HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP
Ms AB King MP
Ms JE Pease MP
Mr A Powell MP

Staff present:
Ms R Easten—Committee Secretary
Ms R Duncan—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SURGEONS) AMENDMENT BILL 2023

TRANSCRIPT OF PROCEEDINGS

Monday, 22 May 2023

Brisbane

MONDAY, 22 MAY 2023

The committee met at 9.03 am.

CHAIR: I declare open this public hearing of the Health and Environment Committee's inquiry the Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023. I thank you for joining us this morning. My name is Aaron Harper. I am the member for Thuringowa and chair of the committee. I respectfully acknowledge the traditional custodians of the lands on which we meet today and pay my respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all now share. With me here today are: Rob Molhoek, the member for Southport and deputy chair; Joan Pease, the member for Lytton; Ali King, the member for Pumicestone; Andrew Powell, the member for Glass House; and Stephen Andrew, the member for Mirani, who will be joining us later due to a delay with flights.

On 20 April 2023, the Hon. Yvette D'Ath, the then minister for health and ambulance services, introduced the Health Practitioner Regulation National Law (Surgeons) Amendment Bill into the Queensland parliament and referred it to this committee for detailed consideration and report. The purpose of today's hearing is to hear from invited witnesses to assist the committee with its consideration of the bill. This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Witnesses are not required to give evidence under oath, but intentionally misleading the committee is a serious offence.

The proceedings are being recorded and broadcast live on the parliament's website. All those present should note that it is possible you may be filmed or photographed during the proceedings and images may appear on the parliament's website or social media pages. I ask everyone to please turn off their mobile phones or put them on silent mode.

FRYDENBERG, Professor Mark AM, Chair, Health Policy & Advocacy Committee and Councillor, Royal Australasian College of Surgeons (via videoconference)

JACKSON, Dr Mark, Executive Member and President Elect, Australian and New Zealand Society for Vascular Surgery, Council of Procedural Specialists

SCOTT, Associate Professor David OAM, Chair, Council of Procedural Specialists (via videoconference)

UNG, Professor Owen, Vice-President, Royal Australasian College of Surgeons

CHAIR: Welcome. I invite you to make a brief opening statement, after which committee members will have some questions for you.

Prof. Ung: Good morning, Chair and committee members. I would like to acknowledge the lands on which we meet and pay my respects to elders past, present and emerging. I am Owen Ung. I am a general surgeon—also breast and endocrine. I perform breast reconstructive surgery as a general surgeon. I am joined by my colleague Mark Frydenberg, who is the chair of our Health Policy & Advocacy Committee for the Royal Australasian College of Surgeons.

The Royal Australasian College of Surgeons, RACS, welcomes the bill to protect the title 'surgeon' and to safeguard the public and strengthen the regulation of cosmetic surgery in Australia. We congratulate the Queensland parliament for moving this important reform forward. RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and Aotearoa, New Zealand. RACS provides accredited training for nine surgical specialities. We have 8,300 fellows and 1,300 surgical trainees and specialist internal medical graduates.

RACS supports the amendment bill but is concerned that protection of title may be weakened, thereby compromising public protection, by one clause. We recommend that (5)(e) of 115A in clause 4 on page 6 of the amendment bill be either removed or, at the very least, strengthened by replacing 'class of medical practitioner' with 'ANC accredited class of specialist medical practitioner'.

We feel that this important bill should deliver the necessary amendments that ensure 'surgeon' titling remains ever clear and unambiguous. The reason for this is our commitment to the maintenance of high standards in surgery in Australia and Aotearoa, New Zealand.

All surgery carries risks including complications resulting in serious harm and even death. These risks are being trivialised by some in the cosmetic surgery sector. RACS's rigorous surgical program usually takes five to six years of full-time training that includes quarterly assessments, entry and exit exams. Trainees are already doctors who have usually spent several years in operating theatres before being admitted. RACS understands the training programs for ophthalmology, obstetrics and gynaecology, and oral and maxillofacial surgery are of similar length and rigour, though it does not manage these programs. It is only after the completion of such programs that trainees are considered safe and competent to perform surgery on the Australian public. To maintain their fellowship, RACS fellows must undergo continuing medical education, professional development and audit. RACS is of the firm view that access to the title 'surgeon', as well as endorsement for cosmetic surgery, should be predicated on meeting similar standards of training and practice. Thus, RACS's approach to reform of the cosmetic surgery sector has been that those who carry the title 'surgeon' should meet the high standards that RACS demands of its own fellows—that is, a FRACS or equivalent qualification.

Any practitioner endorsed or accredited to perform procedures within a limited or lesser scope of practice must still be appropriately trained and credentialed to that level but not identify as a surgeon by title, thereby making the level of their expertise clear to the public. RACS notes that other stakeholders may be affected by this legislation because it would prevent GPs, in particular rural-based GPs, from using 'surgeon' in their title. RACS acknowledges the pivotal role that GPs play in conducting minor surgical procedures in rural areas, where access to specialist surgeons is more difficult. RACS does not in any way wish to narrow the scope of these GP proceduralists and will continue to work and cooperate with them in supporting, facilitating and formally recognising the vital service they deliver such that they will be notably acknowledged by the public they serve.

Our position is a principled one: those who carry the title 'surgeon' should meet standards of accredited training and practice in surgery that are similar to those which RACS fellows must meet. As well as being principled, we have sought to be practical in our approach to reform. RACS does not support the use of 'surgeon' for non-medical practitioners performing surgical procedures on human patients. When a passenger enters an aircraft and in-flight is welcomed by the captain, who carries the immense responsibility for their safety, they are reassured that the designation of 'pilot' is explicitly understood. So it should be that a patient under the care of a surgeon has an unquestionable assurance of their training and ability because, at the end of the day, their lives depend upon it. Thank you again for inviting us to contribute. We would be happy to answer questions.

Prof. Scott: Thank you for the opportunity to speak to you on behalf of the Council of Procedural Specialists. My name is David Scott. I am an anaesthetist who works in northern New South Wales. I am coming to you from Bundjalung lands. I work in both public and private hospitals. My colleague Dr Mark Jackson is with you in person today. He is on our executive committee and is president-elect of the Australian and New Zealand Society of Vascular Surgery. He practises as a vascular surgeon on the Gold Coast and is in both public and private practice.

The Council of Procedural Specialists was formed in 1984 to provide a combined voice for all procedural specialists on matters that impact procedural medicine. Our eight-member organisation is comprised independent procedural specialist groups that represent their members individually when required. Later you will be hearing separately from the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, and we support their submission regarding their specialty.

It is well recognised that Australians generally have a relatively low level of health literacy. To some extent, this is the result of the high level of reliability of Australian health providers, ensuring that our citizens have no requirement to check up on their doctor and their abilities. If someone is labelled as a GP or as a surgeon then that is what they are—you do not need to wonder about it. People went to their doctor generally because they were unwell and they needed care. However, nowadays, Australians are more than ever active consumers of health. They make decisions about what they want, and they see a registered provider for that service. If they are seeking a surgical service they choose a practitioner who carries the title 'surgeon'. Then they assume that they get the whole package: training as described by the president of the Royal Australasian College of Surgeons, an equally qualified anaesthetist, equally qualified nurses and allied health professionals and, if surgery is to be undertaken, in an appropriately accredited healthcare facility. Otherwise healthy people in the recent past have sought services from people calling themselves 'surgeons'—for example cosmetic surgeons—and they have been left with harm, injury or death because all of those

requirements were not met. People do not expect to have to research whether or not the person who is providing their service and who is calling themselves a surgeon has actually completed the training; they just assume that they have.

Australian medicine has achieved very high standards because of its insistence on the rigorous selection and training of surgeons and proceduralists; therefore, the term 'surgeon' should be reserved for those who achieve the high standards required. Our position is that, in the interests of public safety, we ask parliamentarians to understand that the qualifications of those who make significant interventions on whole-body systems will require legislation and regulation. Do not allow the use of the title 'surgeon' in the health sector by anyone who does not meet that standard.

We are also concerned on the reliance of government bodies such as Ahpra to advise on the appropriateness of who should be permitted to use the term 'surgeon', as it is conflicted by the fact that it is a government body. We would support the RACS approach; that is, it should be the AMC that provides that recommendation. On a parallel matter, COPS is not convinced that the recent endorsement pathway for cosmetic surgeons will improve outcomes in this sector and, unfortunately, is likely to create a second-tier standard of surgery. Once again, we support the College of Surgeons' view on that. In the public interest of clarity and safety, COPS believes that now is the time for this legislation to be clear and to define who should be called a surgeon. Obviously, Mark and I are happy to take any questions that you may have.

CHAIR: Certainly patient safety is at the very core of this, and the protection of title for surgeons is obviously very important as well. There has been a lot in the media regarding cosmetic surgery and the things we have all seen. I might just move to subsection (5) that you spoke of, Professor Ung. Have you read the submissions of other submitters? There is a submission there from the Australian College of Rural and Remote Medicine. You did mention that in your opening statement. I just wanted to unpack that a bit more. Obviously coming from regional Queensland and having worked with rural proceduralists in a previous career, I can say that they hold a very special place in remote parts of Queensland. Can you unpack your initial comments about having regard for their concerns?

Prof. Ung: Sure. I might just make a quick statement and bring in my colleague Mark Frydenberg, who may wish to make a statement. As I said, we absolutely recognise the vital role they play. They should have due recognition for the work they do. The public needs to be aware of safety when they go. The issue with GP proceduralists is that they have always worked within their scope of practice. There are very clearly defined boundaries. The College of Surgeons has participated in their curriculum development and training, so we have always worked very closely with them. They have never been an issue and they provide upstanding services to the community. I will ask Mark Frydenberg to answer that question, if you would not mind.

Prof. Frydenberg: Thank you for allowing me to participate in the meeting. I would agree with Professor Ung's comments on that. Rural GPs have always worked within a well-defined scope of practice in regional settings. It is at a lower level scope of practice compared to specialist surgeons, but it is overseen by independent medical directors in accredited facilities, which provides patient safety. At the moment—I am sure the College of Rural and Remote Medicine will expand on this later—we are literally looking at the term 'rural generalist' as an AMC accredited title. Certainly one of the areas of subspeciality within that would be surgery, and, again, the College of Surgeons wants to work very closely with that college to support that.

We have no concerns with the College of General Practitioners' classification of general practitioner surgical proceduralist. There is no question that I think the College of Surgeons would be wanting to look at other novel ways within our system to recognise them within our own structures, because the College of Surgeons and accredited surgeons actually provide the training for the colleges. We do need to make sure the public knows the difference in the scope of practice of a GP surgeon versus a specialist surgeon. I think that is where we have to be a little bit careful about the use of the term.

I would absolutely support Professor Ung's comments about the vital work they do in regional areas. I think there is really nothing in this legislation that would affect that, because they are already working under slightly different titles under a very predefined scope of practice. College of Surgeons fellows are the ones who do the training, so they would be very supportive of continuing that and working even more closely to make sure that rural and remote communities are well looked after.

Mr MOLHOEK: I am just looking through the witness list for today. We have about eight or 10 different bodies represented in relation to this particular issue. I think at the end of it we have Ahpra coming in, so maybe it is a question for them. I am interested to know from some of the other bodies whether it is not actually the role of Ahpra to oversee ethical practices and the behaviour of medical

practitioners and to intervene where people are acting or operating outside of their approved scope of practice. Why do we need so many different bodies and organisations to all have a say about who gets to call themselves a surgeon and how they are regulated?

Dr Jackson: Thank you very much for the opportunity to appear here. Ahpra takes advice from the Australian Medical Council on the stringent standards that should be satisfied in order to grant recognition of a medical speciality. That includes not only surgeons but also physicians and other specialities like dermatology. The point we wish to make is that the AMC accredited pathway for training is currently recognised as the standard for being granted specialist recognition and that that should remain. For the moment, the specialist societies that are appearing today all have AMC accredited pathways for recognition of their speciality. I think particularly subsection (5) of this bill presents the potential to lower that standard by allowing the ministerial council to determine the speciality and the title of, in this case, surgeon, and does not give regard to the important role of the AMC in defining the stringent standards that we all abide by. It is not just individual practitioners but also our colleges and professional bodies which are forced to maintain ongoing recognition of those standards.

Mr MOLHOEK: You just touched on subsection (5), which basically provides an opportunity for the ministerial council to amend regulations in the future. You do not see that there is perhaps a need or some advantage in having the ministers of COAG being able to sign off on a change if there were new trends in medicine? Who knows what the future holds, but surely having a clause in there that at least provides an opportunity to make some changes without every state having to go back through and pass new legislation to adapt to some unforeseen situation would be an advantage.

Dr Jackson: That new speciality is unlikely to arise out of the blue. For instance, if it was robotic surgery, taking on the new frontiers of an advanced technology like that is really done under the auspices of some of the speciality surgical groups themselves. If it was to be suggested that there would be a new subclass of surgical specialisation, it should go through the same rigours of satisfying the AMC credentialing process before that title is granted. Until that case, any new or avant-garde type of surgical procedure is going to be taken on by the existing subspeciality groups.

Mr MOLHOEK: If you look at the last 10 years, where we have seen a lot more non-invasive surgical procedures become the norm, if that provision was not there in the past would that have impeded people's ability to adapt to non-invasive technologies?

Dr Jackson: I am aware that other people want to comment here, but just briefly, from my own personal point of view, the field of vascular surgery has undergone enormous technical advancement and recognition of new minimally invasive techniques, and as a professional body and under the guidance of the college and its own ethics committees and council standards we have been able to embrace those new technologies and audit the process and make sure it is carried out safely and introduced safety in order to protect the public. I think we have a much better opportunity to do that than to grant a new subclass of specialisation and have perhaps less regulation afforded to it.

