The Australasian College of Cosmetic Surgery

Raising Standards, Protecting Patients

Proposal to reduce confusion and enhance safety for patients seeking cosmetic surgery in AUSTRALIA

Key Points

The Australian Medical Council (AMC) does not accredit or assess the training or competence in cosmetic surgery of any medical practitioner in Australia including specialists in plastic and reconstructive surgery. The latter, according to the AMC, "have a gap in this area of practice" when qualifying as specialist plastic surgeons.

To properly protect the public and allow them to make better informed choices, there is a need for an accreditation standard for all medical practitioners providing cosmetic surgery.

This proposal details how this can be achieved utilising the existing Australian Commission on Safety and Quality in Health Care's "Standard for Credentialing and Defining the Scope of Clinical Practice".

Attempts to protect patients by restricting the title "Cosmetic Surgeon" without the creation of such an accreditation standard, will not protect the public and may cause them to them to believe erroneously, "surgeons" offering cosmetic surgery are necessarily trained and competent in it.

Only practitioners who are unable to demonstrate training and competence in cosmetic surgery, or who seek a special advantage for their particular group, should have reason to object to the adoption of the accreditation standard.

The problem:

No agreed consistent method of accreditation for medical practitioners performing cosmetic surgical procedures currently exists. This causes confusion for the public, the media and even for regulators and can result in patients making choices that may put their safety at risk.

Any medical practitioner may call himself or herself a "cosmetic surgeon". Some cosmetic surgeons have expertise by virtue of training, qualifications and experience, others may not. For example, Fellows of the Australasian College of Cosmetic Surgery are formally trained and qualified by examination in cosmetic surgery (see Appendix A [1]), undertake mandatory continuing medical education in cosmetic surgery and are subject to the College's ACCC authorised Code of Conduct and its Disciplinary Committee.

Similarly, some plastic surgeons, because of extra private training undertaken after qualifying as plastic surgeons or because of long experience, are expert in cosmetic surgery but some are not. Despite the frequent and longstanding claims to the contrary from the Societies who represent plastic surgeons in Australia, the Australian Medical Council (AMC) "recognised" specialist qualification in plastic and reconstructive surgery, FRACS (Plast), does not include cosmetic surgery.

The AMC has not assessed the plastic and reconstructive surgery training programme for cosmetic surgery nor does it "recognise" the qualification as being a specialist endorsement for cosmetic surgery. The AMC has acknowledged in its 2017 report that cosmetic surgical training in the program is virtually non-existent,

"**There is currently a deficit in the experience available to trainees with regard to aesthetic surgery which is a significant part of plastic and reconstructive surgery practice, but not often available in public hospitals. Currently the training sites have difficulty providing aesthetic surgery experience for their trainees, and so those graduating from the training program will have a gap in this area of practice.**" *(Source: Accreditation Report: The Training and Accreditation Programs of the Royal Australasian College of Surgeons, The Australian Medical Council, December 2017, p. 123. Available at http://www.amc.org.au/files/ef7bd6c663d9760da00bcd7001717543646d8c46_original.pdf)*

Appendix A provides further evidence about training in cosmetic surgery for plastic surgeons and others. It also contains a tragic example of how a lack of cosmetic surgery specific training can be fatal.

The AMC process for the recognition of a new surgical specialty effectively precludes cosmetic surgery, so using the specialist register to determine cosmetic surgery competence now or in the future cannot be relied upon.

