THE COSMETIC PHYSICIAN

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IN THIS ISSUE: Professionalism in Cosmetic Medicine ▪ The History of Societal Values of Appearance ▪ The Role of Diversity and Cultural Awareness in Medicine ▪ Recent Changes in the Medical Profession ▪ The CPCA's Upcoming Registrar Training Program

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THE COSMETIC PHYSICIAN

Letter from the Editor

Dr Michael Molton, MBBS, FCPCA

Welcome to The Cosmetic Physician Journal. In this first issue you will find content on the topic of cultural safety which continues to receive much attention. The Medical Board of Australia references issues raised by the New Zealand Medical Council that pertain to that nation's first peoples, the Māori and makes certain comparisons with Australia's indigenous population and the activities of the Australian medical profession. However, cultural diversity in Australia extends beyond Aboriginal and Torres Straits Islanders (ATSIC) as migration from many other countries continues to grow the country's overall populace.

Cultural Safety is heavily contextualised in the new regulations on Continuous Professional Development for all registered medical practitioners which is discussed in 'What has changed?' in this issue.

Specific to the practice of cosmetic medicine are the new guidelines for cosmetic procedures, both Surgical and Non-Surgical. It is indeed saddening that there continues to be fragmentation of organisations that support medical practitioners who perform procedures that relate to physical appearance. It seems that this continued fragmentation, represents an inference of competition illustrated by the descriptors 'aesthetic medicine ' versus 'cosmetic medicine'. The MBA viewpoint has now turned to the official fall-back terminology 'Non-Surgical Procedures', which of course is cleverly supported and promoted by surgeons.

The advanced version of the Non-Surgical Cosmetic Procedures guidelines is published in this issue with commentary that emphasises that there's much to do for individual practices to develop policy around the tightening of what medical practitioners must do to comply with these new guidelines. It would be logical to assume that an investigation of a complaint against a medical practitioner performing non-surgical cosmetic procedures, that the practitioner will need to be capable of providing even more detailed contemporaneous patient notes on how the consultation, delegation, administration, and informed consent were all carried out pursuant to the new guidelines.

In closing, the phrase 'publish or perish' comes to mind. There is a paucity of research articles on cosmetic medical procedures that emanate from Australia. By contrast, there is no lack of abstracts for conference presentations. Content for the next issue of The Cosmetic Physician will coincide with CosDoc2023, so if you are presenting at that or any other conference why not submit your topic as a journal article. The Cosmetic Physician is the one and only ISSN listed medical journal for Australian medical practitioners. It is open and free. As Editor you can be assured that whatever organisation you are a member of, or even if you have a focused special independent interest in cosmetic medicine, all abstracts will be welcomed.

Dr Michael Molton MBBS, FCPCA (Dip Cosm. & Derm. Laser)
Editor

Professionalism in Cosmetic Medicine

Dr Mary Dingley MBBS, FCPCA

Introduction

"Professionalism" is defined by The Shorter Oxford English Dictionary as "professional quality, character, method or conduct" [1], which then requires the further definition of "professional" as "pertaining to, proper to, or connected with a or one's profession or calling" [1]. This, of course, requires the further definition of "profession" as "a vocation in which a professed knowledge of some department of learning is used in its application to the affairs of others, or in the practice of an art founded upon it" [1]. The three "learned professions" were considered to be divinity, law and medicine.

In our current context, professionalism is the way that we, as medical professionals, are expected to conduct ourselves or behave.

While we may think we all know how we should conduct ourselves, when trying to categorise the tenets of professionalism in cosmetic medicine, it is useful to use some headings which have been used, generally, to encourage professionalism in other fields.

Specialised knowledge.

While we have certain requirements for fulfilling our continuing professional development (CPD) [2], most of us realise that we have already taken a long road of study and we never get off it. Even a short departure from this makes us out of touch and in need of a catch-up. Our field of cosmetic medicine is constantly evolving, and we need to be aware of what is current with injectables and energy-based devices which we employ to treat our patients.

Those who dabble in any field are at most risk of being found wanting in the knowledge stakes and, especially, in how to apply said knowledge, which leads on to a failure in the next category, also.

Competence.

Cosmetic medicine is what we do and we should do it well. We focus on non-surgical, non-invasive and minimally invasive procedures to improve our patients' appearance and our skill set is honed to deliver an acceptable or high standard of care. This standard needs to apply to the treatments we perform, the advice that we give and the overall service we provide.

We also should know when our patients' needs are outside of the scope of our cosmetic medicine practice and may require referral to a colleague with a different device, or scope, be it surgical, psychiatric, or other.

Honesty and integrity.

Our patients trust us to have their best interests at heart and to do the right thing by them. They trust us to give them the best advice and best treatments that are designed to suit them, not to fill our pockets. They trust us to say "no" when they are requesting a treatment that will make them look disproportionate or silly, even if that is what they've requested or that is what is fashionable or what their friends are having done.
Patients trust us to give them advice about treatments and products that is accurate and complete with all the relevant pros and cons, so they can make informed decisions. They trust us not to advertise inappropriately which might inflate a patient's expectations of treatment results.