Ms KING: Thank you for being with us today and for your service to our health sector in Australia and the contribution you make to keeping it safe and reliable. My question goes primarily to the Royal Australasian College of Surgeons. Professor Ung, would you mind for our benefit painting a picture for us? What is the lowest level of surgical expertise or qualification that might currently be used to justify the title of surgeon in a less regulated medical sector such as some cosmetic surgery contrasted with the most fulsome qualification and training that an accredited plastic surgeon, for example, would possess? Could you show us that spectrum, please?

Prof. Ung: Procedures can range from as small as a simple cutaneous excision when you go to a dermatologist who will sometimes remove a skin lesion, for instance. That is a procedure. Invasive procedures usually involve an anaesthetic and removing large portions of tissue or even entering body cavities. Those are the sorts of procedures that then expose a patient to significant risk and complication. Even though you can technically teach somebody how to do a procedure, it is much more than just doing a procedure. There is the case selection. More harm can be done by doing an inappropriate procedure in the wrong circumstance, plus there is the aftercare of that patient as well.

We talk about 10 surgical competencies in our RACS training program, of which only two are technical. A lot of competencies are with leadership, education—all those other non-technical specialities which are so important in the make-up of the surgeon, not just the ability to cut. We totally accept that there may be lesser scopes of practice that someone who is not trained to that level may be able to perform. So long as the patient and consumer is aware of that capability and that level of expertise, we do not have a problem with that. We do feel that if a practitioner identifies himself as a surgeon then that patient would have the expectation that they can operate at that higher level. I might invite my colleague Mark Frydenberg to answer that.

Dr Frydenberg: I would like to support that. Again, it goes back to the range of titling. There is a wide range and scope of surgery, ranging from major to minor. The problem at the moment is that, from the health literacy of the public, they see the title of 'surgeon' and they view that that person can do the whole range up to the highest level. The problem is that that will not necessarily be the case with lower levels of scope of practice so it is potentially misleading to the public if you suddenly start having groups with lower scopes of practice being able to have unrestricted use of the title 'surgeon'. The concern then is that the patients will have the expectation that they can do the whole scope of practice, including the more advanced surgery that, in fact, they may not be trained to do.

I think that is the concern we have with the subsections (5)(b) and (5)(e), but (5)(e) in particular, because, while we fully respect the fact that the ministerial council does need to have flexibility to look at the legislation, the issue from our point of view is that it is not underpinned by any standards—that clause. The concern is that we need to be making sure the standards of surgical care for the community of Australia are upheld and it would be helpful to have that clause underpinned at least by some standards.

CHAIR: I see David Scott has his hand up. We have one minute, David, and then we will have to conclude this session.

Prof. Scott: I will be very brief. As anaesthetists we also help in the selection of patients. General surgeons and qualified surgeons work with qualified anaesthetists, so that actually enhances patient safety. Following on from Dr Frydenberg's comments, the other part that surgeons bring is the ability to manage their complications. A lot of the barely trained cosmetic operators have very simple training and they really do not know how to manage their complications. That is one of the things that leads to significant harm.

CHAIR: Thank you very much, gentlemen. Thank you for your contribution here today. It was very insightful.

KENNEDY, Dr Dan, Queensland Member, Australian Society of Plastic Surgeons

WON, Dr Rebecca, Queensland Member, Australian Society of Plastic Surgeons

Dr Won: Good morning. The Australian Society of Plastic Surgeons welcomes the opportunity to appear before the Health and Environment Committee for its inquiry into the Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023. The ASPS represents over 600 specialist plastic surgeons, of whom over 100 are in Queensland. We serve approximately 200,000 Australians every year. Our members perform both reconstructive and cosmetic plastic surgery to help members of our communities regain their capacity and confidence and the ability to thrive.

The ASPS strongly supports the passage of this bill. In our country right now it is legal for any doctor to operate on patients, even without any formal surgical qualification. Those practitioners should not be able to call themselves surgeons. The general public rightfully expects someone who calls themselves a surgeon to have been trained as a surgeon.

I am a Queensland-based surgeon with a private cosmetic surgery practice and I also provide reconstructive services at the Royal Brisbane and Women's Hospital. I am a clinical senior lecturer in surgery at the University of Queensland. I regularly see people coming to the emergency department of my public hospital with major complications as a result of cosmetic surgery by non-surgeons that has gone wrong. As other submissions have stated, we all pay for this through taxpayer support for public hospitals and through higher private health insurance premiums. The patients themselves suffer physical and mental harm. It is an absolute priority that patients are no longer misled by inaccurate titling. The ASPS strongly believes that the passage of this bill will address that problem.

We have reviewed all the other submissions to the committee and we wish also to state, like RACS, our strong support for the important work that the GPs and rural generalists carry out, particularly when it comes to surgical procedures outside of metropolitan areas. We in no way wish to diminish their efforts to serve Queenslanders, but it is important to clarify that the passage of this bill will not result in any restriction to their practice.

Our only concern about the bill relates to new section 115A(5)(e). We understand that it has been included with the intent of futureproofing the bill for any new AMC accredited surgical specialty that may arise in future. However, the term 'medical practitioner' is too broad and it is not consistent with the explanatory notes to the bill which define 'surgical class'. This allows the bill to be weakened in future. To prevent this we believe that 'medical practitioner' should be amended to 'AMC accredited surgical specialist', which is already detailed in the explanatory notes. Amending subsection (5)(e) is essential in ensuring that medical practitioners with no AMC recognised surgical qualifications who are practising right now are not afforded an opportunity to access a title that does not match their training and qualifications.

I note that the structure of the colleges, who trains who, and who is AMC credited and who is not can be somewhat daunting to examine for those who are not familiar with it. I have a very clear pictorial diagram, which hopefully has been handed to you, that might go some way to making that a little clearer.

CHAIR: We need to deal with that. Members, is leave granted? Leave is granted. Please step us through that, if you would like to.

Dr Won: Essentially, on that diagram there are AMC accredited surgical specialties. Under that there are different training bodies. The Royal Australasian College of Surgeons, from whom you have already heard, trains plastic surgeons, ENT surgeons, orthopaedic surgeons, general vascular, cardiothoracic, urology, paediatric and neurosurgeons. That is the column on the far left of the diagram.

Specialist plastic surgeons are represented by two separate societies. One is the Australian Society of Plastic Surgeons, which we are representing. The second is the Australian Society of Aesthetic Plastic Surgeons, which is the cosmetic subgroup, if you will. Our members can belong to either/or both of those societies. The one I represent represents 600 members.

The other AMC accredited surgical specialties that have different training bodies but are not part of the Royal Australasian College of Surgeons are specialist ophthalmologists, or eye surgeons; the oral and maxillofacial surgeons, who are dual trained in both medicine and dentistry; and the obstetricians and gynaecologists.

Because of the way it is still currently legal for non-AMC accredited people to perform surgery, there are other groups that do perform surgical procedures. They include dermatologists with Mohs surgery, the Australian College of Rural and Remote Medicine specialist GPs and specialist general

practitioners. Those groups all have specialist titles under Ahpra that are protected. Then there are Ahpra general registrants, who do not have any specialist title and who also perform surgery. It is largely those latter two groups that we see causing patient harm.

CHAIR: You made a statement around—

Dr Won: Yes, the difference between the specialist registrants and the general registrants is that the specialist registrants have a training body with a clearly defined training framework, a clearly defined scope of practice, ongoing CPD. There are protections built into their training and their societies that make it safe for the public. The general registrants generally do not have any of that. They do not have a body that trains them, that maintains standards, that examines their ongoing professional development.

CHAIR: Did you say the rural generalists are AMC accredited or not?

Dr Won: They are non-AMC accredited surgical specialists but they are afforded a specialist general practitioner title under Ahpra.

CHAIR: I will move to the member for Glass House but I will come back and ask you to discuss further option 1 in your submission.

Mr POWELL: Dr Won, based on your position and that of RACS around new subsection 115A(5)(e), how would you accommodate, say, a position like the surgeon general within the Australian Defence Force, given that that individual may not necessarily be undertaking medical procedures but has a title that has been designated now for many decades?

Dr Won: My understanding is that this bill relates specifically to medical practitioners and doctors so that falls outside of this bill and, therefore, should be unaffected.

Mr POWELL: As a follow-up, I was going to be a bit cheeky about what I am sensing is a push around section 115A(5)(e): is it fair to say that you do not trust the politicians to get this right, with the advice from the Medical Board?

Dr Won: This is one aspect of a whole suite of reform that is currently before parliament and being passed by Ahpra. We are not aware of all of the details of the other aspects to that reform, so the endorsement model that is coming is not yet available for us to view. Our concerns are that if the endorsement model allows lesser qualified practitioners to perform surgery then they would have the ability, via that endorsement, to call themselves 'surgeon' without surgical qualification.

We also have concerns about grandfathering. There are practitioners practising now who call themselves 'surgeon'. It has not been defined what will happen to that group of people—whether they will be grandfathered in and allowed to call themselves 'surgeon', therefore undermining the intent of the bill which is to make this clearer for the public.

From an international medical graduate point of view, it has the potential for internationally trained surgeons to come to our country and, rather than pass through the very stringent process that maintains standards for surgical training, which is coordinated through RACS, it would allow them to bypass that and, therefore, has the potential to lower surgical standards in our country.

CHAIR: On the endorsement model that you spoke about, you said it is not released yet. Can you unpack that? Where is it coming from and where do you anticipate it will land?

Dr Kennedy: The endorsement model was a request from Ahpra to the AMC to develop a standard whereby people could practise cosmetic surgery. It is an endorsement in cosmetic surgery. I have been involved in some of the deliberations over that. This was against our recommendation but it was an Ahpra attempt, as part of a suite of packages, to protect the public so that the people who are in practice could potentially prove that they met this endorsement standard or could be trained under this endorsement standard. It is a parallel to the endorsement that is available in acupuncture, for example. So it is not formal surgical training in a college; it is a proposal.

Our concern is that the endorsement may be taken up by universities in the way that has been done in Europe and that the practical component of training may very well be lost or diluted or dumbed down, to be frank. If we look at the European system, surgeons come out of university training without adequate safety and ability. They then have to work under supervision in a university hospital for many years before they are considered to be fit to release on the public. We do not want that situation. We already have a robust training scheme and the AMC administers that very effectively.

What we are saying about subsection (5)(e) is: give it to the AMC to say, 'This is the standard,' whether that be overseas trained surgeons or whether it be people who have potentially asked to be grandfathered in to the term 'surgeon' because of what they have done over the past 30 years. We would say, 'You were never trained if you have not had surgical training.' Practice does not make you a safe surgeon; it is training and supervision and CPD.

CHAIR: I think we hold a very high standard of credentialing across a range of surgical specialties. There are some pretty bold statements there but we will take them on, Dr Kennedy.

Mr MOLHOEK: We have heard a few comments today that GPs typically work within a fairly well-defined scope of practice. In considering, say, rural GPs, rural specialists and general surgeons in some of those broader categories, wouldn't they be self-regulated to some extent because of the insurances they have and the desire to avoid risk of practising in areas where they should not?

Dr Won: Unfortunately, finances mean that people are not always behaving ethically. Given cosmetic surgery operates outside of the Medicare rebate system and outside of Medicare, it does not have the same degree of oversight.

Mr MOLHOEK: I was more referring to people outside of metropolitan Brisbane and the south-east—as in rural doctors and others who are required to provide procedures.

Dr Kennedy: We do not have concerns about the current practices within rural and regional communities. We have concerns about titling. Unfortunately, with the lack of clarity around titling there has been the allowance for practitioners who are not trained to call themselves cosmetic surgeons. Twenty years ago in Queensland we had this covered, but when the Medical Board went national with Ahpra we lost the protections that Queensland had already introduced to the title of surgeon. I think it is quite apposite that it is coming back through the Queensland parliament to correct this aberration.

Mr MOLHOEK: In the diagram that you have provided, the line clearly provides—

Dr Kennedy: That is where the bill would separate—

Mr MOLHOEK: It separates out rural and remote medical specialists and general practitioners and specialist general practitioners.

Dr Won: That line is the line that determines who are surgical specialists and who are not—who has AMC accredited surgical training and who does not. That is not to say that general practitioners do not very competently perform minor surgical procedures.

Dr Kennedy: Or even some quite significant emergency surgical procedures in regional areas. The line is where the bill would currently draw the line on the title 'surgeon'.

Mr MOLHOEK: As I understand it, the concern is these people on the far right of the illustration who are performing cosmetic surgery.

Dr Kennedy: Yes.

Mr MOLHOEK: Should the bill perhaps move that line across one so that it does not exclude specialist dermatologists and the other categories that you have listed there but rather only precludes those who are performing cosmetic surgery?

Dr Kennedy: The line delineates a very extensive difference in level of surgical training. I think if we include that group in the title 'surgeon' we have misled the public into what their surgical training would be. I think the public expects what the dictionary definition is—that is, that a surgeon is a specialist surgeon.

Ms PEASE: Thank you very much for coming in today and thank you for your submission. I know you have talked a little about option 1 in your submission, but could you elaborate on that and give us some more information on what your position is on that?

Dr Won: There were two options in our submission.

Ms PEASE: Option 1 is what I am interested in.

Dr Won: Do I have that in front of me?

Ms PEASE: I can read to you, if you like. It reads—

Section 5 be altered so that "AMC accredited surgical specialist" is put in place of "medical practitioner" in section a). Our understanding is that this would render sections 5d) and 5e) superfluous, and they could be removed.