Claims data from the medical indemnity providers and complaints data from the relevant state bodies indicates that ACCS and FRACS surgeons have similar rates and therefore the premise that "plastic surgeons are safer" than appropriately trained cosmetic surgeons is simply not correct. In fact, the only "evidence" for this assertion are the claims of the organised plastic surgery societies and their parent College which provides their specialist qualification. They argue not only that their qualification offers a guarantee of training, competence and safety in cosmetic surgery, but also it is the only qualification that does so. In short, they define competence as being one of them and vice versa. **The evidence from the AMC report together with other independent evidence detailed in Appendix A, proves this is not true and highlights the risk to the public of such disinformation.**

It is because of this unilateralism that all attempts to better protect the public by creating an objective and evidence based accreditation system for cosmetic surgery have failed, dating back to the NSW Credentialing Council created by the 1999 Walton Enquiry. Appendix B summarises the recommendations of the Walton Enquiry and Appendix C, prepared by a member of that Credentialing Council, describes how the Council was structured and how it was unable to provide an accreditation system because of a combination of stakeholder self-interest and inherent bias in its composition. In short, RACS and its plastic surgical affiliate societies would not agree to any outcome unless it gave them a monopoly and they had enough votes to prevent any other outcome.

A solution:

The ACCS believes an opportunity now exists for the Health Ministers to bring together plastic surgeons from RACS, cosmetic surgeons from the ACCS and other stakeholders to develop a system of accreditation that will favour no particular group but will provide better and safer outcomes for patients.

A framework to accredit all medically qualified providers of cosmetic surgery procedures.

The purpose is to remove confusion for consumers thereby allowing them to make better-informed, and potentially safer, choices.

A joint working party to be set up at the direction of the Minister. Equal representation for the ACCS and RACS plastic surgeons, represented by one of RACS' relevant plastic surgery sub groups, the ASPS or the ASAPS. Independent chairperson acceptable to both groups, ideally a lawyer. A wider

stakeholder group is preferred but it is essential that structural bias be avoided by appropriate terms of reference. Appendix B is relevant in this respect. If the process is not to fail again and patients are to be genuinely protected, **any terms of reference must ensure that no group is over-represented and individual stakeholder self-interest is not allowed to subvert the objective assessment of a practitioner's competence.**

We suggest the terms of reference include developing a system and standard to identify those practitioners who have relevant training, qualifications, recertification and experience specifically in cosmetic surgery procedures. Any standard developed **should not require as a threshold criteria the qualification or membership of either the ACCS or RACS.**

To avoid bias and ensure only competent practitioners are accredited, the new standard should be underpinned by the **existing Australian Commission on Safety and Quality in Health Care's "Standard for Credentialing and Defining the Scope of Clinical Practice"** appropriately modified for cosmetic surgery. This is to ensure that the credentialing process is unbiased and does not favour any particular group of surgeons. Some examples:

The ACSQH Standard requires that credentialing committees: ***"ensure that the threshold credentials are based on objective criteria about the necessary period and character of training and experience, rather than the possession of specific endorsements or accreditation by named professional colleges, associations, or societies;"***

Principle 6 of the Standard mandates *"**the assessment of a medical practitioner's competence, performance and professional suitability to provide services in specific organisational environments, and of organisational capability, should always be contributed to by peer medical practitioners with relevant experience in similar organisational environments**. For example, processes of credentialing and defining the scope of clinical practice of rural general practitioners should always be contributed to by peer general practitioners with relevant rural experience."*

Another excerpt from the ACSQH Standard: Credentialing committees should, *"Where appropriate, seek the recommendations of the relevant professional college, association or society in relation to the period and nature of the training and experience necessary to develop competence and high level performance in specific positions or in specific clinical services, procedures or other interventions;"* and

"Ensure that the threshold credentials address the minimum education (e.g. medical qualification), formal training (e.g. residency, fellowship, continuing education or other relevant training), clinical experience (e.g. years in independent practice, numbers of clinical services, procedures or other interventions performed), leadership experience (e.g. years in clinical leadership positions), teaching and training experience, research experience and communication and teamwork skills required for the specific position, clinical service, procedure or other intervention;"

If this proposal meets with the Minister's approval, the ACCS commits to working cooperatively and objectively with RACS plastic surgeons and others to develop an accreditation standard that will enhance protection for patients. The ACCS strongly believes that the development of such a standard will not only better protect patients but will also provide clarity for regulators and benefit the profession by engendering increased public confidence in the training, competence and safety of all practitioners of cosmetic surgery.

