship. The procedures that these GP-Surgeons can perform are determined by the individual practitioner's training, accreditations, and the local infrastructure and support services available to them. These doctors provide access to important, high quality, safe surgical procedures, and these must be maintained for the benefit of the Australian community. The impact and consequences of the proposed options need to be broadly evaluated.
Additional comments	
Please include any additional comments or identified risks that you believe should be considered by health ministers.	~