Accountability and respect.

This follows on from honesty and integrity in that we must accept responsibility for our words and actions. We should behave with politeness and respect towards our patients, staff, colleagues – everyone – regardless of their beliefs, gender, colour, age, or health.

We must give our advice considering patients' anatomy, skin, motivation, social situation and financial capability so that any treatment is beneficial for them rather than detrimental.
We must also be able to admit when we are wrong and work towards the best method of remediation.

Self-regulation.

This applies to us, as individuals, as well as to us, collectively, as a college, or profession.

As individuals, we motivate ourselves to achieve high standards in our work, to keep learning, to ensure we earn the respect of our patients, staff

and colleagues but we must also know our limits, physically, mentally and professionally.
We belong to a college that provides guidance in setting standards, provides education through conferences and mentorship and represents us when issues arise with government or with colleagues whose professionalism is called into question.

The Medical Board of Australia may seem like it is not really a part of "self" regulation but it is still our medical profession, as a whole, looking to regulate itself.

Image.

This goes beyond how we dress. Most of us are still wearing scrubs at work, anyway, and of course, we are expected to be clean and kempt. "Image" really encompasses everything mentioned before as it is how we are perceived. We should be perceived as "professional" – knowledgeable, competent, honest, trustworthy, accountable, respectful.

Conclusion

Most of the bad press that has come to light lately, mainly relating to cosmetic surgical, rather than cosmetic medical issues, seems to stem from attitude concerns i.e., a lack of professionalism. While knowledge and competence may be debatable, it would seem that the failures have stemmed more from a lack of honesty, integrity, accountability, respect for the patients and a dearth of self-regulation.

Unfortunately, this has led to an image problem for a wider group of cosmetic practitioners who are being tarred with the same brush.

We, who practise cosmetic medicine, must ensure that we all uphold the tenets of professionalism for the benefit of our patients but also for our own image and future.

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The History of Societal Values of Appearance

Dr John Mahony MBBS, FCPCA

Abstract

This article offers some snippets of the history of cosmetic medicine to illustrate and illuminate that the human drive to optimise personal display is biological, historical, perennial and ubiquitous.

Introduction

Broadly speaking, our human culture has an ambivalent relationship with its own reflection and so has a somewhat ambivalent relationship with ourselves. Some, like Narcissus himself, become so entranced with their own reflection that the pursuit of its improvement floods their consciousness and drowns all other concerns. Some, like Odysseus, fearing the power of Beauty's siren-call, are fascinated to observe Beauty but bind themselves against partaking in it. Some, like Odysseus's oarsmen, are deaf to beauty, satisfied with the routine of their daily tasks. Few conceptually reach a Renaissance ideal of seeing and achieving a personal life aesthetic in proportion and harmony with Life's cerebral and corporeal and (if you like) spiritual pursuits.

Discussion

Whereas the diagnosis and treatment of the maladies of internal medicine might attract scientific dispute among medical practitioners and associated health professionals, the essential social paradigm under which such activities occur is rarely challenged either at the academic or lay-persons level. That is, it is generally agreed both publicly and privately that illness is undesirable, that the successful treatment of illness is desirable, and the purveyors of such treatments are to be applauded and rewarded.

Our fellow citizens are sometimes liable to project their form of ambivalence to human appearance towards cosmetic medical practitioners, even as a kick-the-cat phenomenon. And as a post-hoc rationalisation they might claim ours to be an age of rampant superficiality, unleavened vanity, fuelled by voracious multinational pharmaceutical companies and the profession of aesthetics all supercharged by technology and social media playing our young, Pied-Piper-like, over a cliff into an image-obsessed, self-obsessed oblivion.

Are these issues new phenomena? It is actually evident that eradication of wrinkled faces as a detractor of appearance, or ‘beauty’ as it was commonly referred to, have long been a topic for much longer than perhaps most people consider. Consider an example of the 1915 edition "Health and Longevity" by Joseph G. Richardson, MD, Professor of Hygiene at the University of Pennsylvania, which was published as a 1300+ page tome of home medical reference, boasting an input from "twenty specialists".

"Woman's Beauty --- If a vote were to be taken among the inhabitants of the globe as to what one thing, with the exception of the moral qualities, is to be most desired in a woman, the unanimous election would be --- beauty.

Far above influence, social position or money, beauty compels the first admiration and homage of all mankind. So well is this fact known that every woman has an instinctive desire to be attractive, for she realizes that her power for good and, incidentally, evil is thereby greatly increased."

It remains difficult to improve on the tone of the pages here copied, demonstrating the devotion to personal cosmetic improvement, particularly of the female form, was considered important longer than many people might think and long before Facebook and TikTok.