Appendices:

Appendix A -	Training and qualifications in cosmetic surgery.
Appendix B -	Summary of the recommendations of the Walton Commission of Enquiry into Cosmetic Surgery.
Appendix C -	Composition of the former NSW Credentialing Council for Cosmetic Surgery and the events which led to its failure.
Appendix D -	How the Australasian College of Cosmetic Surgery has contributed to raising standards to protect patients since 1999.

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Appendix A

Training and qualifications in cosmetic surgery

1. A Fellowship in cosmetic surgery from the Australasian College of Cosmetic Surgery (FACCS) requires a minimum of seven years of post-graduate training, five of which involve surgical training including two entirely devoted to cosmetic surgery. Fellowship requires the candidates to pass three separate examinations. The College has also developed a cosmetic medicine training program for cosmetic physicians which leads to a fellowship qualification of the College's Faculty of Medicine – FFMACCS, also by examination.

2. The title, "cosmetic surgeon" may be used by any medical practitioner. It is not a restricted title because cosmetic surgery is not recognised specialty. In reality there are cosmetic surgeons in Australia with extensive training, specific qualifications and world class expertise and there are others with deficient training and skills and no relevant postgraduate qualifications. The same disparity exists for the cosmetic surgical training and skills of plastic and reconstructive surgeons. Some are expert and some are not because qualification as a plastic surgeon alone is not a guarantee of cosmetic surgical training or competence (see points 4-9 below).

3. Further confusion exists because specialist surgeons from other disciplines may choose to practice cosmetic surgery. These include ENT surgeons (who are often referred to as "facial plastic surgeons), maxillo-facial surgeons, general surgeons and obstetricians and gynaecologists. Again, some of these may have obtained relevant cosmetic surgery expertise and competence, others may have not done so. What is certain is that none received cosmetic surgery training or assessment as part of their Australian Medical Council (AMC) accredited specialist quaification.

4. The required post-graduate training for plastic and reconstructive surgery is approximately seven years (not ten as is often claimed) including medical internship and four to five years of plastic surgery training almost completely in the public hospital system. Cosmetic surgery is performed in the private health care system, not in the public system, and as a consequence there is little or no exposure to cosmetic surgery in the plastic surgery training programme.

5. The AMC has recognized this in its 2017 report on specialist training, **"There is currently a deficit in the experience available to trainees with regard to aesthetic surgery which is a significant part of plastic and reconstructive surgery practice, but not often available in public hospitals. Currently the training sites have difficulty providing aesthetic surgery experience for their trainees, and so those graduating from the training program will have a gap in this area of practice."** [1] This was confirmed by former Australian Society of Plastic Surgeons director and surgical educator, Professor Peter Haertsch when interviewed by Channel 9: **"I was on the Board of the Society with respect to the training program and organising training and there was not one skerrick of time given to cosmetic surgery and I thought this was rather hypocritical and I left them."**

6. So no recognised specialist surgical qualification in Australia, including FRACS(Plast), has been assessed, recognized or endorsed by the AMC for any cosmetic surgery component. It specifically does not qualify a plastic surgeon as a specialist in cosmetic surgery. Those plastic surgeons who are expert in cosmetic surgery have acquired this competence after qualification as a plastic surgeon either by undertaking further private training or by trial and error in private practice.

7. Misleading claims about training in cosmetic surgery by specialist plastic and reconstructive surgeons are not unique to Australia. Similar examples have been uncovered in countries with comparable health systems such as the UK, where in 2008 the Department of Health warned patients that a practitioner's qualifications in plastic and reconstructive surgery ***"may not indicate that they have received any special training in cosmetic surgery, or that they have experience in doing cosmetic surgery or [in a] particular procedure".***

8. The immediacy of this risk to patients was echoed in a 2010 warning by the UK's National Confidential Enquiry into Patient Outcome and Death, which warned ***"The present reliance on inclusion on the specialist register does not give any assurance that a surgeon has received adequate training in cosmetic surgery".***

