Australian Society of Plastic Surgeons

9 April 2010

Ms Naomi Bleeser
Committee Secretary
Department of the Senate
Parliament House
Canberra ACT 2600

By email: community.affairs.sen@aph.gov.au

Dear Ms Bleeser

Re: Inquiry into Health Practitioner Regulation (Consequential Amendments) Bill 2010

Thank you for your letter of 26 February and invitation to provide a written submission. At the outset, it is appropriate we offer a disclaimer given we are not legally trained or experienced in legal drafting and therefore struggle somewhat with the formal language of legislation. We trust this does not give rise to any misinterpretation on our part. If this is the case, it is entirely unintentional.

We are encouraged by the breadth and depth of the health reform agenda. Real change to assure a better future for health care in Australia is long overdue. The impact of much of the reform around NRAS can only be evaluated over a longer period of time and current concerns with the changes may well evaporate with their implementation.

We are pleased to provide some general observations in relation to the Bill. Our submission addresses issues the Society believes are of importance in ensuring the future provision of high quality surgical care in Australia.

Australian Society of Plastic Surgeons Incorporated (ASPS) is a not for profit organisation whose members are specialists in plastic and reconstructive surgery and who hold a Fellowship of the Royal Australasian College of Surgeons (FRACS) or its equivalent.

The Society promotes, develops and advances the practice of plastic surgery throughout Australia by:

- supporting the highest standard of surgical practice and professional ethics;
- administering post graduate surgical training programs for the specialty of plastic and reconstructive surgery for the Royal Australasian College of Surgeons;
- providing continuing professional development and education in plastic and reconstructive surgery; and
- promoting research in the specialty of plastic and reconstructive surgery.

A 2008 survey by the Society, identified that on average about twenty per cent of members work is undertaken in public hospitals, forty per cent in private hospitals and day procedure centres and forty per cent in private rooms. About sixty per cent of surgeon time is spent on reconstructive surgery. On average members who provide supervision commit about six hours each week of their time to educating plastic surgery trainees. This supervision is provided in multiple settings including public hospitals, private hospitals and private rooms.

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General Observations:

1. We note that most of the changes are consequential.

2. There is a change for specialists whereby the Health Insurance Act (HIA), having previously provided a direct link to the Colleges, the Bill now proposes to link specialist recognition under NRAS and the Medical Board of Australia (MBA).

We welcome and support the role of the MBA which in conjunction with AHPRA will maintain a 'specialist register'.

However, as we have commented in other fora, (10/2/10, MBA Consultation Paper 2: List of specialties and specialist titles and 7/4/10, AHPRA Guidelines on advertising), we are concerned with the responsibility imposed on the consumer to distinguish the qualifications of the practitioner given the new application of the word "specialist".

Behind a medical title is the public expectation of a government recognised training qualification. The public must have confidence that the terms used by medical practitioners to define and describe their qualifications, training and scope of practice are in fact and in perception truly aligned with their recognised and Government approved qualification.

In our submission on Consultation Paper 2, we note that the terms commonly used as descriptors, that is, "surgeon", "surgery", and "specialist", are misunderstood by the general public. Lack of clarity has unintended consequences including potential repercussions for public safety.

The term "specialist" as it seems to apply in this Bill has the potential to be misunderstood by the general public. A clear and consistent framework for this term must be applied and enforced to ensure clarity in public information.

In our view, the only title that should be used by a practitioner is the title for which they trained. As scopes of practice inevitably change, at the very least, the consumer will have an understanding of the training base of the practitioner.

3. There are some changes for vocationally-registered GPs and we note these are to be addressed by the MBA. MBA has recommended that health ministers endorse general practice as a specialty for the medical profession.

We entirely support the need to maintain the distinction between 'general practitioners' and 'specialists' as provided in the HIA and stated in the Notes to Item 9. We do so, not simply because there are differing Medicare items for general practitioners as opposed to specialists, but also because there is a real distinction in the training and scope of practice of these two groups.

It is impossible for the consumer to be across the technical language of medical qualifications or to be sufficiently informed so as to distinguish a genuine qualification from what is not.

For example, the use of memberships as qualifications, titles of specialties that don't exist, or using some or part of a specialty wording is common in advertising and promotional material produced by some practitioners.

Standard terminology and appropriate use of such terms is vital to prevent consumers from being misled. In some jurisdictions, for example, Canada, restrictions were required to ensure that the public does not make important medical decisions based on misperception.

ASPS notes and welcomes the work of the MBA in attempting to define the use of specialist titles. This is intended at least in part to put various levels of safeguards in place for the public. However, we remain concerned. The issue arises in relation to the consumer's ability to discern and determine that the scope of practice undertaken by the practitioner is within the accredited training of that practitioner.

Conclusion:

The current period of health reform is a unique opportunity to set down firm principles and standards that will be preserved over time.

The next 20 years is likely to see increased commercialisation across multiple areas of health services, for example (including, but not exclusive to), podiatrists, nurse practitioners, physiotherapists, pharmacists. The period since the legalisation of medical advertising in 1994 has taught us that there is an enormous temptation for practitioners to "dress up" their qualifications with a variety of terms.

The NRAS is the vehicle to lay down the principle that the only title you can use is the title you trained under. This single principle has the power to provide core protection for the consumer.

In our view the new pathways outlined in the NRAS and this Bill in particular will succeed provided clear boundaries are defined in key areas to ensure the quality of care and the safety of patients. These key areas are:

- Qualifications and scope of practice;
- Advertising and promotion;
- Facilities, equipment and staffing requirements including credentialing; and
- Audit requirements.

Thank you for considering this submission. I am available to discuss any issues raised.

Yours sincerely

Peter Callan MBBS FRACS MBA
President