Manufacturers of anti-wrinkle injection substances may be surprised that this old tome recounts the secret recipe of the "Celebrated Wrinkle Eradicator"

"In your house you have, of course, such things as sweet almonds, cloves and nutmegs. Now go to the drug store and get some powdered benzoin, incense and gum arabic, 32 grains of each. Dissolve these in eight ounces of alcohol. When this is done thoroughly, add as follows:

Powdered sweet almonds ... 46 grains
Powdered cloves ... 16 grains
Ground nutmeg ... 16 grains

Mix all thoroughly and let stand for 48 hours, shaking it now and then. Add half an ounce of rose-water and strain the whole through a coarse rag. Apply to the wrinkled parts every night before retiring. The winkles will disappear."

It seems like a lot of bother for our patients to go to. Our ancestors must have intensely wanted their wrinkles gone yet the drug companies of today can rest easy, and our injectable treatments are safe from competition of the "Celebrated Wrinkle Eradicator".

The ancient Greek use of the word “aesthetic” means perception. Hence anaesthesia, hypoaesthesia, hyperaesthesia, dysaesthesia, and all such medical terms. The term entered into literature on a topic some call ‘beauty’ in the 18th century with the works of German philosopher Alexander Baumgarten, with later contributions by Hume, Kant and Hegel.

“Aesthetics”, generally, refers to a major branch of Philosophy, along with ethics, logic, epistemology, metaphysics, ontology, politics and more. It seeks to understand the nature of appeal and appreciation of such interests that includes art, and music as well as natural beauty and human beauty.

Aesthetics has not been really a branch of Medicine, and hardly even a branch of Science, yet unquestionably aesthetic appreciation has been a highly potent force in determining human behaviour since forever, and motivates both our patients and ourselves, and so merits our examination. Further, our patients and fellow doctors expect us to be au fait with aesthetics. They seek to trust our aesthetic appreciation, and we seek that of each other. No doubt, it comes with the territory.

That said, of course beauty has been the subject of philosophical enquiry and conjecture since Plato was a boy. Remembering fire was once considered an element, it is hardly surprising that philosophical enquiry revolved around whether beauty existed as a thing, as an objective reality of some substance, or whether it was more a conjuring of the human mind. In some respect these kinds of arguments continue today.

Human beauty, of course, is a matter less arcane than the nature of celestial or mathematical beauty, or similar such, we might say, Platonic concerns. Nonetheless, the greatest of minds have pondered the nature of beauty from a range of philosophical, mathematical, celestial, and more latterly scientific approaches, just as human beauty has been the subject all kinds of classical literature, religious texts, CroMagnon graffiti, and plebian gossip.

As doctors of aesthetic medicine, we must understand the multifarious ways in which our species has interacted with the subject of what is ‘cosmetic’. Etymology of “cosmetic” - Greek word kosmos for “order”. Pythagoras is said to have first applied this word to the universe, perceiving up their order and balance. Beauty is universal!
The ancient Greek use of the word “aesthetic” means perception. Hence anaesthesia, hypoaesthesia, hyperaesthesia, dysaesthesia, and all such medical terms. The term entered into literature on a topic some call ‘beauty’ in the 18th century with the works of German philosopher Alexander Baumgarten, with later contributions by Hume, Kant and Hegel. “Aesthetics”, generally, refers to a major branch of philosophy, along with ethics, logic, epistemology, metaphysics, ontology, politics and more. It seeks to understand the nature of appeal and appreciation of such interests that includes art, and music as well as natural beauty and human beauty.

Aesthetics has not been really a branch of Medicine, and hardly even a branch of Science, yet unquestionably aesthetic appreciation has been a highly potent force in determining human behaviour since forever, and motivates both our patients and ourselves. Further, our patients and fellow doctors expect us to be au fait with aesthetics. They seek to trust our aesthetic appreciation, and we seek that of each other. No doubt, it comes with the territory.

Beauty, attractiveness, handsomeness, even ugliness has featured as philosophical enquiry and conjecture since Plato was a boy. Remembering that fire was then considered an element, it is hardly surprising that philosophical enquiry revolved around whether the collective descriptors of aesthetics existed as a thing, as an objective reality of some substance, or whether it was more a conjuring of the human mind. In some respect these kinds of arguments continue today.

Physical appearance of the human, of course, is a matter less arcane than the nature of celestial or mathematical beauty, or similar such, we might say, Platonic concerns. Nonetheless, the greatest of minds have pondered the nature of beauty from a range of philosophical, mathematical, celestial, and more latterly scientific approaches, just as human appearance has been the subject in all kinds of classical literature, religious texts, CroMagnon graffiti, and plebian gossip.
Consider the etymology of "cosmetic", which is a translation of the Greek word kosmos or "order". Pythagoras is said to have first applied this word to the universe, perceiving order and balance. Beauty is universal!

Plato - *aesthetics begins with measurement, which then leads to proportion. Precision in Perception. Precision in execution, parts relate to parts, parts relate to wholes.*

Aristotle - *the chief forms of beauty are order and symmetry and definiteness* which can be interpreted as having basis in mathematical principles.

Persisting with the Greek idea of beauty being equivalent to order, and doubtless other ancient civilisations had the same idea, it is a short jump to seeing order as further being functional, predictable and reliable.