You then go on further to say—

(5) In this section—**surgical class** means the following classes of medical practitioners—

1. (a) a medical practitioner holding **AMC accredited surgical specialist** registration in in the recognised specialty of surgery;
2. (b) a medical practitioner holding specialist registration in the recognised specialty of obstetrics and gynaecology;
3. (c) a medical practitioner holding specialist registration in the recognised specialty of ophthalmology;

Dr Won: 'Medical practitioner' means any doctor, which in simplistic terms is a university degree and one year of working under supervision in a public hospital. 'AMC surgical specialist' indicates someone who has had formal surgical training and completed it successfully. If the intent of the bill is to futureproof, which we do not disagree with, we should be futureproofing in such a way that any future surgical speciality is a surgical speciality, not just any speciality. There should be no reason in future why a general physician or endocrinologist should be able to call themselves a surgeon. There potentially would be a need in future for a new surgical class to come up, but it is still within the AMC accredited surgical speciality. I am not sure that I am making that clear.

Ms PEASE: Yes, I just wanted you to elaborate on what you put in your submission.

Dr Won: The second last paragraph on page 5 of the explanatory notes defines 'surgical class'. When you read that definition it is actually accurate. For some reason that definition does not seem to have come across as a specific in the bill itself. We are just taking your own definition and making it more specific in the bill when it is already written there.

Ms PEASE: I was a little concerned with regard to the comments you made around overseas trained surgeons and them going through the regime of having their credentials recognised. Surely that would go back to RACS to make sure they meet the requirements and fulfil the expectations to be able to uphold that title?

Dr Kennedy: Absolutely, and that is exactly what happens at the present time, but (5)(e) potentially offers an alternate route and that is what we wanted to plug. If ministerial council decided that all surgeons who are trained in the USA were suddenly recognised without further vetting or assessment of their training then they would just be surgeons.

Dr Won: That is tied in a little with the endorsement model. Given we do not know the details of the endorsement model and what the standard will be to obtain endorsement, what could potentially happen is that overseas trained surgeons when they enter the country—at the moment what happens is they all have to apply via RACS and be assessed and so on and so forth—could apply directly for endorsement. If they get the endorsement tick then they are working.

Ms PEASE: Are you claiming that they will not go through endorsement—the credentialing process of RACS?

Dr Won: We do not know because it has not been released. We are concerned with this bill because we do not—

Ms PEASE: So it is hypothetical?

Dr Kennedy: Yes, but that is the (5)(e) problem. We want to plug hypotheticals by putting it as an AMC accredited surgical specialist.

CHAIR: I think you have made your point.

Mr MOLHOEK: I ask this as probably a question on notice because I am not sure you would have the information to hand. We have heard quite a few people talk about cases of significant harm. I am curious as to how many cases—and maybe this is a question that Ahpra will have to answer—of significant harm occur annually. Is it 50, 100 or 200?

Dr Won: It is difficult. We do not have figures partly because some of those are managed in the private sector and some are managed in the public sector. To the best of my knowledge there is no study that has examined that.

Dr Kennedy: I think Ahpra would be the best to answer that question.

Mr MOLHOEK: I will raise it with them.

Dr Kennedy: But can I put in from a personal point of view that the number of patients I have seen over the last 30 years who have said, 'I really thought he or she was a surgeon'—and that is typically said about somebody who has had no surgical training and where there has been a very poor outcome. Both of us have looked after horrendous outcomes from practitioners who are not surgeons and who patients thought were surgeons and have let them do face lifts, abdominoplasties, extensive liposuctions and so forth and the patients almost universally say, 'I thought they were a surgeon.'

CHAIR: Thank you both for your contribution today.

DUNCAN-SMITH, Dr Mark, AMA Council of Private Specialist Practice, Australian Medical Association (via videoconference)

McMULLEN, Dr Danielle, Vice-President, Australian Medical Association (via videoconference)

CHAIR: I recognise Dr Anthony Lynham, a former minister of the Queensland parliament and well-respected maxillofacial surgeon, who is in the audience today. Welcome. I welcome witnesses from the Australian Medical Association. I invite one of you to make an opening statement. We will then move to questions.

Dr McMullen: The AMA thanks you for the opportunity to appear at this inquiry into the Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023 and particularly welcomes the opportunity to address this important issue. The AMA represents doctors in all states of Australia, in all medical specialties and at all stages of their careers. We also advocate strongly for a health system that provides safe, patient-centred care and think that is critical to this bill.

The AMA supports this bill, but, as outlined in our submission, we feel it could be improved to ensure our patients are not misled by the improper use of the title 'surgeon'. I am a GP based in Townsville. As you know, becoming a general practitioner takes years of education, training and supervised practice. I am a fellow of my college and am proud to use the title 'specialist general practitioner'. What may come as a surprise to many in the community is that there are no restrictions on me also calling myself a surgeon.

When discussing surgical procedures with my patients, particularly cosmetic surgical procedures, I spend a degree of time explaining to them how surgical policy works and how to assess a practitioner's qualifications and experience as part of making an informed decision about whether to proceed with surgery, but not all patients attend their GP before a procedure and our system does need strengthening to ensure it is transparent, clear and safe for patients accessing care.

My colleague appearing with me today, Dr Mark Duncan-Smith, is a specialist plastic surgeon and, like me and all specialist doctors, he spent years on his path to fellowship. I will not speak for Dr Duncan-Smith, but I encourage you to ask him about the training and competencies expected for a Fellow of the Royal Australasian College of Surgeons, which I understand you heard from this morning.

The AMA has long been concerned by the loophole in the national registration and accreditation scheme that allows any registered medical practitioners to use the title 'surgeon'. We are pleased the health ministers have finally acted to close it, even if it has taken some harrowing reports in the media about cosmetic procedures going wrong to bring us to this point. Taken together with other reforms to the regulation of cosmetic surgery, we think this bill will go some way to improving the safety of the cosmetic surgery industry and, more broadly, to improve the transparency and safety of the health system for our patients.

There are, however, important improvements to be made. The bill would be improved by removing the ability of non-medically trained practitioners such as podiatrists to use the title 'surgeon'. There are instances where podiatrists are performing quite invasive procedures, and when calling themselves podiatric surgeons patients understandably expect that that provider is a medical practitioner with appropriate surgical training. Particularly after this bill and the media and other attention that it has received, we anticipate that patients may falsely assume that anyone using a title 'surgeon' is an appropriately trained medical practitioner. We feel there is an opportunity here to improve the transparency of the health system more broadly for patients.

We also ask the committee to remove the additional pathway to accessing the title 'surgeon' provided to the ministerial council under proposed section 115A(5)(e). We feel that this is an unnecessary clause and may potentially lead to a lowering of standards and thus an undermining of the intent of this bill. We think the preceding clause, providing for the AMC to grant access to new specialties that are appropriately accredited, is appropriate and allows for the futureproofing of this bill. Beyond those two suggestions, we support this bill and are happy to take questions.

CHAIR: Thank you very much. I was going to see if Dr Duncan-Smith wanted to make any comments before we move to questions.

Dr Duncan-Smith: Members of the committee, thank you for the opportunity. By way of disclosure, I am a plastic surgeon who does burns, general plastic surgery and cosmetic surgery. There seems to be a bit of a transcription error in proposed section 115A(5)(a), (b), (c), (d) and (e).

The explanatory notes refer to 'AMC surgical specialist' whereas 115A(5)(a), (b), (c), (d) and (e) refer to 'medical practitioner'. Certainly tightening that and using 'AMC surgical specialist' would be more consistent with the national law—division 2, sections 57 and 58 of the 2009 national act.

There is the also the potential unintended consequence of the bill as it stands with clause 4—proposed section 115A(3) and (2)—which refers to the use of 'surgeon' for professions other than the medical profession. This, as it stands, creates a potential loophole where a podiatric surgeon who goes to do medical training and becomes a GP could then use the title 'surgeon', even though they are not technically part of the surgical class. Podiatrists do not just shape bunions; they actually do joint replacements in feet and surgery of this type. By leaving it the way it is, it means that potentially the public—and this bill is about the safety of the public—would consider podiatric surgeons to be part of the surgical class. In fact, this bill therefore strengthens that position of podiatric surgeons and the public having the perception that they are in fact part of the surgical class. Thank you for allowing me to make some comments.

CHAIR: Thank you. I give a shout-out to Dr McMullen, a fellow Townsvillian. We will not talk about the Cowboys game! I will just take you back, Dr McMullen, to the submission from the AMA. Under 'Newly recognised surgical specialties', the second paragraph states—

> An exception to this would be rural generalist surgery where there is currently an application for recognition of this field of practice before the Australian Medical Council (AMC).

Do we have any idea of how long that will take? A lot of people are talking about this particular section. Do you have any idea where that is at in terms of coming to a conclusion? Can you unpack that a little bit?

Dr McMullen: The question around time frames is probably better put to the AMC or the body putting that application forward to the AMC. We understand that it is a contentious issue. We understand that there are varying views around the role of rural generalist to provide surgery as part of their scope of practice and the impacts on them of this bill. We feel strongly that protected titles should be AMC accredited and that there needs to be an external and robust regulatory process to make sure the quality and standards of a specialist field are monitored.

Should the AMC decide to accredit a title such as 'rural generalist surgeon', we think the bill does have the scope there to then allow them to use that title. That was really the intent of fleshing out that sentence. We do think there is scope within this bill as it stands, depending on the decision of AMC, but I do not have further information as to when that decision is likely to be made. Hopefully AMC will be able to provide more information.

CHAIR: Just to clarify, the AMA would be supportive of the title 'rural generalist surgeon' should the AMC grant endorsement?

Dr McMullen: As we have said, if the title of the recognised specialty as accredited through AMC included the word 'surgeon', we would be supportive of them using that recognised title, but there is a process in place under AMC for them to determine whether that title itself is appropriate or not, and we would leave that decision for them.

Mr MOLHOEK: Dr McMullen, I asked a question earlier around GPs typically working within well-defined scopes of practice. Would it be fair to assume that there would be very few rural generalists who would be wanting to work outside of that scope of practice because of insurance risk or other risk, both reputationally and—

Dr McMullen: We have not had concerns raised with us about rural doctors and those performing surgery as part of their scope stepping outside of a defined scope of practice. The role of general practitioners in providing surgical procedures particularly to rural and remote patients has a long-established history and we do not seek to change that scope of practice or to hamper those doctors in being able to provide that practice. As I think you heard from RACS and other groups this morning, they are of a similar view that GPs working with a surgical scope are working well with other specialist surgeons in expanding the services available to rural and remote patients. As we understand, the rural generalists are seeking to have a separate AMC accredited specialty put in place. That is a bit of a moving thing at the moment. We will await the outcome of that decision. Regardless, we would hope that this bill does not impact the scope of service open to those doctors.

Ms KING: Dr McMullen and Dr Duncan-Smith, I would love it if you could make some comments about the emergence of cosmetic surgery as a consumer-driven set of decision-making by patients as opposed to a health focused or health-driven set of decisions that patients make and how that has changed the landscape of surgical safety in the provision of those services. In some ways it is a broader and more philosophical question, but I think it is an important part of the context in which this bill is put forward.

Dr McMullen: I will make some initial comments and then hand over to the Dr Duncan-Smith. From my experience as a GP, I see more patients accessing more information about cosmetic surgery from outside of the standard medical referral pathways. By that I mean that more patients are getting information from the internet, direct from service providers, through social media and from friends and family. As I mentioned earlier, some of them will come and see their usual GP for further information and advice and referral, but there are others who are accessing sometimes quite major surgical interventions without that medical GP advice or other referral advice.

That is why we think it is important that there is transparency in the system and information and education for patients about how to assess or look at or understand a doctor's medical qualifications and experience when choosing how to proceed with surgery. We understand that an education campaign is one of the parts of the cosmetic surgery reform that has been recommended by health ministers. We feel that that is important but also that the protection of title 'surgeon' will help patients to understand who has had what type of training before proceeding with surgery, because we are seeing more people get information from different places.

Dr Duncan-Smith: You are right. There is a very large social element to cosmetic surgery and it is consumer-driven. A lot of it is via social media. What that does is make that group or cohort of patients vulnerable. Unfortunately, some of the doctors who do not have formal training in surgery who do major invasive surgery display significant narcissistic personality traits in that they feel the patient is there for their benefit—typically to make money for doing surgery that they are not really trained to do. You have to ask: what is the motivation? The motivation is monetary. They are smart. They are intelligent people, unfortunately with narcissistic traits. They will get around systems. They will get around any barriers that are put up for them. Protecting the title 'surgeon' helps to protect the people in society who are potentially vulnerable. Part of the surgical training is assessment of the candidate's ethics, their decision-making ability and their ability to carry out safe and effective surgery.

Mr MOLHOEK: Dr Duncan-Smith, I think what I am hearing pretty clearly is that the real concern is around cosmetic surgery and the growth of that as a sector or the growing demand for it. We have heard evidence this morning expressing concerns around significant harm. People have perhaps embarked on medical tourism and gone overseas to have procedures and then come back with botched jobs or complications. Is that risk of harm predominantly coming from people who have been overseas or people who have been to some of these other people who claim the title 'surgeon' in Australia who are in contention or under discussion in this bill?

Dr Duncan-Smith: Everyone gets complications. It is a matter of the rate at which you get complications. It is also about your patient selection. I see complications from both the cosmetic cowboy industry and overseas. Ultimately, it is about the decision-making process for the people of Australia and having a safer environment for them to make that decision so that they know they are getting a properly qualified, AMC accredited surgeon as opposed to someone who has a very good social media page or a very good social media campaign. That is really the thrust of this bill. It is ultimately about safety and quality.