9. The consequences of misleading claims can be fatal. Lauren James was a healthy young woman who died following a liposuction procedure in Victoria. Her plastic surgeon was a respected expert in reconstructive surgery but was unable to provide to the Coroner evidence of formal training in liposuction. The coroner determined her death would have been avoidable had the surgeon been able to distinguish what was and what was not normal following a liposuction procedure. The coroner specifically noted that "irrespective of a practitioner's provenance or primary qualifications, there was a need for specific training and experience in performing liposuction surgery".[2] Liposuction requires specific training to understand the procedure, patient selection and, critically and as clearly demonstrated in the case of Ms James, *recognition and management of post- operative complications.*

10. The ACCS has for more than a decade, outside of its Fellowship programme, provided surgeons and other medical practitioners with appropriate surgical experience, formal training and qualification in liposuction.

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[1] Accreditation Report: The Training and Accreditation Programs of the Royal Australasian College of Surgeons, The Australian Medical Council, December 2017, p. 123. Available at http://www.amc.org.au/files/ef7bd6c663d9760da00bcd7001717543646d8c46_original.pdf

[2] Finding into death with inquest: Inquest into the death of Lauren Katherine James, Coroners Court of Victoria, 6 August 2010, Ct ref: 300/07, p. 11.

Appendix B

Copy of the summary of the recommendations of the Walton Commission of Enquiry into Cosmetic Surgery

General safety and quality issues

Cosmetic surgery credentialling

1a. A Cosmetic Surgery Credentialling Council (CSCC) be established for all registered providers of cosmetic surgery procedures to provide independent and accountable verification of qualifications and training. The Council would have the following features:

- provision of reliable information for consumers;
- peer review, but independent of any particular guild or registration body;
- industry funding, based on membership fees or subscriptions;
- voluntary membership, not affecting practitioners' rights to practice;
- effective sanctions for members who fail to comply with credentialing requirements, including loss of credentials and publishing the provider's name where appropriate.

1b. The CSCC expand membership to include unregistered providers of cosmetic surgery procedures within two years.

2a. The CSCC establish credentialing committees of peers to make credentialling decisions. The credentialling process would be based on the following principles:

- peer responsibility for credentialling on a non-discriminatory basis that requires the same standards for all providers, regardless of background training or speciality;
- published requirements for credentialling;
- procedural fairness, including an appeal process for review of unfavorable decisions and a procedure for resolving conflicts of interest.

2b. Credentials will be renewed regularly (two to three years) and will require:

- demonstration of continuing professional indemnity insurance;
- compliance with codes of conduct on advertising, informed consent, appropriate patient/client selection, and financial disclosures; and
- satisfactory participation in a systematic audit process for activity and outcomes.

3a. The Department of Health sponsor and set up the Cosmetic Surgery Credentialling Council.

3b. The structure and membership of the CSCC be representative and accountable to all stakeholders in the industry.

Licensing of doctors' rooms

4a. Amend the *Private Hospitals and Day Procedure Centres Act* and the *Day Procedure Centre Regulation* to require licensing for facilities where medical procedures are performed using local anaesthetic and sedation. New risk factors should be recognised under the Act including level of drugs and drug combinations, patient assessment and selection, adequate provision for recovery and discharge, and risks associated with lasers. (majority view)

4b. The licence should be conditional on certification by a third party accreditation body, provided on a fee-for-service basis.

4c. Consistent with the *Private Hospitals and Day Procedure Centres Act* and regulations, medical practitioners with licenced facilities should be required to:

- maintain records of surgical procedures and drugs administered including, type of procedure, duration, adverse events and post-operative care; and

- notify NSW Health if the procedure results in death or removal to a hospital within 72 hours of cosmetic surgery or a cosmetic medical procedure.

4d. Amend the *Medical Practice Act, Nurses Registration Act* and *Dentists Act* to deem non-compliance with licensing and reporting requirements unsatisfactory professional conduct.

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Appendix C

Composition of the former NSW Credentialing Council for Cosmetic Surgery and the events which led to its failure.