Its antithesis "ugliness" was thought to correlate with chaos, and it again is a short jump to seeing chaos as connoting dysfunction, caprice, and unreliability, especially remembering that in former times untreated disease and unmanaged disability would have been included in appearances such cultures would have seen as "ugly". The ancients could not have taken health and public order quite as much for granted as we do today, making "beauty" all the more desirable, all the more worthy of study and pursuit, in contrast to the disease and disorder they would have seen as ugly.

And so by happy, not-quite-coincidence, our very own Greek god of medicine, Apollo, was also an exemplar of beauty. (As an aside, Sydney is said to be an Angicisation of "St Denis" said in French, St Denis being the patron saint of Paris. The name Denis is derived from the Greek name Dionysus, god of chaos and of wine, who is the same god referred to by the Romans as Bacchus, from whom we get the word Bacchanalian, used to describe hedonistic disorder).

Given this philosophic approach, it is not surprising that ancient Greeks sought to find mathematical rules to explain human beauty, and these rules have been described as "canons" of beauty. Such "rules" persist today in our ideas about a rule-of-thirds, a rule-of-fifths regarding human facial features, aesthetic triangles, and the whole theory of Phi, or golden ratio. Similar canons arose in Egypt, India, and Japan, and in all likelihood most cultures that had moved through agriculture into mathematics and geometry. Yet even as early as the first century in the common era certain writers, notably Vitruvius, were becoming aware that the mathematical canons were overly restrictive, failing to account for undoubted beauties who did not conform to the numbers, and failing to account for unquestionably beautiful sculptures made in defiance of the canons.

As touched on previously, because beauty in an ordinary procreative sense correlates with health, predictable behaviour and longevity, such choices find themselves being propagated. To find beauty in disease requires an anti-instinctive, anti-intuitive rationalizing effort, which may well be driven by tribe-based altruism, or more developed forms of altruism, but such findings of beauty seem to represent a minority of representations of attractiveness. The closest we get to that in most societies currently is the appreciation of beauty in frailty or delicateness. This may be driven by the normal human desire to nurture, as nature has endowed us with an attraction to those we can protect and care for, in order to ensure children are looked after.

Cosmetic improvements to human beings are as old as time, but only became incorporated into medicine more recently. A Papyrus text dating back to around 3000 BCE is the oldest known medical text that discusses trauma and surgical procedures and is alleged to contain descriptions of broken noses and their repair. There is ample evidence suggesting reconstructive surgeries were taking place in ancient Rome and India as well. Breast augmentation procedures date back to the nineteenth century, and facelifts date back to the early twentieth century. Cosmetic medicine has evolved alongside this with early chemical peels performed with caustic or acidic substances and

decorations on the skin created by scarification, as well as dermabrasion in various forms.

Most of the recent past is well known as far as procedures and technologies are involved. Yet the quest for an appearance that is not necessarily better in the eyes of the beholder appears to have emerged commonly. Many patients attending after COVID lockdown complained they had seen their face on Zoom. Most of us have had these experiences ourselves revealing that the perception of our own appearance does not necessarily relate directly to what we imagined. It seems we are not the best judges of our own aesthetics, or lack of, whatever that means. The question therefore remains, are we, as medical practitioners practising cosmetic, or aesthetic medicine, the best judges of how any patient 'should' look. But then again, is the patient?

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The CPCA's annual online conference "CosDoc", is back for 2023 and registrations are still open for post-event, on-demand content viewing! This year's content consists of presentations from over 20 different speakers, covering a myriad of non-invasive cosmetic medicinal topics, and live Q&A-style discussions that were held throughout the day. All CosDoc2023 delegates will have access to all content, vendor pages, and networking facilities on demand until 21 July 2023. For more information about registering for CosDoc, the speakers, and the topics of discussion, head to https://cpca.net.au/cosdoc2023/.

The Role of Diversity and Cultural Awareness in Medicine

Dr David Kosenko MBBS, FRACGP, FCPCA, and Dr Michael Molton, MBBS, FCPCA

Abstract

Acknowledgment of land and country and has been commonplace for many years now. It is most obvious prior to gatherings whether they be sporting, cultural or professional, such as conferences, and plays an important role in recognising Australia's First Nation People. Cultural Awareness and Safety is part of the curriculum of many courses and degrees including medical education. An understanding of Australia's past as well as cultural differences is vital in being able to reduce racism, foster inclusiveness and promote equity.
Diversity and the need for inclusiveness is not limited to ethnicity or race. The LGBTQIA+ group is another where an understanding of Gender Identity, Expression and Experience is required in order to be able to provide appropriate medical care.

The diversity of Australian culture necessitates an awareness of these differences in order to be able to create the trust and empathy that is required for an effective medical relationship. The Medical Board/Ahpra as of January 2023 requires all medical practitioners to reflect and construct statements that represent the identification of conscious and unconscious cultural bias, how this may impact upon the doctor/patient relationship and what steps might be taken to address any adverse effects such biases may cause.

What is cultural safety?