Yes, it happens from overseas and it does happen from the cosmetic cowboys. I get complications too, but it is the rate at which you get them. I should also say that the measure of your surgeon is their ability to deal with the complications. That is where you find out how good your surgeon is. The surgical abilities of these cosmetic cowboys are incredibly limited, and when they get these complications they just throw their hands up in the air and push them off to the public healthcare system. This is where I really strongly support this legislation. It would be nice to see it as tight as it can be.

Ms PEASE: I really appreciate you coming in and explaining the level of confusion with regard to people accessing suitably qualified surgeons to undertake the work that is going to be done and the amount of training they have to undergo. I am looking at the different memberships and the different organisations. There is a huge cohort of organisations that represent different surgical organisations. Is that in itself relatively confusing? We have the Royal Australasian College of Surgeons and as part of that we have the Society of Plastic Surgeons, the paediatric surgeons and the aesthetic plastic surgeons. There are a range of different surgeons that are all part of that cohort. Is that in itself confusing to people?

Dr Duncan-Smith: Yes, I think it is. For example, this afternoon I could start the 'Australian College of Awesome Cosmetic Surgeons' and let people join it and then all of a sudden I am a 'Fellow of the Australian College of Awesome Cosmetic Surgeons'. We have had this problem for years now. That is why the key to this is 'AMC accredited'. That way you weed out people like the 'Australian

College of Awesome Cosmetic Surgeons'. We in the industry call them Weeties packet colleges or associations, because all you need to do is get a Weeties packet and fill out the form on the back and you are a member of it. That is where the AMC accredited—

Ms PEASE: What I am interested in knowing is: would all surgeons belong to the Royal Australasian College of Surgeons and then the subsurgeon organisations or would they just be a member of their own surgical college?

Dr Duncan-Smith: Surgeons need to be an FRACS, Fellow of the Royal Australasian College of Surgeons. Membership of the Australian Society of Plastic Surgeons is not compulsory. It is more of a craft group.

CHAIR: I thank Dr Duncan-Smith and Dr Danielle McMullen for their consideration here today.

HALLIDAY, Dr Dan, President, Australian College of Rural and Remote Medicine (via videoconference)

CHAIR: Welcome, Dr Halliday. I invite you to make an opening statement.

Dr Halliday: Thank you very much for your time today. I recognise my colleagues who have already presented and appreciate their comments. Thank you very much for allowing me to present today. ACRRM believes that this bill presents the final stage in a period of protracted consultation around establishing protected title of the designation of 'surgeon' under national law. At each stage of the consultation process, ACRRM has categorically stated that it does not support moves to legislate to protect the title 'surgeon'. However, whilst the college appreciates the aim of the legislation to protect the public from risk of harm from the practice of cosmetic surgeons, we do believe that one of the unintended victims of the legislative changes are rural generalists and rural generalist surgeons in particular.

Rural generalists are specialist general practitioners who are trained to provide context-appropriate skilled services in rural and remote areas. They have a scope of practice which is defined across primary, secondary and emergency care, meeting the needs of their communities. They might provide much needed surgical, obstetrics and gynaecological, and other non-procedural advanced skills to Australia's rural and remote communities. I note that the development of rural generalist medicine was first categorised in Queensland and recognised by the Labor Party at the time in 2005.

Rural generalist medicine was recognised in Queensland as a medical discipline specialist equivalence in 2008. The Queensland Health Rural Generalist Pathway commenced in 2007, with the goal to provide medical officers with an interest in rural medicine, including hospital-based practice, with an advanced skill suitable to a rural location.

The 2005 Roma Agreement led to the concept of 'rural generalist' as a rural medical practitioner who is credentialed to serve in hospital and community-based primary medical practice, hospital-based secondary medical practice in at least one specialist medical discipline—commonly but not limited to obstetrics, anaesthetics and surgery and without supervision of another specialist medical practitioner in the relevant discipline—and also hospital and community-based public health practice, particularly in remote and Aboriginal and Torres Strait Islander communities. The ACRRM two-year assessed AST Curriculum of Surgery is supported by the College of Surgeons and fellows of the college. The ACRRM AST Curriculum in Obstetrics and Gynaecology has been developed with the joint consultative committee between ACRRM, RACGP and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Further, the Commonwealth and jurisdictional governments have enlisted substantially in the National Rural Generalist Pathway, supporting training of rural generalists to deliver services to rural people including surgical services. The proposed amendments undermine the national validity of these programs as well as their utility, potentially discouraging doctors, patients, communities and health systems from recognising these doctors' qualified services. The perverse outcome is that rural generalists who have completed advanced skills training in surgery or obstetrics in accordance with nationally accredited ACRRM fellowship curriculum will not be able to call themselves 'surgeon'.

ACRRM fellows follow ASTs in surgery or in obstetrics and gynaecology and have the necessary surgical training, qualifications and credentialing, yet will not be entitled to refer to themselves as 'surgeons', nor be able to clearly communicate the services to patients, employers and communities. We feel that title restrictions will lead to competent and qualified practitioners in rural and remote areas being discouraged from providing critical surgical services and that people in these locations already facing significant barriers to accessing care will have their access restricted even further.

Based on appropriately informed departmental advice, we ask ministers to reconsider their agreement to the amendments on 24 February 2023 to ensure that rural generalists holding the advanced skill title mentioned above are not disenfranchised and communities they serve not disadvantaged by having to travel to major centres to access surgical procedures within the remit of local rural generalists. ACRRM recommends that the health ministers amend their approval of the title restrictions to permit fellows of ACRRM who have completed advanced specialised training in surgery and obstetrics and gynaecology to use the term 'surgeon'. I am very happy to assist with any further discussion.

CHAIR: Thank you, Dr Halliday. As I declared earlier today, I practised in the mid-2000s with rural generalists in some training. I deeply appreciate the work that they all do in rural and remote Queensland in serving the community. Your suggested amendment states—

A registered medical practitioner who has completed the Australian College of Rural and Remote Medicine Advanced Specialised Training in Surgery and/or Obstetrics and Gynaecology;

As we understand it, rural generalists are awaiting an AMC accreditation. Should that be taken into consideration? We do not know how long that will be, but would that go some way to including you within this subclause?

Dr Halliday: From a national point of view, I agree. There is a nationalised process in place which is definitely underway. As I pointed out, though, in my statement, rural generalist medicine was actually defined and accepted in Queensland as a specialised equivalent qualification, confirmed in 2008. The documents through the Rural Generalist Pathway have actually been recognising rural generalist medicine as a specialist equivalent qualification since then—so for 15 years. That has been—

(Audio missing)

CHAIR: Given the technical challenges we have, we will move to the next group of witnesses.

BORDBAR, Dr Patrishia, President, Australian and New Zealand Association for Oral and Maxillofacial Surgeons

LYNHAM, Associate Professor Anthony, Member, Australian and New Zealand Association for Oral and Maxillofacial Surgeons

MELLOWES, Ms Belinda, Executive Officer, Australian and New Zealand Association for Oral and Maxillofacial Surgeons

CHAIR: Thank you very much for joining us. I invite you to make an opening statement before we move to questions.

Dr Bordbar: Good morning. I would like to acknowledge the land we are on and pay respects to elders past, present and emerging. My name is Patrishia Bordbar and I am the current president of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons. I also work as a surgeon at the Royal Children's Hospital in Melbourne and I am also in private practice.

The Australian and New Zealand Association of Oral and Maxillofacial Surgeons welcomes the opportunity and thanks the committee for taking the time to consider our concerns. Firstly, we wish to draw the committee's attention to a serious and potentially dangerous flaw in this bill. Secondly, we request that the committee recommends an amendment to this bill to correct this loophole. ANZAOMS supports the restriction of the title 'surgeon' in national law; however, we wish to reiterate to the committee an unintended adverse consequence of the bill as it currently stands. We raise this in order to protect the public. Specifically, this legislation only covers medical practitioners, in our case oral maxillofacial surgeons. The committee may not be aware that non-medical practitioners also perform cosmetic surgery and use the title 'surgeon'. This bill will allow that to continue.

Oral surgeons who are dental specialists perform cosmetic surgery. They are a subspeciality of dentistry. They are not regulated by the Medical Board or the Australian Medical Council. As it stands, oral surgeons are exempt from this legislation as they are simply not medical practitioners. To enable them to continue to use the title 'surgeon' is a total oversight and potentially worse than the scenario that prompted this regulatory review, as they do not hold any medical qualifications.

The public deserves to be fully aware that they are being operated on by a non-medically qualified practitioner. There are many alternative titles that could be used in place of 'surgeon' for this group. We are not here today to request that oral surgeons stop service provision; we are simply trying to protect the public and futureproof the bill to ensure people are clearly aware that they are not seeing a medically qualified surgeon when they see oral surgeons. As it stands, oral surgeons can expand their scope further into cosmetic surgery without the restrictions of this bill, which only applies to medical specialists. The oral surgeons draft scope of practice in New South Wales clearly outlines their desire to expand their scope of practice beyond confinement to surgical dentistry and, may I add, across all age groups including paediatric.

Medical regulators have undertaken extensive work to protect the public in the area of cosmetic surgery; however, this has not extended to the dental regulators. In order to overcome this problem and to be consistent, the legislation must restrict the use of the word 'surgeon' to those recognised Australian Medical Council specialities. As Ahpra states in its submission—

> We welcome an explicit provision being inserted in the National Law to protect the use of the title 'surgeon' within the medical profession, to ensure that only medical practitioners with significant surgical training can use the title, make claims, or hold themselves out as being a surgeon.

It is clear that as a society we are concerned about regulating the term 'surgeon' for cosmetic clinicians who hold only medical degrees. It follows, then, that we should be even more concerned about non-doctors holding themselves out to be surgeons. This is a public protection issue. We therefore ask this committee to recommend amending this legislation to restrict the term 'surgeon' from any group performing cosmetic surgery such as, in this instance, the group of dental specialists that presently use the title of 'oral surgeon'. Restricting the term 'surgeon' to medically qualified Australian Medical Council specialities is the logical way to avoid the loophole and futureproof the proposed amendment of the act as it currently stands. Thank you. I welcome questions from the committee.

CHAIR: Thank you very much. That was well articulated, Dr Bordbar. I have to get Dr Lynham on the record with his views. With the indulgence of the committee, I will allow some latitude.

Prof. Lynham: Thank you very much, Chair. I completely concur with the president of our association. The loophole in this legislation is simply that: the legislation only covers medical practitioners. Oral surgeons are completely exempt from this. As the president pointed out, it is

extremely dangerous. They know there is a loophole there, and presently there is a submission before the New South Wales dental board to exploit this loophole. It seems a very simple thing to me and to a number of my colleagues to restrict the title of 'surgeon' to AMC recognised specialities.

CHAIR: I think that is articulated in the submission. We have heard it again with the rural generalists' argument. They have an application before the AMC. That is certainly articulated in your submission. Deputy Chair?

Mr MOLHOEK: I am not sure where to go with this, Chair. Perhaps my question is to Dr Lynham, only because I sort of know him. I have a little bit more trust in his opinions, I guess, because there is some history. As a group, you have opened up another category that we should be concerned about. We heard earlier that the concern is around medical practitioners who practise cosmetic surgery. Now we are hearing about concerns around people who practise oral surgery. Is that correct? I wonder how far we go and how detailed we end up getting on the use of titles and whether there are other unintended consequences with the legislation that we become so prescriptive that it just makes it really difficult for anyone to administer. How big is the problem? We have heard about cases of significant harm. The OHO reports to this committee fairly regularly, and I am scratching to think of any of any occasions when it has raised concerns around harm.

Dr Bordbar: You have put a few things in there. I will take them one by one. I would say that in contemporary society, in 2023, even one patient being harmed is one too many. That is the first thing. In Queensland you have experienced the unique situation of one practitioner, Dr Patel. One practitioner can do a fair bit of harm, because it often takes years and years for all the patients to come together and understand that they have all been collectively treated by this one practitioner. When there is an opportunity such as this, which is a clear debate about what as a society we will want to agree on—on this use of the title 'surgeon'—it would be a missed opportunity if we did not take a look at it at this point in time in our society. I do not think it is necessarily about what is happening now and what harm has been caused and whether there are volumes of it. One is too many, in my opinion.

Mr MOLHOEK: I take that comment on board. None of us wants to see anyone harmed. We hear so often in debate around legislation 'if it saves just one life' or 'if one person is not harmed', and the almost unspeakable question that I find myself asking is: how many other people missed out on better care or access to care because the rules and the legislation were so prescriptive that it discouraged others from getting involved in providing those services?

Dr Bordbar: Perhaps I did not clarify it, sorry. As I said in my statement earlier, we do not want to prevent service provision by this group. There are other titles they could use to demonstrate to the public that they are specialists in surgical dentistry, rather than calling themselves oral surgeons. The problem that we see is the use of the title 'surgeon'. No-one is suggesting any restriction around service provision. That is actually what we are here to discuss: who should use the title and what does the public think when they see that person? Nobody is suggesting they should stop providing good service.

Mr MOLHOEK: I am a little confused by that, though. If they are providing oral surgical procedures, does it not therefore follow that they are an oral surgeon?

Dr Bordbar: The draft scope has gone in front of the New South Wales committee. In 2019 they proposed performing facial trauma surgery as well as laser surgery. I can send that to you later. By 2023 they have expanded to salivary gland surgery, which would include parotid and submandibular gland excision, which is external surgery through the skin, as well as performing jaw surgery—jaw reconstruction and corrective jaw surgery—which they have put in their scope now. This is what we are now bringing to your attention, which is that they are drifting outside surgery confined to the teeth.

Mr MOLHOEK: They are drifting into areas of cosmetic surgery?