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Former member of the NSW Cosmetic Surgery Credentialing Council.

Following the Commission of Enquiry into Cosmetic Surgery, chaired by Commissioner A/Prof. Merrilyn Walton from March 1999 to October 1999, on which I had the honour to serve as a member, that enquiry recommended the setting up of a NSW Cosmetic Surgery Credentialing Council the terms of reference of which, can be found in Appendix B.

The then Minister of Health, The Hon. Craig Knowles proceeded to ask the AMA to set up the NSW CSCC which duly met. Its membership (detailed below) comprised 14 members and a Chairman. Of the 14 Committee members 7 were FRACS (Fellows of the Royal Australasian College of Surgeons) or FRACS aligned & 7 were non FRACS. Of the 11 medical practitioners on the Committee, only 4 were not FRACS or FRACS aligned. The Australian Society of Plastic Surgeon (ASPS), the Australian Society of Aesthetic Plastic Surgeons (ASAPS), are societies comprising solely of RACS accredited plastic surgeons. By giving each organization a seat on the council plastic surgeons received 3 votes instead of one.

The chairman was also FRACS and almost certainly would have suffered at least unconscious bias against the non FRACS component of the committee. Nevertheless, he appeared to act impartially at all times.

Because of the inherent bias and stakeholder self-interest, a fair and objective outcome to enhance patient safety was unable to be agreed and the Council delivered nothing. In the hope of avoiding these problems in the future, here follows a summary of those events:

At its meeting held on Monday 22 July 2002, the Cosmetic Surgery Credentialing Council of New South Wales passed the following motion:

"In summary, practitioners performing Category I procedures (significantly invasive procedures including for example facelifts, breast augmentation and large area liposuction) would be credentialed by the CSCC if they hold an appropriate surgical qualification from an Australian

Medical Council (AMC) accredited training body (with its prescribed CME processes) and be credentialed for cosmetic surgery by an appropriate institution (eg. approved by the AMHAC). Those practitioners without the above credentials would need to be assessed in detail, individually by the CSCC Credentialing Sub-Committee."

At the time this motion was passed, with a slim majority, the only organisation that had in fact been accredited by the AMC (although not for cosmetic surgery) was the Royal Australasian College of Surgeons (RACS). A second organisation the Royal Australasian College of Radiologists was in the process of being accredited by the AMC and the AMC advised various colleges that it would take approximately five years for all of the colleges to be reviewed and either accredited or not accredited as the case may be.

As a result, the above motion effectively gave authority ONLY to graduates of the RACS to perform Category I procedures.

Also, it was felt that this meant that any FRACS holder would therefore, be qualified to perform cosmetic surgery, whether they had had formal cosmetic surgery training or not and many members of the CSCC felt that this was not a reasonable process.

Consequently, at the next meeting of the CSCC held on Monday 9 December 2002 the following motion was put:

"In addition to the requirement to hold a surgical qualification as recognised by the AMC two riders should be attached to the motion passed in respect of Category I procedures at the meeting held on 22 July 2002:

(a) A moratorium on this requirement be put in place until all the member colleges and associations of the currently constituted CSCC have had the opportunity to be reviewed by the Australian Medical Council.

(b) Appropriate grandfathering arrangements for credentialing by the CSCC in Category I by existing stakeholders in cosmetic surgery, who would otherwise not qualify under the parent recommendation be put in place immediately.

This motion was passed by a clear majority and as a result the virtual exclusive monopoly of FRACS graduates was removed.

The representatives of that surgical group however, after considerable lobbying proposed the following motion, which was addressed at the CSCC meeting on Monday 17 February was passed with the majority of 1 (7 to 6):

" That the resolution adopted by the CSCC meeting on 12 December 2002 concerning appropriate minimum training requirements for Category I providers be rescinded."