Cultural safety is more than just being aware of other cultures and respecting all people. It is about creating a workplace where everyone can examine personal cultural identities and attitudes and be open-minded and flexible in our attitudes towards people from cultures other than our own.

It also requires everyone to understand that values or practices are not always or only the best way to solve workplace problems.

Discussion

Late in 2021 the MBA outlined changes to the recommendations of programs for Continuous Professional Development (CPD) including the intention of the introduction of 'CPD Homes'. It is clear from the enclosed report that the annual requirement 'of reflection' is to self-assess conscious and unconscious biases that impact on the care of the diverse nature of Australia's population, including First Nations Peoples, and is central to the approval of CPD Home Accreditation. Although Cultural safety is one of four items that require provision of evidence to comply with the CPD rules as of January 2023. The remaining three requisites are professionalism, ethical healthcare and health inequities.

Self-Reflection and Cultural Safety

Published by Medical Board Aphra/Australian Medical Council that points all medical practitioners in Australia to issues of Cultural Diversity is The Cultural Safety Baseline Data Report Release and Recommendations, produced by the New Zealand Medical Council, 23rd October 2020 (1). The principles in this document have been adopted as a baseline for all Medical Practitioners in Australia to acknowledge and comply with in 2023.

The New Zealand model identifies cultural safety relevant to the Māori population, however most of the issues identified are also acknowledged as comparable and relevant to Australia's First Nations Peoples. Ideally, a selection of statements are presented here for consideration for all professional associations and colleges as collectives of registered medical practitioners.

1. Of primary importance is the collective acknowledgment of systemic racism and privilege in Australia in our health system. Reflection of this principle for those organisations that are signatories to the Australian Ethical Healthcare Alliance (AEHA) group (2) that member organisations are required to review, acknowledge and provide responses annually as a requirement of the commitment to ethical healthcare in Australia.

2. From January 2023 the Medical Board/Ahpra requires medical practitioners to formulate an annual ‘reflection statement’ as a conscious awareness that is aimed at improving cultural safety (3) in the healthcare sector in Australia. The annual statement should not only identify risks to cultural safety caused by internal unconscious bias. The annual statement is expected to also contain strategies to overcome failings in cultural safety wherever this has the capacity to occur. In addition, gaps in managing the biopsychosocial model of our patients due to lack of professionalism or reduction in ethical conduct should similarly be identified with the aim to uphold the trust and reputation of the medical profession. Finally, consideration of how to reduce health inequities, which can often coincide with cultural bias, is a task all doctors should be making a positive contribution to and the first step again is to consciously identify any imbalances that lead to inadequate societal healthcare that may be hiding within.

3. Identifying barriers to cultural safety within the health system, especially those common or unique to the profession of cosmetic medicine is an important task to define and remedy. Patients do not have access to the benefits of private health insurance cover or Medicare for cosmetic medical procedures. As such, a major component of the doctor-patient relationship is transactional. Cosmetic medicine patients pay directly or indirectly from personal asset holdings. Occasionally a third party may also be involved to fund procedures. Acknowledgment of the transactional basis of the doctor-patient relationship in cosmetic medicine is essential. Contractual agreements that remunerate practitioners on a commission-only basis risks an imbalance between the transactional basis of cosmetic medical procedures and the patient’s best interest. There is irony in the fact that a longstanding cosmetic medical practice is commonly built upon an enduring relationship with the patient. It makes sense therefore to favour the patient’s best interest rather than consider the patient to be a client to transact as much as is affordable to the patient, whether the patient needs to transact the goods or services offered.

4. Disempowerment figures strongly in culturally diverse communities. Language, literacy and numeracy (LLN) plus differences in custom systems produce an element of vulnerability that can be the source of exploitation through unethical practice. According to the Australian Government Style Manual that describes how government design publications for low literacy and numeracy, 60% of the Australian population have low levels of Health LLN (4). Exploitation of vulnerabilities is not a feature of good medical practice and wherever it occurs it should be called out and eliminated universally throughout the profession by each and every medical practitioner. Cultural bridges should be built that overcome disempowerment and there is no better place to start than at grass roots medicine since the profession itself is representative of cultural diversity in Australia. It is incumbent upon doctors to be confident that the patient is empowered in decision making processes and therefore assistance to the processes of informed consent. This is particularly important where risks and complications exist, and in respect of the transactional aspect of the doctor-patient relationship.

5. Recognition of the existence of specific belief systems and how these systems may impact upon decision making and the understanding of explanations of procedures, their side effects and potential complications is of mutual benefit to doctor and patient, wherever belief systems are different to the health practitioner.

6. In the case of ATSI doctors, it is not unusual for these practitioners to carry more cultural loading and responsibility to patients from ATSI communities and the same applies for ethnicity sameness of our culturally diverse medical fraternity. Recognition of these factors shall be formally identified and remedied wherever possible.

7. Workforce recruitment will not be influenced by bias, remembering that the broad diversity of Australian residents requires a culturally diverse workforce.

8. Taking the above points into consideration, data that measures progress on reducing

inequities require design and implementation to assess forward progress in minimising the impacts failures of cultural safety.