Dr Bordbar: If you do jaw surgery and move jaws around and do chin surgery, that starts to become cosmetic, certainly.

Mr MOLHOEK: So really the concern is around performance of cosmetic surgery by unqualified individuals?

Dr Bordbar: Correct.

Prof. Lynham: It is quite simple: the public just has to know who their surgeon is, who is operating on them. If they have the title 'oral surgeon', people would consider that to be a properly qualified surgeon.

Ms PEASE: Thank you very much for coming in. It is lovely to see you, Dr Lynham. I would like you to elaborate on the requirements in your field to be able to undertake the sorts of works that you do—the jaw and facial surgery—and all the sorts of training that is required in terms of being able to do that surgery as compared with a dentist.

Dr Bordbar: Thank you for the opportunity to answer that. Currently, the requirements to be a specialist oral maxillofacial surgeon in Australia are a degree in dentistry and a degree in medicine, so that is dual qualification. In addition to that, there is one year of training as a medical intern and then a further year of training in surgery in general in hospitals and a further four years minimum of registrar training, so specialist training, in specifically oral maxillofacial surgery, which is hospital based. Many of us go on to also do subspecialty training once we finish and receive our qualifications. For instance, I have done cranial facial surgery for a further couple of years in the UK, so most of us will go on to do more. That brings it to about 17 years of training, following completion of your high school diploma. Oral surgeons currently complete their dental qualifications and then go on to do a university-based degree, which is a three-year degree and is not hospital-based training. We have heard about that from some of the other speakers today. That is a university masters program which they can utilise to register with.

Ms PEASE: Once those oral surgeons have completed that three-year university qualification, can they become members of the Royal Australasian College of Surgeons?

Dr Bordbar: No.

Ms KING: Is the pathway following on from that oral surgery—the degree and the masters that you have mentioned—then generally into private practice?

Dr Bordbar: For us as oral maxillofacial surgeons?

Ms KING: No, for oral surgeons—for people currently holding themselves out as oral surgeons.

Dr Bordbar: Oral surgeons do not do a medical degree.

Ms KING: You talked about the dentistry degree and then the masters degree.

Dr Bordbar: The masters degree, yes.

Ms KING: Is the pathway thereafter normally straight into private practice?

Dr Bordbar: Many do private but some do some public work.

Ms KING: In what kinds of contexts would they do that public work—in a hospital setting or in a public dental setting?

Dr Bordbar: It could be in a public dental setting. There are not many in my city, so I cannot give you specifics, but if you could perhaps tell me what you are alluding to I perhaps could. Here we are specifically talking about the issues to do with cosmetic surgery, which obviously is done in a private setting and has financial incentives. Again, I want to circle back to saying that I understand, just like RACS does, the role that clinicians play in providing service to patients. What is not necessary, though, is that specific title of oral surgeon. That can be done with a title that signifies there are specialist surgical dentists and that will not cause confusion. That is what we are really talking about here. No-one is talking about preventing anyone from providing good service.

Ms PEASE: What sort of surgery would a dentist perform?

Dr Bordbar: A general dentist?

Ms PEASE: A general dentist, yes—that masters degree.

Dr Bordbar: People currently called oral surgeons?

Ms PEASE: Yes.

Dr Bordbar: Traditionally they have performed surgery confined to surgical extraction of teeth and the jaws, but what we are now finding, as I said with this draft scope of practice in New South Wales, is the desire to do a range of things well outside that—and also the jaw surgery, which clearly falls into this cosmetic surgery sphere.

Ms PEASE: That is clear. What are the oral surgeons performing now in Queensland, for example? Are we aware of any work that they are doing in a dental setting, not necessarily in a cosmetic surgery setting?

Dr Bordbar: They would be performing a range of work within the scope of practice, which is not restricted at the moment and why we are here to discuss the title.

CHAIR: Dr Lynham, you have performed maxillofacial surgery for decades. What does that look like from a training perspective? I know I am asking you to go back. Can you unpack that?

Prof. Lynham: As my good colleague the president pointed out, we train for decades before we operate for decades. Obviously with my face, I look like I have done both. It is unfathomable the difference between the two groups. Oral maxillofacial surgeons have a wealth of surgical training in head and neck surgery, most of the trauma surgery, and mostly public hospital domain treatment, whereas the group calling themselves oral surgeons—that is all university-based training, working in dental hospitals. As with cosmetic surgeons now, they have the full remit to enter into private clinical rooms or into a private hospital and perform a vast array of procedures without the appropriate training. We are not here to debate that. We are here to make sure that the public is fully aware of who is operating on them; it is as simple as that. Off the tip of my tongue I can think of five different names they can call themselves rather than surgeons—and they would still have people attending their practice, but the people would know completely that these people were not AMC qualified surgeons. That is all we ask. All we ask for is the warning of the public.

CHAIR: I think that is a good way to conclude this contribution. Thank you all for being here today. It is much appreciated.

Proceedings suspended from 10.41 am to 11.03 am.

HARRIS, Mr Ben, Director Policy and Research, Private Healthcare Australia (via videoconference)

CHAIR: The hearing will now resume and I welcome the representative from Private Healthcare Australia. Ben, welcome. Over to you for an opening statement before we go to any questions.

Mr Harris: Private Healthcare Australia is the peak body for Australia's health insurers. Our members, which include all of the major health funds, hold funds for over 98 per cent of the 14.4 million Australians with private health insurance. We welcome the opportunity to present to the committee on the Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023. Private health insurers have a strong vested interest in ensuring that quality standards are in place for any medical practitioner offering procedures. We support the highest possible standard of care where training and standards are accepted and accredited independently on advice from the learned colleges. I also note that we are the only consumer-centred organisation that chose to make a submission to the committee. I welcome the consensus between the medical groups and the public interest which demonstrates the significant support for this legislation.

In the interests of patient safety, it is necessary to address public confusion regarding the qualifications and training of practitioners performing surgery and ensuring patients are not misled. It can be very difficult for health funds to explain the difference between an accredited surgeon with a qualification and a person self-nominating as a surgeon and why they might not be covered for a particular procedure. Consumers can be misled regarding the role of their insurance cover which places additional financial burden on individuals to cover the full medical costs of medically unnecessary surgical procedures performed by non-surgeons. Further, private health insurers are often called upon to fund medical procedures provided by accredited surgeons to fix issues caused by inappropriate surgery provided by poorly trained medical practitioners. This increases the premiums for all policyholders. Funding corrective medical procedures and surgical complications that can be caused by doctors who are not appropriately qualified puts additional pressure on the health system cost, including private health insurance premiums. For that reason, Private Healthcare Australia supports title protection for health practitioners using the title 'surgeon'.

The bill is supported. However, it is unclear to us why the bill is only limiting title protection to medical practitioners. The bill's explanatory material does note that the diversity of qualifications and experience of those calling themselves 'surgeons' has caused confusion, but I reasonably assume that all practitioners using the title have comparable qualifications with an appropriate level of advanced surgical training, so we ask that the parliament consider extending the title protection for 'surgeon' to all registered health practitioners covered by the national law. I have noted the government's response to the committee submissions arguing against that and suggesting that current protections are sufficient. I would argue that they are not and that the committee should recommend to the parliament that all registered health practitioners covered by the national law have this title protection. Thank you.

CHAIR: Thank you, Ben. With regard to your opening statement, you talked about inappropriate surgeries and corrective surgeries. Do you have any data on that in terms of numbers?

Mr Harris: We do not have firm data on it, but what I have done is gone and spoken to our health fund members and asked for any data they have. Of course when something is covered by Medicare and by the health insurer, we actually do get good data. One of the great problems we have is that a whole lot of this happens outside of the Medicare system and outside of the health insurance system using private funding or people using their superannuation inappropriately, so it is very difficult for us to get firm data. I have a couple of estimates but none of them I consider good enough to put on record.

Mr MOLHOEK: Just for clarity, your submission states—

> We ask that the Parliament consider extending the title protection for 'surgeon' to all registered health professions covered by the National Law.

Just so I am clear, are you suggesting that you support rural health specialists and oral surgeons, as we heard earlier, being able to retain that title? I am a little bit confused by that statement.

Mr Harris: We do not have a role in determining who is appropriately qualified or not; our role is as a funder. Our view is that the Medical Board for medicine and the other boards for other professions should be able to make that determination. For example, to use oral surgery, that is a recognised qualification that would fit the definition that we are putting forward because it would be recognised as someone covered by the national law with an accredited qualification.

Ms KING: Thank you so much for providing the viewpoint of health insurers and health funds for today's hearing. You mentioned in your opening statement issues with people paying for presumably cosmetic procedures by using their superannuation inappropriately. Are you referring to the period during COVID where people could access their superannuation in lump sums, ostensibly as cost-of-living support, and then multiple news stories said that some were going on to use those for cosmetic procedures or are you talking about bariatric surgery? In what circumstances are people accessing their superannuation and potentially undergoing procedures that may be conducted by somebody who is not in fact a qualified surgeon?

Mr Harris: The Australian Taxation Office at the moment can release superannuation for a range of medical and dental procedures, so it is not the COVID superannuation thing, and I am sorry but I will send figures after the meeting. What we have seen is a very large increase over recent years of people using their superannuation for medical procedures and cosmetic dental procedures. We have put in a submission to the Australian government which is currently looking at the purpose of superannuation and we are recommending that that get tightened up. In that submission we found that there were several dozen people who call themselves 'surgeons' who are not actually surgeons who are advertising that they could do cosmetic procedures by using superannuation. These will not be covered by Medicare because they are not medically necessary, but there is a bit of a gap in the current rules where basically the doctor who is wanting to provide the surgery is the person who signs off that it is necessary to use your superannuation. There is a clear conflict of interest there and we have seen many examples of people pulling out tens of thousands of dollars to use their superannuation for some very marginal procedures. Our view is that if it is medically necessary it will be covered by Medicare; if it is not medically necessary you should not be using your superannuation. Importantly, when we looked at the websites of the people advertising to pull money out of superannuation to do cosmetic surgery, very few of them were surgeons; they were doctors calling themselves surgeons.

Ms KING: That is interesting. Just to clarify, in order to justify that access to superannuation, the practitioner providing the service signs off that it is medically necessary and that is the test for access to the superannuation funding?

Mr Harris: Yes, that plus one other doctor, the patient's general practitioner.

Ms PEASE: Referring to your submission, for medical practitioners and specialists and surgeons, they have to be, I understand, recognised or registered by the health funds and health insurers.

Mr Harris: When someone is registered by Ahpra, the Australian health practitioners registration authority, then, yes, they will be registered for private health insurance purposes.

Ms PEASE: In your submission you say that consumers are disappointed often by the level of rebate that they get when they are seeing people who make out that they are surgeons and they are not getting the same rebate that they had expected to get. Does that happen often?

Mr Harris: It is a significant problem which health funds deal with on a weekly basis. Occasionally they will get a rebate if it is an MBS procedure with a cosmetic add-on and then occasionally there is no private health insurance rebate because there is no Medicare rebate payable for a purely cosmetic procedure. When a consumer goes to somebody who is calling themselves a surgeon, the consumer has, in my view, a reasonable expectation that the person is properly qualified and they are providing medically necessary surgery. In many cases consumers are disappointed when they ring their health fund and say, 'How much will I get back for this procedure?', and they are told, 'Actually, they're not a proper surgeon and it's not a medically necessary procedure.'

I want to be very clear that the learned colleges that do do the proper surgical training are really good at making sure that patients get what we call informed financial consent where the practitioner is very clear what is covered and what is not and the consumer is well informed. The Australian Medical Association has put out a good guideline for its members on this as well. What we find is that those practitioners who have gone through the learned colleges, such as the College of Surgeons, the College of General Practitioners and basically any of the specialist colleges, are good at informed financial consent. Those who have not gone through that ethical framework and the peer support of speciality training are where we run into problems.

Ms PEASE: Thanks very much.

CHAIR: Thank you. Apologies, Mr Harris. Your contribution has been very helpful for us. We had a technical issue before with one of the other witnesses, so we will give him a couple more minutes. Thank you for your contribution today.

HALLIDAY, Dr Dan, President, Australian College of Rural and Remote Medicine (via videoconference)

CHAIR: We now welcome back Dr Halliday. Our apologies for the technical issue. We will let you continue.

Dr Halliday: My apologies from my end; I had to completely reset.

If I can restart with a quick refresh about the recognition of rural generalist medicine in Queensland in 2005 and the formal recognition in 2008, which tied in with the AMC accreditation of ACRRM at that point in time. Then, of course, the collateral recognition of the Royal Australian College of General Practitioners with their far GP qualifications, obstetric skills and the extended skills program that they have. Rural generalist medicine is recognised as a qualification of specialist equivalence in Queensland already. It has an industrial framework which backs that up and which directly aligns within the specialist framework in Queensland.

If we look at the comments that have already been made, the rural generalist qualification—as it applies to Queensland and looking at the legislation—ACRRM as well as the RACGP are both AMC-accredited colleges. They have been through that rigorous process. ACRRM has accreditation for six years up to 2028, and that accreditation also undertakes reviews of the advanced specialist skills terms. All of those processes are in line with the scope of practice and, of course, within the context of practice as well. Rural generalist medicine, particularly in Queensland, is aligned with the Modified Monash Model's 3 to 7 areas, and it has been defined with an industrial context. We have the specialist equivalence recognition, we have industrial recognition and we have AMC recognition of the qualifications. There is recognition—as my colleague Danielle McMullen referenced—of the concept of a general practitioner surgeon and increasingly over the last 15 years rural generalist surgeon has been well recognised, and it has robust methodology and accreditation associated with it.

