Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

Use of the title "surgeon" by medical practitioners in the Health Practitioner Regulation National Law

March 2022

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.* It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM represents over 5000 doctors in rural and remote and Aboriginal and Torres Strait Islander communities and medical students working toward rural careers.

Initial Comments

ACRRM welcomes the opportunity to provide feedback on the issue of establishing protected title of the designation "surgeon" under the National Law, however, the College does not support moves to legislate to protect the title 'surgeon. Whilst we acknowledge the problem that it seeks to solve, we see considerable perverse outcomes arising from this proposed solution.

If there is possible public confusion over cosmetic surgeons titling, the College would view this as an isolated and particular problem that should be addressed in isolation, on its own merits. We agree that currently there is common misunderstanding arising from the use of the term 'cosmetic surgeon'. We see the problem arising from issues specific to this field whereby the medical profession operates in the beauty industries which are essentially non-medical and predominantly focused on aesthetic rather than health outcomes. This is likely to result in mixed messaging to clients/patients, and to client/patient decision making, which may not necessarily give due scrutiny to practitioner's medical qualifications.

Use of the term 'surgeon' has been an evolving part of the popular lexicon for hundreds of years. A range of well-established and broadly understood meanings within our common language are attached to the title which extend well beyond Fellowship of the College of Surgeons. We consider

moves to impose regulation upon this generic title are likely to involve excessive compliance costs, litigation, and overall, increase rather than reduce popular confusion.

We would be especially concerned if these developments were to lead to competent and qualified practitioners in rural and remote areas, being discouraged from providing critical surgical services, and the people in these locations who already face significant barriers to accessing this care, having their access restricted even further.

We have responded to the survey questions pertinent to the work of the College.

Response to Survey Questions

SECTION ONE Title protection and its functions

1.1 What level of qualifications and training would you generally have expected a practitioner using the title 'surgeon' to have?

Our College (ACRRM) would expect a medical practitioner to have the necessary training and qualifications for providing surgical procedures within their appropriate scope of practice. It should be noted that surgical skills sit on an expertise continuum.

Our College has a designated, independently assessed Advanced Specialised Training (AST) surgery curriculum which includes an option for two years dedicated advanced training in surgery. The curriculum has been endorsed by the Royal Australian College of Surgeons and forms part of our AMC accredited Fellowship training program and Fellowship qualification.

Doctors who complete this would appropriately describe themselves as rural generalists in surgery or rural generalist surgeons. Our members may however also use the terms general practitioner in surgery or general practitioner surgeon. Our preferred terminology is rural generalist in surgery as we feel this reflects the full scope of the practitioners' training attainments as well as their rural competencies. Furthermore, in rural communities with the Government's commitment to support Rural Generalist Training support programs in every state and territory, the Rural Generalist terminology is coming to have broad awareness and understanding.

We consider this terminology is helpful for patients in making decisions about their care options. Further, we would consider, that should these doctors be prevented from describing themselves in these ways (as per Option 4), this would reduce patients' and communities' ability to understand their practitioners' assessed competency. Being able to understand and make informed judgements on these issues is especially important in rural and remote areas where people's access to Fellows of the College of Surgeons may involve considerable time delays in receiving care, or significant financial and personal burdens.

To draw the distinction:

- FRACS means Fellow of the Royal Australasian College of Surgeons. This distinction is awarded to specialist surgeons who have completed a minimum of 12 years medical and surgical education, with at least five years of specialist postgraduate training. A Specialist Plastic Surgeon with the letters 'FRACS' appearing after their name is accredited to perform invasive reconstructive and cosmetic plastic surgery.

- FACRRM means a Fellow of the Royal Australasian College of Rural and Remote Medicine. FACRRMs with an AST in surgery have completed a minimum of 10 years medical and surgical education, with at least two years of assessed specialist postgraduate training in surgery.