9. Finally, the extent of self-reflection and actions that propose an individual's cultural safety maturity depends upon self-motivation. Self-reflection is not a 'going to do it'. Self-reflection is a sincere, conscious exploration of a medical practitioner's conscious and subconscious biases that may impact upon culturally diverse patients.

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Recent Changes in the Medical Profession

Dr Michael Molton, MBBS, FCPCA

There are two significant changes that have emerged recently regarding the practice of medicine. New rules for Continuous Professional Development and new Guidelines of Non-Surgical Cosmetic Procedures.

With few exceptions, the Australian Medical Council has invited organisations to apply for accreditation as a CPD Home. All fifteen (15) of the Specialists Colleges have successfully graduated to the strict requirements and policies that are described in detail by the AMC to be awarded accreditation. A further five (5) non-Specialist organisations were invited to apply, one of which was the Cosmetic Physicians College of Australasia. This application resulted in preliminary passage to a more in-depth analysis by the AMC and achieved partial approval. The College received a detailed account of the deficiencies in the College's application. A CPD Committee separate from the Board is currently working through the AMC's critique.

The new requirements apply to all registered medical practitioners who must complete 50 hours of CPD annually and must be registered with a CPD Home accredited by the Australian Medical Council. CPD Homes are monitored by the Medical Board of Australia and must be compliant at all times with the criteria of accreditation. CPD Homes, as of 1st January 2023, must maintain and uphold a set of policies that support and assist medical practitioners to comply with the requirements. The 50 hours are divided up into categories (Fig1).

There are four main pillars that must be addressed in the activities that make up the 50 hours of CPD, and the CPD Home is required to support members achieve compliance in completing these various activities. The four pillars are Cultural Safety, Professionalism, Ethical Healthcare and Health Inequities. In addition to the 50 hours, each registered medical practitioner is required to produce an annual 'reflective statement' on personal biases that may impact on the delivery of the standard of healthcare consistent with the practice of medicine.

The second regulatory impact involves new guidelines for Non-Surgical Cosmetic procedures. There are significant changes to these guidelines from the previous publication. Firstly, cosmetic medical procedures are separated from Cosmetic Surgery and published under the heading 'Non-Surgical Procedures' (Fig 2). Secondly, a number of 'must' processes now exist in place of any implication of 'should'. 'Must' is categorised as an absolute rule, and where this word appears and is not complied with will likely be regarded as non-compliant with aspects of the National Law. Using the following example:

Assessment of patient suitability 2.1 *The medical practitioner who will perform the cosmetic procedure or prescribe the cosmetic injectable must discuss and assess the patient's reasons and motivation for requesting the procedure including external reasons (for example, a perceived need to please others) and internal reasons (for example, strong feelings about appearance). The patient's expectations of the procedure must be discussed to ensure they are realistic.*

Demonstration of compliance with this type of rule is best evidenced in the patient notes. While it is advisable to always consult with your medical insurer, one approach to the provision of evidence of compliance with the 'must' features could be to design a record check sheet that the practitioner can use as a template. In the event of an investigation, this completed template, covering all the 'must' features of the guidelines should be helpful in demonstrating compliance with the rules.

It would not be unreasonable to consider publishing the new guidelines on websites and social media connected to the practice where these procedures are performed.

Whether the practice is an accredited healthcare facility or not, it would also be wise to develop written policy on the key points of the guidelines that can be produced on request in the event of an investigation of a complaint.

There are many topics that arise from the new guidelines and readers are encouraged to participate in the Comments section of this article.

Please remember to maintain civility consistent with expected standards of the medical profession. Participation in the Comments section can be in the form of questions and suggestions on how to mitigate unfavourable findings in the event of perceived non-compliance of the guidelines by the Medical Board of Australia.

An advanced copy of the MBA/Ahpra's Guidelines as applicable to registered medical practitioners who perform non-surgical cosmetic procedures is available here.

Double click image below for relevant guidelines

ADVANCE COPY

Guidelines for registered medical practitioners who perform cosmetic surgery and procedures

Effective from: 1 July 2023

The CPCA's Upcoming Registrar Training Program

Dr Keturah Hoffman MBBS, FACP, MASCC, FCPCA

Dear Reader, let it be known that if you are interested in cosmetic medicine the CPCA can certainly assist you on your journey.

At the time of writing, the CPCA offers *Preliminary Essentials in Cosmetic Medicine* as a short online course that is available for immediate start. This course is all about the history, governance and management surrounding cosmetic medicine. It will show you things about the field that you may not have thought of and is essential starting knowledge, but will also not be wasted on other specialties, as half the content is applicable to most doctors.

Preliminary Essentials of Cosmetic Medicine can be treated as either a standalone course or a head-start on the upcoming Registrar Training Program (RTP). Candidates who successfully complete this course are awarded a digital credential for their website and professional networking pages and will be eligible to sit an assessment for Recognition of Prior Learning (RPL) credits towards *52900WA Graduate Certificate in Cosmetic Medicine*. If you are interested in studying *Preliminary Essentials of Cosmetic Medicine*, please visit our website https://cpca.net.au/preliminary-essentials-of-cosmetic-medicine/ to find out more about this course.