The college is not necessarily asking to be seen in the same vein as the Royal Australasian College of Surgeons fellows, but that it recognised that there is a defined scope of practice, with robust accreditation basis behind it and to have the qualifier of 'general practitioner' or 'rural general surgeon' applied to the legislation. It is context appropriate in terms of the practice of rural generalist medicine and, of course, the rural generalist practice associated with the use of the title 'surgeon'. I appreciate I did not have much time. I hope I made sense, and I am certainly happy to take comments.

Ms KING: Thank you for returning to continue your submission. I, and all of my colleagues, acknowledge the work that your members do in caring for people across the length and breadth of Queensland; it is very much appreciated. Say one of your members has endorsement—you will be able to correct me on the terminology—for ob-gyn work. What is the difference in training that that person may have received as opposed to a member of the ob-gyn college who is not a rural generalist? Can you explain that for us?

Dr Halliday: Yes. I am a rural generalist obstetrician, as well as my other roles. It comes with the context of care that we provide for patients. My specialty training took just under five years by the time my qualification came through. The minimum time frame, everything going well, would be four years specialist qualification under the general practice training pathway. The DRANZCOG advanced component is a minimum of 12 months training. Some people, depending on their ability to access the requisite number of case load and skills mix, would take anywhere between one and two years. Generally, you are looking to four to five years of practice before you can be a fellow. Of course, it is a defined scope of practice within a rural generalist context—so Modified Monash Model 3 to 7. The Royal Australasian College of Surgeons will have the generalist qualifications, then they might have orthopaedic surgeons and ENT surgeons and the like so there is a defined scope of practice, but we are rural. It is within a scope of practice that is more rural and, of course, it is not just how you operate in theatre but it is how you manage the patient case load, how you deal with someone who is 400 kilometres away and they have a complication? How do you manage their retrieval? How do you manage their referral processes around that? There is a lot of context-based care.

When you look at the specialty pathway through the Royal Australasian College of Surgeons, obviously they have up to 10 to 12 years, depending on the pathways that they choose. Some of them take a long time to get onto their accredited training pathways. Of course, they have defined scope in terms of what they do, and we certainly have scope. As I said, the title in itself is a qualifier of 'rural generalist' or 'general practitioner'. Specifically, [ACRRM focuses on the rural generalist concept of surgeon.

To put it into the context of a patient, I will be managing someone in the birth suite and for all intents and purposes everything goes okay, but unfortunately we have a potential complication and we advise an emergency caesarean section. We provide the advice, we understand the context about why and how we get to the recommendation of the surgery that needs to be done. We get everything ready, we go into theatre to prepare to perform the procedure and the question is, 'Who is the surgeon today?' Do we say that I am not the surgeon today if I walk into that emergency caesarean section and perform that procedure or my colleague who will be doing an emergency appendectomy for someone who comes in, is diagnosed and is 200 kilometres from Toowoomba? We have a defined scope of practice—absolutely. We have a context of practice—absolutely. That process has been in place for over 15 years in Queensland. Generally, the concept of general practitioner and increasingly rural generalist surgeon is recognised through the community as much as it is within the medical fraternity. As I said, the training is not only about the content but also the context of care that is provided.

Mr MOLHOEK: You have already answered my question. I should disclose, too, that my son is a rural generalist who was recently moved from Emerald to Toowoomba. In your submission you talk about the challenges that are facing rural health and securing enough doctors to work in rural and remote Queensland. How important is this as an issue from your perspective, in light of the comments that you have made in your submission on page 3 where you talk about devaluing the role of rural generalists?

Dr Halliday: I can absolutely reference the work that has been done in Queensland already and the Ernst & Young report from 2013, in terms of the evaluation of the rural generalist program. There are four pillars that were recognised through the Ernst & Young report that apply to the Queensland recognition of rural generalism. One of those key pillars is the specialist endorsement. Queensland has been successful and one of the reasons for that is the specialist equivalence recognition of rural generalist medicine. That is one of the four key pillars of rural generalist medicine and the rural generalist program. The other three being value and, of course, the industrial framework—which has recently been updated to fully recognise that—that is a significant part. Obviously it is the package, not just money. It is the training pathway. So both colleges have now aligned with support for rural generalist medicine, not just in Queensland but across Australia, so that is really important as well.

The other pillar is the recognition to value-add as an identity because you can't be what you can't see, and to value the recognition of the identity of a 'rural generalist'. Specifically as we talk to the use of the title of 'surgeon' as it applies to rural generalist surgery, rural generalist surgeons and rural generalist obstetricians to actually be involved in changing service redesign. We know that there are significant issues in terms of rural health. We know that there are issues in terms of the ability to attract and retain general practice trainees who will become rural generalists, but we need to have those multitalented, multiskilled rural generalists to work with pharmacists, nurses, midwives and allied health providers to provide those multidisciplinary models of care that our rural Queenslanders need. One of those key pillars that is recognised is the identity and the recognition of the qualification. The title of 'surgeon' is a significant component of that.

CHAIR: Thank you. We are a little over time. We appreciate you returning to finish your contribution, Dr Halliday. It is greatly appreciated.

COSENZA, Mr Adrian, Chief Executive Officer, Australian Orthopaedic Association (via videoconference)

PEEREBOOM, Dr Jeffery, Orthopaedic Surgeon, Australian Orthopaedic Foot and Ankle Society

CHAIR: I now welcome the next witness, via Zoom, from the Australian Orthopaedic Association and the witness from the Australian Orthopaedic Foot and Ankle Society, who is here. I invite you to make a brief opening statement after which the committee members will have some questions for you.

Mr Cosenza: Good morning. I am here today with Dr Peereboom. This is a joint presentation, with the Australian Orthopaedic Foot and Ankle Society and Dr Peereboom. I will make an opening statement, invite Dr Peereboom to also make a few comments and then we can open it to questions; is that okay, Mr Chair?

CHAIR: Certainly, thank you.

Mr Cosenza: Thank you for the opportunity to meet with the committee to share the views of the Australian Orthopaedic Association. I am the chief executive officer of the Australian Orthopaedic Association. The Australian Orthopaedic Association is the peak professional body for orthopaedic surgeons in Australia. AOA provides high-quality specialist education, training and continuing professional development. AOA is committed to ensuring the highest possible standard of orthopaedic care and is the leading authority in the provision of orthopaedic information to the community. AOA's contribution to this hearing is made with the following goals in mind. Firstly, ensuring public safety. Secondly, ensuring the parity of surgical training with all other surgical specialists operating on members of the Australian public. Thirdly, ensuring accreditation of courses to educate any medical practitioner prescribed by surgical class who operates on the public is to the same standard as that required by the Australian Medical Council. Fourthly, that the surgical training of such medical practitioners is accredited by an independent accrediting body with experience in the field of surgical training programs such as the Australian Medical Council.

The [Australian Orthopaedic Association strongly supports the passage of the Health Practitioner Regulation National Law (Surgeons) Amendment Bill 2023 as a way of ensuring the protection of the public from harm from operations carried out by those who are not surgeons. The Australian Orthopaedic Association's interest in the bill relates to one key area: the insertion of the new section 155A(5)(e) relating to another class of medical practitioner prescribed as a surgical class by regulations made by ministerial council. We are concerned with the implication of subsection (5)(e) of the proposed bill. The freedom to allow future classes to be free to use the title 'surgeon' is a serious weakness, as it allows those without full specialist education and training to adopt use of the title 'surgeon'. Full specialist education and training takes up to 14 years. Some medical or allied practitioner craft groups, who currently undertake surgery, train for only six to eight years in comparison and carry the title surgeon. The AOA believes this is misleading the public and should be corrected. The AOA holds longstanding concerns about podiatrists who title themselves as paediatric surgeons and perform invasive surgery on bone and tendon procedures which should only be undertaken by someone with a medical surgical fellowship.

We do not consider that the podiatry-based training of Australian trained operating podiatrists (1) meets the parity of standards of education, skills and training as that of an orthopaedic surgeon; (2) demonstrates uniformity with the training requirements and accreditation equal to every other group of health professionals that perform surgery on the Australian public; and (3) that the education and training is not assessed by an external independent body such as the Australian Medical Council. To address this potential weakness we would suggest that proposed subsection 115A(5)(e) line 32 is changed to read 'another class of' and the words 'AMC accredited surgical specialist prescribed as a surgical class by regulations made by the ministerial council' inserted. This change will ensure that the standard of training of surgeons would be preserved into the future. Alternatively, subsection 115A(5) could be altered so that AMC 'accredited surgical specialist' is put in the place of 'medical practitioner' in proposed subsection 115A(5)(a). Our understanding is that this would mean that proposed subsection 115A(5)(d) and (e) would be superfluous and could be removed.

Currently, allied health professionals are allowed to use the term 'surgeon', but in the current confusion of nomenclature and in the absence of AMC certification the AOA believes that these persons should be referred to as 'operative allied health professionals' and not 'allied health profession surgeons'. It does not serve the interests of the public or patient safety to have arrangements whereby a discrete area of a more general speciality such as surgery is covered by a

different accreditation standard for education and training. We believe this should be the Australian Medical Council. The AOA has advocated for over a decade on the harm to members of the community who are subjected to procedures from operating podiatrists using the term 'podiatric surgeon'. This is a community health problem that is long overdue to be addressed before more patients are further harmed. We would urge the committee to review proposed subsection 115A(5)(e) and its future implications in order to preserve the positive intent of this important legislation. I would now like to invite Dr Peereboom to make a few comments through you, Mr Chair.

Dr Peereboom: I think that the goal of this legislation is laudable. It wants to protect patients, and it protects them by giving them a crystal clear understanding of what the word 'surgeon' means. Once you understand what 'surgeon' means, you are then in a position to give informed consent to undergo a surgical procedure. The bill aims to define what a surgeon is. Each of us is a normal person and we have in our brains what 'surgeon' means. Almost everybody is going to say that it is a doctor who has had specialist training in some sort of surgical intervention. To its credit, that is what this legislation puts down and is hoping to protect. You would think it is crystal clear what a surgeon is, but we have a few minutes. Let's talk.

Let's run a scenario where this legislation passes, and in a couple of weeks time somebody you love falls over and breaks their ankle. You go and see someone who says, 'I'm a registered health practitioner, Dr Jim Jones. I'm a foot and ankle surgeon. This fracture is terrible. It needs an operation. If we don't it may not heal, or it may heal and you may get arthritis in it.' In that turmoil you are trying to decide. You are worried about the future. Have you seen a surgeon? In your own internal thoughts of what a surgeon is, did you see a surgeon? You are special because you have read this legislation, so under the legislation side of things have you seen a surgeon? The simple answer is that if you are sitting there going 'I don't know' or 'what's the angle?' this legislation has failed because it was supposed to make it crystal clear who is a surgeon. It fails because you know about proposed subsection 115A(3)(b), which says that people from other allied health professions can use the term 'surgeon' quite legally. They are not included in this. The reasoning behind it is that allied health professionals such as oral surgeons and podiatric surgeons are used to using the term 'surgeon'.

I am absolutely convinced this is the right thing to do, but you can imagine the fight we are going to have when we say to our rural surgeons, 'Guys, before you get your AMC accreditation you have to swallow it. Even though you have done a great job up until now, you have to say, "I'm going to call myself an operative GP." Once you get the accreditation you will be a surgeon, because that is what the definition of a surgeon is. Until then you have to cop it, but an allied health professional does not.' That is where the confusion lies. This legislation has not only failed but it is inconsistent. It has this inconsistency in it and it is not futureproof because as people expand their scope of practice every allied health professional can use the term 'surgeon' if they venture into the surgical side of things because 115A(3)(b) specifically allows it. You have to ask yourself, 'How did we get here?' We got here because patients went off to see somebody. They had an operation thinking that they were seeing this person, but this person—qualification wise—had the capacity to use the word 'surgeon' completely legally. This legislation enshrines exactly that because that is what proposed subsection 115A(3)(b) does. So if this encompassed all health practitioners—not just medical practitioners, but all practitioners in every medical situation—that question would never arise because everyone would know that the second the word 'surgeon'—it does not matter what the adjective is—came out of their mouth they were a medical practitioner with AMC accreditation.

I know this scenario thing sounds silly, but I can inform you that, in the last two weeks, two patients went through that. Those patients went to somebody, had an operation and had major complications. They were then admitted into Queensland public hospitals where they had multiple operations. They are still not sorted out and they are planning to have more operations due to those people. They failed that test because they believed their internal definition of what a surgeon is. They are now sitting there saying, 'Who could let this happen? How can these people, who are not doctors, have the right to use the term "surgeon"?' We have to ask how this legislation can enshrine that inequity, when its whole argument is by making it absolutely clear that the word 'surgeon' means exactly what you think it does but there are exceptions. I do not think the legislation, as it is currently formed, is adequate because it does not encompass everyone.

CHAIR: How long have you practised as an orthopaedic surgeon?

Dr Peereboom: About 25, 27 years.

CHAIR: How long did your training take?

Dr Peereboom: You do your medical degree, so I will not even count that. Then you do four or five years before you get onto the training program, four years of specialist training to get that level of AMC accredited specialist, but then I did another four years of expert training just in foot and ankle surgery overseas before I came back and set up practice.

CHAIR: Have you been practising in Queensland for a long time?

Dr Peereboom: All that time.

CHAIR: I worked with Dr Bruce Low many, many years ago.

Dr Peereboom: We are not the same.