It should be noted that our College together with the RACGP is in the process of applying to the Medical Board of Australia, with the support of the Commonwealth Department of Health, the relevant Health Ministers and the National Rural Health Commissioner to have Rural Generalist Medicine recognised as field of specialty practice within the discipline of general practice. This is hoped to go some way to further clarifying these issues.

Available data: quantitative and qualitative

5.1 Are the issues relating to title restriction accurately outlined in this RIS?

The College (ACRRM) considers that the RIS focuses on cosmetic surgical procedures without giving due consideration to the range of surgical procedures necessarily and properly performed by Rural Generalists in rural and remote parts of the country with limited or no access to specialist surgeons, working fully within their scope of practice, training and qualifications.

The positive contribution of these Rural Generalists and other rural General Practitioners is undermined by the RIS's failure to give proper attention and consideration to these procedures, whilst at the same time acknowledging that most General Practitioners working in rural and regional areas do not provide cosmetic procedures.

The lack of consideration given to the healthcare contribution of these services, and the diverse range of other medical services involving surgical procedures provided by doctors other than Royal College of Surgeons Fellows and the implications to them of the RIS Options, seriously undermines the analysis.

From this perspective, the objectives of the consultation RIS do not align with the policy options quoted for consideration. The focus on cosmetic surgery without due consideration of other surgical procedures carried out by medical practitioners other than surgeons could, as we have stated previously, lead to a wide range of perverse outcomes.

5.1 How do you currently satisfy yourself that your practitioner is qualified to perform their desired surgery, cosmetic or otherwise? How did you satisfy yourself that a practitioner was qualified prior to reading this RIS?

The College (ACRRM) notes that surgical skills sit on an expertise continuum. While the FRACS indicates attainment of a highly specialised level of skills, it is important for patients to be able to know and understand where their practitioners have attained a less specialised but nonetheless significant level of skills in providing surgical procedures. This differentiation is particularly important for rural communities for whom access to a FRACS qualified specialist often involves dangerous, physically painful, or financially prohibitive travel and travel times. Understanding the qualifications of their in-situ practitioner thereby becomes an especially important consideration for their personal safety and well-being.

5.2 Does this RIS accurately describe surgical procedures (cosmetic or otherwise) performed by practitioners, the types of specialists and other registered practitioners that perform them and the accepted parameters of practice for these practitioners?

The College (ACRRM) notes that there is no mention of the role of Rural Generalists in rural and remote parts of Australia and the surgical work they perform which include emergency response to accidents, skin cancer management and procedures associated with obstetric deliveries. The RIS

does not discriminate between the work of these doctors. Nor does it reference the surgical procedures which may be performed by General Practitioners in urban areas that are not related to cosmetic surgery. There is brief mention of other surgical procedures in Appendix 3 of the RIS, however, the RIS would benefit from providing a more comprehensive analysis, rather than focusing almost exclusively on cosmetic surgery.

To properly consider the case for and against restricting the title surgeon, the RIS should provide a more balanced overview of surgeries performed by non-FRACS doctors, not only cosmetic surgery.

It is noted that this consultation appears to not be cognisant of our College's role in this space. We note question 4.2 refers to "*procedures performed by practitioners who do not have advanced surgical training"* which appears to be used to mean, doctors that do not hold FRACS. We would like the review to recognise that our College delivers an optional two-year assessed Advanced Specialised Training curriculum which has been supported by the RACS. It forms part of our AMC accredited ACRRM Fellowship program and as such is subject to review as part of the AMC assessment process.

Options and cost-benefit analyses

6.1 Do you support maintaining the status quo (Option 1)? Please explain why.

The College (ACRRM) supports Option 1 on the basis that it would not like to see either Option 4 or to a lesser extent Option 2.2 progressed. Both of these options are considered to lead to public costs which outweigh any public benefits.

ACRRM would nonetheless see value in some alternative actions being undertaken to promote better public awareness of the issues of public safety related to cosmetic surgery and the qualifications associated with its safe practice.