At this stage, there were clear lines of division within the Council, there being a group of people who were graduates of the RACS or affiliated with it who were in favour of retaining the July motion and a second group, consisting of some FRACS graduates and surgical graduates from other colleges, who were opposed to the July motion. As a result, the second group proposed a motion as follows:

"In respect of CSCC endorsed appropriate minimum training requirements to perform Category I procedures that the following apply:

(1) All motions in respect of Category I training requirements taken by the CSCC on July 22, 2002, December 9, 2002 and February 17, 2003 be rescinded and replaced with (2) and (3) below:

(2) All practitioners, irregardless of background and training who wish to be accredited for Category I procedures must be assessed in detail by the CSCC (on the basis of the standards as agreed) by providing:

(a) Evidence of training in cosmetic surgery: observation/meeting/preceptorships ;

(b) Logbook of cosmetic surgery procedures performed.

(c) CME verification in cosmetic surgery.

(3) All member colleges and associations represented on the CSCC be invited to submit their training, credentialing and re-certification programmes, relating to cosmetic surgery to be assessed in detail by the CSCC (on the basis of standards as agreed) and be credentialed by the CSCC (where they have met the agreed standards) as training and certification colleges/ associations for cosmetic surgery.

Those fellows and/ or members of the CSCC Accredited Colleges and Association will be

(a) exempt from individual assessment, and

(b) automatically accredited by CSCC (on the recommendation of the CSCC accredited college/ association) to perform Category I procedures.

The group believed that the above motion embraced the original terms of reference for the CSCC which was to accredit in cosmetic surgery. Further, the group felt that as all practitioners applying for Category I procedures accreditation would be subject to the same process hallmarked the equitability of the process.

The motion was to be put at the meeting of the CSCC scheduled for 28 April 2003, which was subsequently delayed until 12 May 2003.

At the last meeting Associate Professor P Thursby, Chairman of the CSCC advised the CSCC that since unanimity on matters in respect of Category I could not be reached and that there were two groups who would not, in any way, accept the other side's stance that he was not going to put that motion, but rather report directly to the Minister.

Since that time, the only cosmetic surgery specific credentialing has been the training programmes and qualifications by examination of Australasian College of Cosmetic Surgery. (See Appendix A). No other body has attempted to credential medical practitioners in cosmetic surgery.

Composition of the former NSW CSCC

A/Prof. Peter Thursby FRACS, Chairman,
Mr. Andrew Dix, Nominee of The NSW Minister for health (Non FRACS)
Dr. Alan Evan, Nominee for the Australasian Academy of facial Plastic Surgery. (FRACS)
Dr. Raf Ghabrial, Nominee for the Royal Australian & New Zealand college of Ophthalmologists (FRACS Aligned).
Prof. Thomas Havas, Nominee for the Australian Society of Otolaryngological Head & Neck Surgery. (FRACS)
Dr. Geoffrey Heber, Nominee for the Cosmetic Physicians Society of Australia. (Non FRACS).
Dr. David Jenkins, Nominee of the Australasian College of Phlebology (Non FRACS)
Mr. Geoffrey Lyons, Nominee of the Australasian Society of Aesthetic Plastic Surgery, (FRACS)
Dr. Colin Moore, Nominee of The Australasian College of Cosmetic Surgery, (Non FRACS)
Ms. Rona Naicker, Nominee of the NSW College of Nursing, (Non FRACS)
Mr. Norman Olbourne, Nominee for the Australian Society of Plastic Surgeons. (FRACS)
Mr. Matt O'Niell, Nominee of the Australian Consumer Association. (Non FRACS)
Dr. Sharron Phillipson, Nominee of the Royal Australian College of General Practitioners, (Non FRACS)
Dr. Stephen Shumack,
Nominee of the Australasian College of Dermatology, (FRACS aligned)
Mr. David Storey, Nominee of the Australasian College of Surgeons, (FRACS)

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Appendix D

How the Australasian College of Cosmetic Surgery has contributed to raising standards to protect patients since 1999

The College (ACCS) was formed in 1999 from the Australian Association of Cosmetic Surgery which began 23 years ago. Our main purpose is to provide training and accreditation to improve outcomes and patient safety in cosmetic surgery. In this way, we believe our members and the wider profession also benefit as patients will have confidence in a safe, well regulated industry.