CHAIR: We just heard from rural generalist representatives, who gave a couple of examples of an emergency appendectomy and I think a C-section. I know they are going through AMC accreditation at the moment, so would that settle it in your mind? I do not want to put the cart before the horse, but if the AMC accredits that particular group and they sit within the—

Dr Peereboom: They should absolutely have the title. That is just it: if it is an independent thing, nobody gets an opinion other than the AMC, and if they say they are an equal standard to a surgical practitioner, they should absolutely have the title. Until then, I think we have to ask them to swallow—and they will not like it—the term 'operative GP' until they get that. Then when they get it, it is absolutely right. That is what every allied health professional should be doing. I also feel that if you are not as well trained you should think twice about offering your service. If you want to use the term 'surgeon', you will be trained as well as anyone else and there should be no argument. In other words, there might be podiatrists, operative podiatrists, but fellows who have gone off and actually got accredited by the AMC to the same standard as a normal surgeon, and so they would then be a podiatric surgeon. That would be completely consistent with the legislation.

CHAIR: Just unpack podiatric surgeon for me. So they are not AMC accredited?

Dr Peereboom: No. There are a group of people who have registered with their board, so they have a subspeciality registration. When that subspeciality registration was put in they approached the Australian Health Ministers' Advisory Council—AHMAC—and they got approval to set up a specialist register and they got approval to use the term 'surgeon.' That is not because the board or anyone else said they had the same standard as an AMC certified surgeon; it was to differentiate them from other podiatrists. There are podiatrists who do operations and those who do not. So they were given the title 'surgeon', but they could have equally been differentiated by using the term 'operative podiatrist'. It is our recommendation that, when allied health professionals move into the realm of doing surgery, unless it has absolutely been approved by the AMC they are compelled to use the term 'operative' whatever the health professional is—for example, an operative physio, an operative OT—so it would then be clear to patients. If they went to see somebody who said, 'You need this operation,' you could say, 'You're an operative podiatrist. Does that mean you're a surgeon?' Then they would say, 'Well, no. "Surgeon" is a specific term under the legislation that I am not allowed to use because I don't have AMC accreditation. I am a specialist trained podiatrist. I can do this operation and this is what it will involve.' Now, you as a consumer can then say, 'That sounds reasonable. He picked the problem; he's got an answer. I'm happy with that.' Or you might as a consumer say, 'I would like a doctor to operate on me rather than somebody who's a podiatrist.' That is exactly your right and you should have that knowledge. At the moment it is all confused. It is one cloudy mess, and this legislation does not clarify that to patients at all.

Mr ANDREW: You mentioned that the complications for one of the patients are ongoing. Could you explain how these people get to practice or go in and operate on people? Do they have to book a room or do they have to go through a system? How do they get access if they really do not have that qualification?

Dr Peereboom: They cannot go to a public hospital. Operative podiatrists can get access to some day surgery units, but many day surgery units have what they call a medical advisory council where you have to go, present your credentials, and people sort of say, 'Yes, we think this guy is okay to go ahead with it.' Some of the smaller ones do not have that. In fact, if you set up your own day surgery clinic, you can set it up yourself and you can give yourself the right to have access through that.

Mr MOLHOEK: I just wanted to ask you about your comments with respect to proposed subsection 115A(5)(e). There seems to be some contention around whether politicians should be deciding on future categories, should they emerge, or the AMC. Could not it be argued that a ministerial council would have less self-interest in making those determinations than the AMC, which essentially controls surgeons and surgical procedures in Australia, and that it would be in the greater public interest to have an external objective group of people make that determination?

Dr Peereboom: From my point of view, the AMC is absolutely independent, so it gains nothing by creating a new standard of surgeon. I would spin it the other way. As a politician, do you want to be trying to differentiate between somebody who is a thoracic surgeon and an abdomino-thoracic surgeon and saying, 'They're a different group now'?

Mr MOLHOEK: It would not actually be me. It would be the state ministers who make up the ministerial council.

Dr Peereboom: But it is coming. You could be the state minister. Don't sell yourself short!

Mr MOLHOEK: If I were the state minister, the level of advice that ministers receive in that sort of setting would be fairly significant and they would be drawing on the AMC and other bodies for advice.

Dr Peereboom: Absolutely. It would go from the AMC to the Medical Board to you, so there still is that line of communication between them.

CHAIR: I am terribly sorry, gentlemen. Unless there are any concluding remarks, we really do need to push on to the next witnesses. Thank you very much for your contribution here today.

COULSON BARR, Dr Lynne OAM, Queensland Health Ombudsman

FLETCHER, Mr Martin, Chief Executive Officer, Ahpra and Medical Board of Australia (via videoconference)

ORCHARD, Dr Jamie, General Counsel, Ahpra and Medical Board of Australia

TONKIN, Dr Anne AO, Chair, Medical Board of Australia (via videoconference)

CHAIR: I welcome representatives from Ahpra—Mr Martin Fletcher via Zoom is joined by Dr Jamie Orchard, General Counsel, here in the room and Dr Anne Tonkin also via Zoom—and our Queensland Health Ombudsman, Dr Lynne Coulson Barr. Who would like to start?

Mr Fletcher: Perhaps I will lead off with some opening comments. Thank you for the opportunity to appear today as part of the committee's inquiry. As you said, I am joined by Jamie Orchard, who is the General Counsel for Ahpra and is in the room with you, and Dr Anne Tonkin, who is the Chair of the Medical Board of Australia and is on Zoom as well.

In 2022 all Australia's health ministers supported our call for reform of the cosmetic surgery industry. It was necessary and it was urgent. Nine months later a comprehensive package of regulatory reforms is in place. This includes higher standards, tougher advertising rules and stronger requirements for the facilities where cosmetic surgery can take place.

This bill is a key element of that reform package and has our full support. In short, protecting the title 'surgeon' will stop any doctor without specialist registration in surgery, obstetrics and gynaecology or opthalmopathy from calling themselves a surgeon. This is a sensible change that will empower patients by making it clear who is a qualified surgeon and who is not. Without this amendment, any medical practitioner currently can call themselves a surgeon. In the cosmetic surgery industry in particular, this looseness of language has caused confusion. I would like to acknowledge and thank the brave individuals who have shared with us their often harrowing experiences of cosmetic surgery.

I know the committee is interested in some of the data about patient harm. The cosmetic surgery hotline that we established in September last year has received 222 calls, leading to 112 new notifications—what we call complaints—related to cosmetic practices. We are currently managing 259 notifications, 218 of which relate to 53 individual doctors. We get nearly as many notifications about surgeons as we do non-surgeons, although the more serious concerns seem to be either generally registered practitioners or general practitioners. Despite the numbers, we continue to be concerned about under-reporting.

As the committee has heard in earlier evidence, many of these patients have told us that they thought that by choosing a doctor who called themselves a 'cosmetic surgeon' they were choosing someone safe. Many of the people who were harmed found out too late that it did not. With this amendment to the law, only medical practitioners with advanced surgical training, accredited to the highest standards by the Australian Medical Council, will be able to call themselves a surgeon.

Protecting the title 'surgeon' is one of two particularly important reforms about medical practitioners that will help clear up confusion in the cosmetic surgery industry. The other reform which you have heard a bit about this morning is an area of practice endorsement for cosmetic surgery. This was a specific recommendation of the independent review of the regulation of medical practitioners who perform cosmetic surgery, led by Andrew Brown, who is of course well known to the committee as the former health ombudsman in Queensland.

An endorsement on a medical practitioner's registration for cosmetic surgery is the strongest regulatory tool the Medical Board and Ahpra has. Along with title protection, it will help stop medical practitioners from creating the impression that they have qualifications they do not have. Doctors who have the endorsement will still not be able to call themselves surgeons unless they are in the surgical classes for specialist registration.

I said earlier that cosmetic surgery is a growing industry. Demand for cosmetic surgery already outstrips supply by surgeons. An area of practice endorsement aims to provide a safe alternative for patients when they seek cosmetic procedures by doctors who are not surgeons. The endorsement creates a high standard, set by the Australian Medical Council and Medical Board of Australia, where until now there have been no standards.

Despite the earlier evidence the committee has heard, following a period of consultation, the standard, outcome statements and capabilities for the endorsement were published in full by the Australian Medical Council on 19 April, along with the ministerially approved registration standard.

Patients can still choose a surgeon for cosmetic procedures, and we would support this choice. However, the area of practice endorsement provides important information for patients who do not choose a specialist surgeon.

Specialist title and area of practice endorsement will be published on the public register so that consumers can see which doctors are trained and qualified. Both reforms aim to help reduce the confusion that has caused so much harm in the cosmetic surgery industry and help patients choose where to go to receive safe care. This is because cosmetic surgery is where surgery is happening by choice, when patients need most help navigating a system in which they must be wary and in which social media can play such a big part.

This bill will put clear boundaries around using the title 'surgeon'. It will limit what doctors can call themselves and better inform patients. However, it is a restriction on language, not a restriction on practice. Protecting title will not restrict what doctors can do because that is not how the national law works. In particular, protecting the title 'surgeon' will not stop skilled doctors in rural and regional Australia providing much needed surgical care when they have the skills to do so. However, it will stop doctors calling themselves surgeons. It is important to be clear on this distinction in the context of wider conversations about pressures on Australia's health workforce.

I also note the committee has heard evidence expressing concerns about the power of ministers to prescribe another class of medical practitioner as a surgical class by regulation. We believe this is about futureproofing the title protection, not lowering the bar. The bill specifies that health ministers must have regard to any advice from the Medical Board of Australia and the required surgical training. The explicit role of the Medical Board of Australia is to protect patients. I can assure the committee that the board will not be recommending lowering the bar if this increases risk to patients. Thank you again for the opportunity to appear today and we are very happy to take questions.

CHAIR: Thank you very much, Mr Fletcher. I will hand over to our Health Ombudsman for some general comments.

Dr Coulson Barr: I would like to start by acknowledging the traditional custodians of the land on which we meet today and pay my respects to all elders past and present. Thank you for the opportunity to appear today as part of the committee's inquiry. As the committee would know, I am Lynne Coulson Barr, the Health Ombudsman for Queensland, and my office is the Office of the Health Ombudsman, known as the OHO. The OHO works in a co-regulatory model with Ahpra in respect of the concerns raised about registered health practitioners.

As the Health Ombudsman for Queensland, I welcome the introduction of this bill and support the amendments which have been proposed by the Australian health ministers. As we know, it is about protecting the title of 'surgeon' and also there is another amendment around clarifying the decision-making authority of tribunals after hearing a matter about a registered health practitioner.

While the focus of my opening statement will be in relation to the proposed amendment to protect the title of 'surgeon', I also support the amendments that clarify the decision-making authority of tribunals. These amendments will address the ambiguities that have been identified in the relevant provisions. Importantly, they will support informed decision-making by consumers through the publication in the public register of any prohibitions of practice that have been decided by tribunals. I just wanted to make that point about those amendments.

In respect of the proposed protection on the title of 'surgeon', I echo the comments made by Martin Fletcher, the CEO of Ahpra, and note the way in which the proposed changes will strengthen the protections of the public health and safety and the regulation of cosmetic surgery in Australia which we have recognised there is an urgent need to do so. These proposed changes will strengthen these protections by—and we have heard a lot about this—reducing consumer confusion about practitioner titles and qualifications. We know that this confusion has caused harm to consumers. I note that there is further work to look at in terms of reducing that potential consumer confusion. We have heard also that these proposed amendments will support more informed decision-making by consumers. I think they will also contribute to improving health literacy and understanding around cosmetic surgery. Lastly, these amendments are important to meet the community expectations that the known risks of harm associated with cosmetic surgery will be addressed.

I welcome the explicit provision being inserted into the national law to protect the use of the title 'surgeon' within medical professions. I know we have heard about the application to other professions. In terms of that provision, it will ensure that only medical practitioners with appropriate qualifications and surgical training can use the title, make claims or hold themselves out to being a surgeon. I note that these proposed amendments are part of a suite of reforms that are designed to protect consumers from serious risk of harm from cosmetic surgery.

As the committee would know, the OHO plays a critical role in protecting the health and safety of the public, providing high standards of health service delivery and maintaining public confidence in the health service complaints management system. We are the single point of entry in Queensland for all health service complaints, and through this role you would be aware that we have received a wide range of concerns raised by consumers about their experiences with cosmetic surgery. As Martin Fletcher has indicated, it is not as high as you might expect, but the hotline that Ahpra has created has created greater exposure and encouraged more people to come forward. The OHO has contributed the insights from our work to the independent review of cosmetic surgery that was commissioned by Ahpra and the Medical Board, and we made a detailed submission to the National Registration and Accreditation Scheme review that proposed to regulate the use of the term 'surgeon'.

As the committee has no doubt heard, the difference between the current regulation of cosmetic surgery and other surgery specialties can lead consumers to believe that they are undergoing safe and effective procedures when this may not be the case. We have heard of these types of matters. Surgery, including cosmetic surgery, has the potential to result in significant and permanent harm to individuals, including the loss of function, disfigurement and even death. These risks are amplified, as the committee would be aware and no doubt has heard, if the surgery is not performed by an appropriately qualified, trained and experienced medical practitioner.

Through dealing with these matters over many years, the OHO can confirm that there is a lack of understanding amongst consumers about the specific skill set that a practitioner using the title 'cosmetic surgeon' has. Consumers may not necessarily understand that the person they have selected to carry out the procedure may have no specialised training in this procedure. These amendments are designed to address that.

From the OHO's experience, my view is that protecting the use of the title 'surgeon' will be an important safeguard that will enable consumers who seek to undergo such surgery to make more informed decisions about their health care as well as their choice of medical practitioners to perform that surgery. Again, we have heard lots of discussions about that.

In our submissions we have highlighted that the proposed protection of the title of 'surgeon' also needs to be supported by a comprehensive public education campaign to improve consumer engagement and further reduce the risk of harm. I understand the Commonwealth is leading a nationwide public campaign on this matter.

In closing, I consider that the bill will strengthen public safety and confidence in the provision of health services. Thanks again for the opportunity.