As surgeon is a generic term with wide, established applications we expect that any actions to regulate its use would also create a problematic precedent for regulating use of a wide range of other generic medical terms.

Use of the term 'surgeon' has been an evolving part of the popular lexicon for hundreds of years. A range of well-established and broadly understood meanings within our common language are attached to the title which extend well beyond Fellowship of the College of Surgeons. We consider moves to impose regulation upon this generic title are likely to involve excessive compliance costs, litigation, and overall, increase rather than reduce popular confusion.

In particular, we consider that this would serve to inhibit our doctors' capacity to appropriately communicate their qualifications and competencies to their patients, and thereby enable rural communities to make appropriately informed decisions about their care. We also see risk that increasing restrictions and complexity generally is likely to discourage our doctors who are competent and qualified practitioners from providing important surgical services to rural people

These issues notwithstanding, the College recognises and supports the need for stronger regulation of the cosmetic surgery industry and improvements to public health literacy in this field of practice. It is our contention that there are more appropriate and fit for purpose mechanisms to achieve these aims than blanket protected title of the term surgeon.

6.2 Do you support implementing alternatives such as Options 2.1 or 2.2 to amending the National Law? Do you support implementing one or both? Please explain why. If this option is preferred, what reforms or initiatives would be required to realise either or both sub-option/s?

ACRRM would be prepared to support Option 2.1 but does not support Option 2.2.

As outlined at 6.2, ACRRM would see value in proactive efforts to advertise, educate and promote better public awareness of the issues of public safety related to cosmetic surgery and the qualifications associated with its safe practice. This would counterbalance any commercial imperative to minimise public scrutiny regarding the safety risks associated with cosmetic procedures.

The College has some concerns regarding Option 2.2 and the precedence and wider implications it may have for the provision of surgical procedures by doctors that do not hold FRACS that deliver safe and appropriately credentialed care. The additional professional risk and compliance this is likely to engender, will discourage these practitioners and at worst may lead to reluctance by many appropriately qualified doctors to provide important services to their patients. For our College which is dedicated to services for rural and remote people and has many doctors working in rural and remote areas where there are no FRACS qualified doctors or very limited access to them, this is of considerable concern.

6.3 *Do you support strengthening existing mechanisms in the National Scheme (Option 3)? Please explain why*.

ACRRM in principle supports the approach suggested in Option 3. It is noted however that it is not clear at this stage what changes this may involve, and we may review this position in the light of further detail.

The College acknowledges the value to the public of being better empowered to make informed judgements regarding cosmetic surgical procedures and to discourage the emergence of business models based on unsafe practices. Any changes that might achieve this without significant perverse outcomes would be supported.

6.4 Do you support restricting the title 'surgeon' under the National Law (Option 4)? Please explain why. If option 4 is preferred, which medical practitioners should be eligible to use the title 'surgeon', and why should option 4.1 or 4.2 be preferred?

ACRRM does not support moves to legislate to protect the title 'surgeon' and is particularly opposed to Option 4.1.

Option 4.2 could potentially address some of these issues however it would still have considerable capacity for potential perverse outcomes. It is noted that there is no clear definition of what constitutes "substantial" surgical training which would be germane to the any firm position in support of this option for our College.

Whilst we acknowledge the problem that Option 4 seeks to solve, we see considerable perverse outcomes arising from these proposed solutions. The issue of public confusion over cosmetic surgeons titling is an isolated and particular problem that should be addressed in isolation, and on its own merits.

As outlined above (see ACRRM response to Q 6.6) protecting the title would prevent the many doctors that do not have FRACS from easily and simply communicating their training and qualifications for providing surgical procedures within their appropriate scope of practice.

We also anticipate that significant administrative effort and adoption of an unduly litigious attitude towards practitioners and practitioner communications would arise from enacting this proposal which may well further inhibit rural doctors' provision of important surgical services in rural areas.