52900WA Graduate Certificate in Cosmetic Medicine

Course Overview

This qualification is the first of three to be produced by the CPCA in conjunction with Niche Education. It has been compiled according to government standards with the assistance of many extremely experienced cosmetic physicians, and we at the CPCA believe there is no comparable collection of wisdom in Australia.

52900WA Graduate Certificate in Cosmetic Medicine is the first course of its kind to not only be developed in Australia by Australian doctors for Australian Doctors, but it is also the first of its kind to be accredited by the Training Accreditation Council (TAC) as having demonstrated compliance with the requirements of the AQTF2021 Standards for Accredited Courses.

This course will provide an in-depth education on the history and application of cosmetic injectables and some surface treatments, covering normal anatomy, biochemistry, and physiology in order to explain how to optimise structure, function and appearance. Information on how to run a practice and guidance regarding regulations, ethics and cultural safety are also featured.

It is anticipated that the course will be compliant with any requirements proposed in future reviews of guidelines as the CPCA is committed to assisting its members to fulfil professional development and standing guidelines.

Course Delivery

Online theory units will be delivered using the latest e-learning technology allowing for interactive and flexible learning. Assessments will be in the form of workbooks and case studies, as well as multiple choice exams. Practical training will be delivered in Sydney, Melbourne, Perth, and Gold Coast over a week with assessment of clinical acumen and patient handling at this time also.

The volume of material provided is expected to take a working doctor 6 – 12 months to complete with a study commitment of approximately 12 hours per week. Time taken to do the course will depend on the chosen study load and pre-existing knowledge. Support from trainers is available throughout the course.

Units of Study

52900WA Graduate Certificate in Cosmetic Medicine will consist of the following units of study; *Principles of cosmetic medicine* covering the history and structure of the industry; *Patient assessment and consultation* which discusses all aspects of how to consult with patients with a view to doing cosmetic medical treatment whilst being aware of medical aspects; *Dermatology in cosmetic medicine* covering all dermatological aspects that a cosmetic physician will need to know to perform their job safely and effectively; and *Cosmetic injectables* covering all aspects of injecting cosmetic medical

drugs and preparation into patients for cosmetic enhancement and skin rejuvenation.

Prerequisites
A good grounding in general medicine is essential to being a good cosmetic physician and doctors who wish to enrol in *52900WA Graduate Certificate in Cosmetic Medicine* are required to have several years of postgraduate experience. Much of the prerequisite knowledge for this course is acquired in hospital and general practice. Some useful rotations for cosmetic medicine are general medicine, plastic surgery, dermatology, rheumatology, immunology, and general practice, but we understand that you can't always engineer the terms you are given.

Once enrolled into the course, candidates will be required to successfully fulfil the requirements of each unit prior to proceeding to the next, so will have a good grounding in how to operate within the cosmetic medical industry and recognise general medical and dermatological concerns and deal with them prior to being expected to treat cosmetic medical patients.

The Cosmetic Physicians College of Australasia will have a registrar membership category which is attached to the training course.

Recognition of Prior Learning (RPL) Credits
Existing cosmetic physicians may wish to apply to be awarded the graduate certificate on the grounds of Recognition of Prior Learning (RPL). The RPL process will involve gathering of evidence to demonstrate competence in the areas covered by the certificate and there will be various avenues to achieve this.

Course Outcomes
Acknowledgment of successful completion of each unit will be recognised with a digital badge. Course graduates will be eligible to enrol in the *Graduate Diploma in Cosmetic Medicine* and are entitled to apply for Full Membership with the CPCA.

Graduate Diploma in Cosmetic Medicine

Course Overview
The CPCA is currently developing the *Graduate Diploma in Cosmetic Medicine* so that its content and assessments will also align with the *Training Accreditation Council's* Australian Quality Training Framework (AQTF) at Level 8. This course will focus primarily on energy-based devices and skin resurfacing. As with the graduate certificate, this course will consist of online theory units that will be delivered using the latest e-learning technology and practical training over a defined period, and available in most major cities. Assessments will be in the form of workbooks and case studies, as well as multiple choice exams and practical assessments of clinical acumen and patient handling. Support from trainers will also be available throughout the course. Highly experienced cosmetic physicians may wish to apply to be awarded the diploma on the grounds of Recognition of Prior Learning (RPL). The RPL process will involve gathering of evidence to demonstrate competence in the areas covered by the diploma and there will be various avenues to achieve this.

Course Outcomes
Digital badges will be awarded to candidates for successful completion of each unit, and course graduates will be eligible to apply for Fellowship with the CPCA.

The Graduate Certificate in Cosmetic Medicine represents the official start of the CPCA's Registrar Training Program and is expected to launch in mid-2023. Expressions of interest in the CPCA's Registrar Training Program are welcome by way of email to cpca@cpca.net.au, and updated information about the Program will be disseminated via the CPCA's Training Program Mailing List. Those that have already placed enquiries will be acknowledged as priority.