The ACCS has established training programs for cosmetic surgery and medicine and provides the only cosmetic surgery specific postgraduate training and qualification by examination in Australia. The College has had a particular role in providing cosmetic surgical training to specialist general and breast surgeons who are unable to access such training through their own college, the Royal Australasian College of Surgeons.

A Fellowship in cosmetic surgery from the College – FACCS, requires a minimum of seven years of post-graduate training, five of which involve surgical training including two entirely devoted to cosmetic surgery. The College has also developed a cosmetic medicine training program which leads to a fellowship qualification of the College's Faculty of Medicine – FFMACCS.

Cosmetic Surgery is not recognised as a specialty by the Australian Medical Council. This is a source of confusion and risk for patients seeking cosmetic surgery because they cannot use the specialist register to reliably identify practitioners who are appropriately trained and certified. This confusion is worsened because providers come from a range of different specialties and craft groups, many with competing claims. Over the last 12 years, the College has spent very considerable resources attempting to rectify this so that patients could identify recognised specialists in cosmetic surgery and be better protected. However, this process revealed that ultimately the wording of the specific requirements for the recognition of any new specialty by the Australian Medical Council automatically precludes Cosmetic Surgery by its very nature no matter what the weight of other evidence. Thus, other methods of protecting the public need to continue to be developed.

The College worked closely and collaboratively with NSW Health and former Minister Skinner in formulating the recent guidelines and regulation of cosmetic surgery procedures that came into effect in 2017. The new guidelines and regulations were developed as a response to the

dangerous and illegal practices that had occurred at "The Cosmetic Institute", an aggressively commercial clinic whose medical director and supervisor of "training" is a plastic surgeon. None of the surgeons working there were fellows of the ACCS nor would have met the standards for College Fellowship.

Senior members of the College's executive alerted the HCCC and NSW Heath to anaesthetic practices at The Cosmetic Institute that resulted in patients suffering convulsions and cardiac arrests. These College members, resisting intimidatory threats, collected, analysed and provided to the regulators detailed information of these dangerous and illegal practices. This ultimately resulted in the full investigation and findings which confirmed the College's concerns.

We have a close working relationship with the TGA and currently sit on their BIA-ALCL expert advisory panel, indeed the advisory panel was formed at the ACCS' request to federal Chief Medical Officer and the TGA. The College also played a leading role in the Chief Medical Officer's expert advisory committee and the TGA's scientific committee concerning the PIP breast implant crisis and provided, at its invitation, testimony to the Senate on this matter. We sit on the Medicare Benefits Review committee and are invited to the federal health department yearly budget lock up. We have regularly contributed to various senate standing committees.

The College's continuing medical education program was recognised by the then NSW Medical Board as an approved program meeting the annual re-registration requirements for medical practitioners and continues to be so under the National Law.

We are partners in the Australian Breast Device Registry together with the breast surgeons and the plastic surgeons.

In 2000, the College established the first Australian scientific meeting dedicated to cosmetic surgery and medicine. This has been held every year since and attracts speakers and delegates from around the world. We regularly host cosmetic surgery stakeholder meetings with various specialty and industry groups, medical insurers, regulators, complaints bodies and consumer groups. Our next meeting is scheduled for the end of November and is to address improvement in the safety of cosmetic injectables.

Following a rigorous public consultation process, we were the first medical College to have a code of conduct approved as being in the public interest by the ACCC in 2009. This code of conduct formed the basis for the AHPRA code of practice guidelines for cosmetic surgery which came into effect in 2016.

Many of our Fellows regularly act as performance assessors for the various state medical boards and we work closely with the HCCC and other state complaints bodies.

The ACCS has developed a close collaboration with the College of Psychiatrists where to develop training modules for our registrars, so they can better recognise mental health disorders in patients presenting for cosmetic surgery. We are also jointly exploring a public education strategy to educate the public about body dysmorphobia. This collaboration is an Australian first for a surgical college.