CHAIR: Thank you very much, Dr Coulson Barr. I did want to clarify the data on the number of complaints. I thank Mr Fletcher for providing that data. This could be taken on notice. Does the OHO have data prior to the existence of the hotline in terms of cosmetic surgery and complaints that you might be able to share with the committee?

Dr Coulson Barr: I will take that on notice. I can say more broadly that the numbers were a lot lower than what you would expect. The hotline that has been created by Ahpra has increased the numbers nationally, and some of those have been in Queensland.

Mr MOLHOEK: On that particular issue, is it possible for you to provide that data and break it down by the various areas—complaints from practitioners who are perhaps Fellows of the Royal Australasian College of Surgeons or from people who sit outside of that scope in terms of the AMC? There are about four or five categories that we have heard discussion around today. It would be interesting to see what the complaints are by category.

Dr Coulson Barr: We will do our best to try to interrogate the data. Some of our data is not that granular. I have been making inquiries with my office as to whether our office has had any complaints of the nature that has been discussed in the earlier sessions—for instance, in relation to oral surgeons and podiatric surgeons. We cannot identify any to date, but I will check.

Mr MOLHOEK: It would just be great to have that as a context around some of the other discussion.

CHAIR: We are limited in time with the bill being—

Mr MOLHOEK: Sorry, Chair.

CHAIR: No, we have the witnesses here for 15 minutes. I wanted to move to Dr Tonkin. Did you want to make any remarks before we go to general questions?

Dr Tonkin: I strongly support what both Mr Fletcher and Dr Coulson Barr have said. There is significant misunderstanding and confusion within the public about who is a surgeon and who is not and who has specialist qualifications in surgery and who does not. These reforms are designed to

clear up that confusion and give people a much better sense of to whom they are entrusting themselves when they undergo cosmetic surgery. The issue of future classes potentially being declared by ministers would obviously be a ministerial decision, but it is something that the Medical Board feels very strongly about—that people with specialist surgical training should be the ones allowed to use the title 'surgeon', and we would continue to recommend that.

CHAIR: Thank you. There were three key themes from this morning's evidence, particularly around the rural generalist program. With that group having an application for AMC accreditation, I think that covers that off. We earlier heard concerns from the maxillofacial surgeons around 'oral surgeon' and from the orthopaedic surgeon representatives around 'podiatric surgeon'. The bill still protects those titles. Is there any commentary around those two groups?

Mr Fletcher: I certainly listened this morning to the concern that, as you have indicated, Chair, some patients might be confused that they are seeing a medically qualified surgeon when they are seeing an oral surgeon or a podiatric surgeon by way of the examples given. By way of background, specialist recognition for dentists and for podiatric surgeons has been in place under the national law since 2010. That was the time when health ministers approved the list of dental specialities, the speciality of podiatric surgery and the associated protected titles. Over the past 13 years, we are not seeing anything significant in our complaints data or our offences data that suggests that people are confused, that they are seeing a medical practitioner when for example they are seeing an oral surgeon. It is probably also important to note that it would be an offence under the national law for an oral surgeon, by way of example, to mislead a patient into thinking they are a medical practitioner. That is known as 'holding out' and is an offence under the national law. It could also be grounds for a notification around the conduct of that practitioner as well. Chair, as you have noted, health ministers have agreed on the scope of the title protection in the bill the committee is looking at today.

CHAIR: Thank you very much.

Mr ANDREW: I am just looking at your national implementation. In relation to the amendments proposed by the Australian College of Rural and Remote Medicine and the Australian Orthopaedic Foot and Ankle Society, this is probably a question on notice: do you think that there can be some changes; would you consider those to situations where we would look at changing the bill to make it a better bill?

Mr Fletcher: I am not entirely sure. What amendments are you suggesting?

Mr ANDREW: That is what I was going to say. It is probably a question on notice because the Australian College of Rural and Remote Medicine's submission states—

Clause 4, Insertion of New S 115A

… subsection 5 should be amended …

…

(d) A registered medical practitioner who has completed the Australian College of Rural and Remote Medicine Advanced Specialised Training in Surgery and/or Obstetrics and Gynaecology;

They are just trying, I think, to broaden their scope by putting that in there. In their submission the Australian Orthopaedic Association states that the legislation be amended—

"AMC accredited surgical specialist" is put in place of "medical practitioner" in section a). Our understanding is that this would mean that sections 5d) and 5e) would be superfluous and could be removed.

They are trying to tidy up some of the clauses in the bill. Have you looked at that and taken into consideration the submissions in terms of the alternative arrangements presented because no doubt you will be the ones enforcing this nationally? Maybe it is a question on notice. It is probably a bit of a hard one if you have not—

CHAIR: We will let Anne try to answer that.

Dr Tonkin: To a degree it is a question on notice, and we can certainly provide more detail given some notice. In principle, I can say what the Medical Board's position is; that is, that at this time we consider that the title 'surgeon' should be restricted to people who have done accredited specialist surgical training which takes many years to complete. We would need to look at what the College of Rural and Remote Medicine was providing to its rural generalists. As you know, that is not yet a recognised speciality but is in the pipeline to become one. We would need to have a close look at that to be able to make a good recommendation to ministers about whether those people who have been through that training should be allowed to call themselves 'surgeon'. That would be a matter for the future when we know what that looks like.

Ms PEASE: Thank you very much for coming in. I know the great work you all do, so thank you for that great work looking after we Australians and we Queenslanders. Dr Coulson Barr, thank you very much for your introductory statement. You mentioned that you think this is an important piece of legislation in terms of the amendments being made, particularly around education. Can you elaborate on that? How might it look and who do you think should be responsible for letting the public know who is appropriate to attend to their medical needs?

Dr Coulson Barr: I understand this is part of a broader suite of reforms that Ahpra has been working on with the Commonwealth. Can I refer that to Martin Fletcher who is more familiar with the state in terms of those suite of reforms and planned education?

Mr Fletcher: Two major things are intended. First of all, the Commonwealth Department of Health is leading a national awareness campaign that is very much consumer focused. That is already underway to actually help inform safer choices that people might make around cosmetic surgery and cosmetic practices more widely. Secondly, subject to the bill passing, we intend to do quite a lot of awareness work both with practitioners and the community to explain the title protection and more widely around the area of practice endorsement. As I indicated in my opening statement, the fact that you as a practitioner have an endorsement or have the right to use the specialist title of 'surgeon' is also on the public online register. We have an ongoing campaign of trying to increase public awareness of using the register as well.

Ms PEASE: Thank you for that. I am sorry if it was you who made that comment around education. What does the education from Ahpra look like? How will it take place? You can visit doctors and engage with doctors that way. How will you engage with consumers?

Mr Fletcher: We are working quite a lot with consumer organisations and consumer representatives. One area of focus has been the sort of questions that consumers might ask if they are thinking about undergoing cosmetic surgery or cosmetic practices more widely. We are certainly more widely, I guess, and much more proactively auditing social media as well and taking quite strong action if individual practitioners or practices are making claims that are misleading or underplaying the risks of cosmetic surgery. Indeed, one issue which we have worked on with the Medical Board more recently is more strengthened guidelines for advertising requirements. As you know, this is an area where social media plays such a big role. We need to be very active. Often that social media tends to emphasise benefit over risk and seeks to glamorise cosmetic surgery in a way that I think just underplays the fact that this is a serious medical intervention. It is really about working on a range of fronts to get that message out to the community.

Ms PEASE: In terms of operating in a range of areas, you are addressing the social media area. Does that look like your taking down posts or taking action on practitioners who are falsely misleading people? Are you also putting out information from Ahpra around, 'Do you know where to go to for information about cosmetic surgeons'? There are three issues, I suppose.

Dr Tonkin: I am chairing the board's national special issues committee on cosmetic practices. I can tell you from personal experience that we are seeing a large number of practitioners who have social media presences which are not in keeping with our guidelines and sometimes not in keeping with our code of conduct. We are taking a much more proactive approach to those now and requiring them to fix their advertising and take down their misleading posts. We are doing a lot of that at the moment, and we have the assistance of some IT experts who are helping us proactively look at people's advertising and social media presence on the basis of if a consumer googles a cosmetic surgeon, who do they see first? We will look at those people first. We are up to something like 64 or 65 different groups or individuals we have looked at. Of those, something like 59 were noncompliant. The number of compliant people was four or five. We are taking action on those practitioners and trying to get as many of those misleading posts removed as we can as quickly as we can. I might leave Martin to talk about the cosmetic surgery hub that is on the Ahpra website.

Mr Fletcher: We have gathered a whole lot of resources on our website for practitioners and the community as well. As Dr Coulson Barr has indicated, the consumer hotline has been important for us. Essentially, we want people to make safe choices. We want them to know they are seeing qualified and trained people. If things go wrong, we want them to get follow-up care and we want them to know where to come if they want to report a concern so we can take action if needed.

Ms KING: I suspect this question might best be directed at Dr Tonkin, but please pass over to one of your colleagues if needed. Could you tell us more about the practice endorsement for cosmetic surgery that is due to come online on 1 July? What are the requirements to get that endorsement? How does the training required compare to traditional surgical qualification?

Dr Tonkin: As you know, this has been a controversial area. There are people who object to having what they think is a second-grade standard, if you like, of surgical recognition. At the moment, we have two tiers of qualification: we have surgeons and we have nothing at all. What we are putting in place for the endorsement is a high standard of training which would allow somebody to say that they have an endorsement in cosmetic surgery where currently there is no standard at all. It is not going to be as high a standard as being a fellow of the Royal Australasian College of Surgeons, because that takes many years and it is very comprehensive surgical training, but the endorsement will only be available to people who have completed a program of study which meets the AMC's standards that have now been published. They are not low standards; they are high standards. While it is true that they are not the same as being a fully trained surgeon, they are very high standards and sufficient for people to have confidence that the person they are going to see—if they have an endorsement—has sufficient training to be safe doing the procedure that they want done.

CHAIR: That was a very well-articulated response, Dr Tonkin. Thank you.

Mr MOLHOEK: Dr Tonkin, I fully appreciate the concern around cosmetic surgery. However, could you reflect on the submission that was made by rural health and the comments that we have received from Dr Dan Halliday? Are we perhaps taking a sledgehammer to crack a nut in wanting to tighten the definitions? There are a whole lot of hardworking doctors who perform all sorts of challenging procedures in regional, rural and remote Queensland, and Australia for that matter. Why would we want to take away from them the title that they have worked hard for?

Dr Tonkin: It is a really good question. I take my hat off to all the people who do, at that really high level, provide those surgical services in rural and remote areas where there are no qualified specialist surgeons. They will still be able to do that. I think a crucial part of this is to know that if I were a GP surgeon, currently able to call myself that, working in regional, rural or remote Queensland then I will still be able to do exactly what I am doing now. I will be able to call myself a GP with additional training in surgery or a GP with expertise in surgery. I can use all manner of words to describe myself so long as I do not use the word 'surgeon'. I think it may seem semantic but the word 'surgeon' is something whereby the people who do fellowships in the surgical specialties work very long and hard to get to that level. On the Medical Board our view was that the public would expect that someone calling themselves a surgeon is a specialist surgeon.

The College of Rural and Remote Medicine has a training program and it would be open to them, at some point later if the regulations allow, to make an application to use the title 'surgeon'. That would be up to health ministers, obviously, but, as I said before, the board would need to have a very close look at how well trained they were and how much experience they had to see whether they cross that bar to actually use the title 'surgeon'. The key thing to remember is that they will not be prevented from doing what they are doing now. I totally agree that they do an amazing job where there are no surgeons.

Mr MOLHOEK: In the Australian College of Rural and Remote Medicine submission, they say that the decision communicates a lack of confidence in rural generalists, it discourage aspiring doctors to pursue rural careers, it does not allow them to effectively communicate their capacity to provide services and it represents another demonstration of devaluing the skills of rural doctors by governments and the profession more broadly—or words to that effect. Given the health crisis that we are currently seeing in regional and rural Queensland and other parts of the state, the shortages, seeing maternity units closed, are you concerned that that sort of disincentive will discourage aspiring doctors, gynaecology and obstetric specialists from wanting to work in rural and remote Queensland?

Dr Tonkin: I do not think that is going to happen, particularly at this time when the specialty of rural and remote medicine is in the process of being recognised by the title 'rural generalist'. I think people will come to understand that rural generalists have very broad training and are able to do a large number of those specialised tasks that are usually the province of specialists such as surgeons or obstetricians. I have been told by a number of people within the college and who work in the rural space, the existence of the specialty of rural generalist—assuming that that goes through the pipeline and comes out the other end as a specialty—will be a big incentive to people to go to rural and regional areas. If you can say you are a rural generalist or a specialist rural generalist in the fullness of time, that would imply that you can do surgery, you can do obstetrics, you can do anaesthetics, you can do all manner of things that skilled general practitioners currently do out in the country without having to use the title 'surgeon'. I would doubt that the absence of the title 'surgeon' by itself would be a disincentive, quite frankly.

Mr MOLHOEK: Yet ironically it is very difficult for rural generalists to transition back into metropolitan health services because they are not considered to have the qualifications needed to work in metropolitan health services and they actually have to re-skill if they want to work in those

services. It is a bit of an irony in that they have advanced skills from having to deal with fairly challenging life and death situations and then when they come back into South-East Queensland and metropolitan parts of Australia they are not considered qualified enough to provide other services within the health services. Take that as a comment, Chair.

CHAIR: We will take that as a general comment, Deputy Chair. On that note, I thank each of you for being here today and providing your contributions. It is very helpful to the committee. I now declare this hearing closed.

The committee adjourned at 12.20 pm.