As surgeon is a generic term with wide, established applications we expect that any actions to regulate its use would also create a problematic precedent for regulating use of a wide range of other generic medical terms.

6.5 *What other impacts will restricting the title 'surgeon' have on surgical specialists and other medical practitioners, including those who obtained their qualifications overseas?*

ACRRM recognises that the College of surgeons appropriately are the arbiters of their professional qualification (FRACS).

It should be noted however that surgery is part of undergraduate, junior doctor and fellowship training curricula which are AMC accredited and operate outside the RACS purview. It is appropriate that this training be appropriately recognised and communicated to patients, professional colleagues, and health services. To legislate to prevent this would be misleading and we consider would in effect legislate to ultimately restrict the public from understanding the qualifications that their practitioners have attained.

We note the common use of terminology such as GP in surgery, RG obstetrician, GP anaesthetist etc. and see this as an important opportunity to clarify to patients what their practitioner's skill set is, as well as its scope and limitations. We would see any moves to restrict this terminology as not just unnecessary but also retrograde for patient health literacy and well-being.

6.6 *Are you concerned that a particular option might have serious, adverse, and possibly unanticipated effects? Please state which option/s and unanticipated effects, and why you hold these concerns.*

ACRRM is concerned regarding the implications of Option 4 and particularly 4.1, and Option 2.2.

We agree that currently there is common misunderstanding arising from the use of the term 'cosmetic surgeon'. We see the problem arising from the use of the term 'cosmetic' and its associations with beauty industries which are predominantly non-medical. The adoption by a medical professional industry of an identifying term related to an essentially aesthetic outcome brings with it inherent risk of such confusion.

As surgeon is a generic term with wide, established applications we expect that any actions to regulate its use would also create a problematic precedent for regulating use of a wide range of other generic medical terms.

We see no practical conflict or confusion however arising where the 'surgeon' terminology has been paired with other non-medical areas such as for 'tree surgeons', 'veterinary surgeons' or 'dental surgeons.' We would also see that any moves to legislate to prevent these popularly understood usages would be both unhelpful and impracticable.

Use of the term 'surgeon' has been an evolving part of the popular lexicon for hundreds of years. A range of well-established and broadly understood meanings within our common language are attached to the title which extend well beyond Fellowship of the College of Surgeons. We consider moves to impose regulation upon this generic title are likely to involve excessive compliance costs, litigation, and overall, increase rather than reduce popular confusion.

In particular, we consider that this would serve to inhibit the capacity of ACRRM doctors who are general practice doctors specifically trained for broad scope (rural generalist) practice in rural and remote areas capacity to appropriately communicate their qualifications and competencies to their patients. This in turn inhibits the capacity of people in rural communities to make appropriately informed decisions about their care. We also see risk that increasing restrictions and complexity

generally is likely to discourage our doctors who are competent and qualified practitioners from providing important surgical services to rural people

We would make a distinction between all these usages and the usage of the term 'surgeon' in combination with terms which have clear medical professional understandings such as General Practitioner (GP) or Rural Generalist (RG). These provide a clear and unambiguous signal to consumers that the term used first is the principle professional qualification (i.e. GP or RG); that the term 'surgeon' relates to medical training; and that this training is confined within the scope of the principle professional qualification. It is noted that Option 4.2 may go some way to allowing this however it is likely to nonetheless introduce inflexibilities for the provision of rural services as a whole.

These issues notwithstanding, the College recognises and supports the need for stronger regulation of the cosmetic surgery industry and improvements to public health literacy in this field of practice. It is our contention that there are more appropriate and fit for purpose mechanisms to achieve these aims than blanket protected title of the term surgeon.

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Proceeding to restrict the surgeon title would prohibit Rural Generalists and Rural General Practitioners from working fully within their scope of practice, and would cause significant detriment to people living in rural and remote areas with no access to specialist surgeons who rely on their local medical practitioner to perform these surgeries.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.