To Lease or Not to Lease – Equipment Finance Explained

Medpro Finance Corporation Pty Ltd (CPCA Silver Corporate Sponsor 2021/2022)

Unlike purely consultation-based medical professionals, medical practitioners who commit to performing the complete services of cosmetic medical procedures with devices such as lasers, cannot function without the right equipment in their practice.

When deciding how to fund the purchases, here are some options to consider:

1. Pay for the equipment outright.
Paying for the equipment outright (i.e., not borrowing to finance the purchase) will avoid interest costs, however this may not be the most effective use of your funds. Having sufficient cash reserves in your business and optimising your tax position are important considerations which you should discuss with your accountant, and in our experience most accountants will recommend that business assets be financed rather than purchased outright.

2. Lease/rent the equipment.
With a lease or a rental, the financier purchases the equipment and leases/rents it to the customer in return for fixed monthly payments. Once the agreed number of rental payments has been made, the customer can:

- continue renting the equipment, OR
- hand it back to the lender (with no further payments required), OR
- buy the equipment from the lender at an agreed value.

The main advantages of this option are the ability for the renter to claim a tax deduction for the total monthly lease/rental payments (i.e., not just the interest component) and the fact that this asset and corresponding liability does not appear on the balance sheet of the business.

Please note that the terms “rental” and “lease” can be interpreted differently by financiers, depending on how their products operate, so please ensure you take the time to understand the conditions of the finance contract before proceeding.

3. Business loan.
Borrowing via a Business Loan means the customer owns the equipment, and it appears on the practice’s balance sheet. The interest costs are tax deductible (assuming the equipment is used for business purposes), and depending on the financier you approach, some will even fund the GST on the purchase.

Your accountant should be your first port of call for advice on which structure is best for your business each time you are considering acquiring equipment.

This article contains general information only and is not for the purpose of providing specific financial advice. Please see below some great advice from the Editor about protecting your personal information. Medpro Finance will never ask you for information like your Credit card numbers, passwords and/or login details or PINs. Of course, certain personal information will be required to be provided as part of a finance application e.g., Bank Statements, ID documents etc – please rest assured that we will always discuss this with you prior to requesting the information, so that you can be confident it’s a legitimate request.

For a confidential discussion about your finance needs please call our experienced consultants - Ross Andrews on 0488 767 722 or Hannah Smith on 0467 667 555.

Editors Comments

This article is kindly provided by Medpro, a CPCA Corporate Sponsor. Whenever the topic of loans, accounts and online transactions come up it is fitting to be on our guard for scams which are becoming increasingly common and sophisticated. Here are some general helpful hints:

- *never provide details of accounts, driver’s license details, in fact any personal details to phone callers purporting to be your banker or financier.*

- *scam callers will attempt to convince you that your credit card/account has been hacked and you are told to move your funds to a safer account as soon as possible (like, now).*
- *common recommendations in these situations is to hang up immediately.*
- *call the telephone number on the back of your debit/credit card or*
- *personally visit a branch to clarify any claims made by callers.*
- *authenticator apps and two-step verification are now in common use and designed to protect against scammers.*
- *regular changes of passwords is often recommended by*
- *avoid easily guessed passwords such as date of birth, mobile number.*
- *avoid using passwords that are used on multiple sites.*
- *consider using Apps that will provide alerts that central credit agencies have received enquiries about your credit rating which is a common indication an application is underway for loans on your behalf that you did not make.*
- *Billions of dollars are stolen by scammers every year and increasing in frequency and sophistication.*
- *end to end encryption communication systems are also available.*
- *develop a high degree of suspicion when the caller is pressing urgency to provide details of accounts PINS, telephone banking passwords, etc.*

The Cosmetic Physician is a Free Open Access Journal

The Cosmetic Physician is an open and free journal published by the Cosmetic Physicians College of Australasia for all medical practitioners who have a special interest in non-invasive cosmetic medicine. All members of the public are invited to submit Letters to the Editor and/or Manuscripts for publication (subject to approval by The Editor. T&C's apply).

How to Submit a Manuscript

Manuscripts for publication in future volumes of *The Cosmetic Physician* can be submitted via https://cpca.net.au/the-cosmetic-physician-journal/.

All materials submitted to The Cosmetic Physician, or the Editor, must include any and all applicable references and disclosures at the time of submission. Disclosures should indicate whether the material is supported or sponsored by any person, company, or organisation, whether you consult, advise for, or are a KOL for the entity, and whether you are receiving any financial gain or payment for the material. References are to be written in the Vancouver referencing style. A helpful guide for writing references in the Vancouver style can be found at https://guides.library.uq.edu.au/referencing/vancouver.

Publication of manuscripts is subject to approval by The Editor. T&C's Apply.

How to Submit Letters to the Editor

Letters to the Editor can be submitted via the upload facility available on https://cpca.net.au/the-cosmetic-physician-journal/. Alternatively, please email your Letters to the Editor to cpca@cpca.net.au.

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