Final report

Independent review of the regulation of medical practitioners who perform cosmetic surgery

August 2022

Commissioned by the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia

Contents

Executive Summary

On 30 November 2021, the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia announced the establishment of an independent review of the regulation of medical practitioners who perform cosmetic surgery. This announcement followed media reporting that raised various concerns about alleged conduct of some medical practitioners, including alleged serious hygiene breaches, patient safety issues, poor patient care, unsatisfactory surgical outcomes and aggressive and inappropriate advertising. While media stories focused on the practice of a small number of practitioners, they raised questions about practices in the broader cosmetic surgery sector and the current approach to regulation.

In the period since November 2021, the review considered evidence from a range of sources on these matters. This report sets out the review's findings and 16 recommendations to improve Ahpra and the Medical Board's approach to regulation of the sector.

Defining cosmetic surgery

Cosmetic surgery refers to operations that involve cutting beneath the skin to revise or change the appearance of normal bodily features where there is otherwise no clinical or functional need for the procedure. Examples of cosmetic surgery include breast implants, abdominoplasty (tummy tuck), rhinoplasty (nose surgery), surgical face lifts and liposuction.

By virtue of this definition, a range of cosmetic treatments fall outside the scope of the review including cosmetic injectables (such as Botox and dermal fillers), laser skin treatments, dermabrasion and cryolipolysis (fat freezing), as do any procedures that either restore normal bodily features (such as reconstructive plastic surgery) or serve a clinical or functional purpose (such as breast reduction).

A range of registered and unregistered health practitioners are involved in the cosmetic surgery sector. However, the focus of this review, commissioned by Ahpra and the Medical Board, was on medical practitioners (doctors) who perform cosmetic surgery.

Cosmetic surgery sector in Australia

While it is generally accepted that the cosmetic surgery sector has undergone rapid growth in recent years, the actual size of the sector in Australia is difficult to accurately quantify for a range of reasons. As cosmetic surgery is not covered by Medicare or private health insurance, funding data is not available and there is no central reporting of procedures.

A range of medical practitioners provide cosmetic surgery, across several specialties and registration types, using a variety of titles and having membership of an array of professional bodies. These factors make it challenging for governments and regulators to accurately know the full size of the cosmetic surgery workforce.

This review found that the cosmetic surgery sector, as a health service, is unique and somewhat of a health market disrupter, largely sitting outside of the existing health system frameworks. It is not a recognised medical specialty and it challenges the traditional specialist registration model. As noted above, Medicare item numbers are not available for purely aesthetic cosmetic surgery and therefore general practitioners are generally not involved in recommending treatment or directing patients to specialist surgeons.

Likewise, purely aesthetic cosmetic surgery is not offered by the public health system or covered by private health insurance, again bypassing systems that fit within the specialist model. The net result is that the existing traditional systems that tend to ensure that patients access appropriately qualified medical practitioners do not necessarily apply in cosmetic surgery. This poses various regulatory challenges.

Cosmetic surgery regulation in Australia

Ahpra and the Medical Board are one part of a complex and multi-jurisdictional system that regulates cosmetic surgery in Australia. Some aspects of regulation in this space are national, while others are state and territory based. Each regulator plays a different and important role in overseeing elements of the cosmetic surgery sector and protecting people from harm.

Ahpra and the Medical Board regulate individual medical practitioners, including those who undertake cosmetic surgery, registered under the National Registration and Accreditation Scheme.

However, other laws, regulators and standards in the cosmetic surgery sector also apply including:

- state and territory laws which set out certain requirements about cosmetic surgery (including the facilities where procedures must be undertaken)
- state and territory laws that regulate private health facilities, including private hospitals
- state and territory health complaint entities that deal with complaints
- national standards for accreditation of health facilities
- national regulation of medicines and medical devices
- consumer laws and regulators, such as the Australian Consumer Law, overseen by the Australian Competition and Consumer Commission (ACCC) and the state and territory consumer protection agencies.

The review's analysis and recommendations were focused on Ahpra and the Medical Board's responsibilities, powers and areas of influence. While these are very important, the review acknowledges that there are many aspects related to cosmetic surgery that fall well outside the control and responsibility of Ahpra and the Medical Board and sit with various regulators across the country.

Chapter 1: Education, training and qualifications

One of the most consistent themes to arise during this review was the issue of the education, training and qualifications of practitioners undertaking cosmetic surgery, or more specifically, the absence of any minimum standards about these matters. Most previous reviews undertaken in Australia have highlighted this as a concern. Submissions received as part of this review overwhelmingly raised it as an issue. Feedback from consumers (through the consumer survey and focus groups) emphasised that these are important matters to them and that they rely heavily upon what they are told by their doctors about their training, qualifications and experience.

The review found that when it comes to cosmetic surgery, universal minimum standards for education, training and qualifications are non-existent in Australia. The Medical Board's codes and guidelines place the onus on the individual medical practitioner to ensure they practise within their skills, knowledge and competence, and therefore it is up to the practitioner themselves to decide this, without reference to any minimum standards or other more specific guidance. In these circumstances, it is possible for any medical practitioner to offer and perform invasive cosmetic surgical procedures without having undertaken appropriate training or having amassed sufficient supervised experience to reach an acceptable level of competency.

Against this background consumers are largely left on their own when it comes to selecting a practitioner to perform cosmetic surgery. Often they are required to sift through a plethora of advertising and marketing material, seek to understand various titles and try to make sense of numerous qualifications, all in an attempt to identify a qualified and competent practitioner. This is an unacceptable situation.

While the problem is easy to identify and define, the solutions are much more complex and controversial. They are complex because the Health Practitioner Regulation National Law (the National Law), governing Ahpra and the Medical Board's powers and responsibilities, is based largely on a title protection model (that is, it seeks to regulate what practitioners are allowed to call themselves) and less on a model that directly regulates scope of practice (that is, what practitioners are allowed to do). The solutions are controversial because they require navigating some disputed territory that is at the core of a very public battle between groups representing specialist surgeons (and in particular those that have a plastic surgery subspecialty) and those who are not specialist surgeons.

Medical practitioners who do not hold specialist registration, must not 'hold themselves out' as a registered specialist or claim to be qualified to practise in a recognised specialty. Cosmetic surgery is not, however, recognised as a medical specialty. While the title 'surgeon' is part of a number of protected specialist titles (for example, 'specialist plastic surgeon' and 'specialist orthopaedic surgeon'), there is no standalone title 'surgeon' that is protected by the National Law.

As a result the title 'cosmetic surgeon' (which is a commonly used term in the cosmetic surgery sector, irrespective of the level of training and qualifications of the practitioner) is not a protected

title and therefore it is unlikely that the use of the term 'cosmetic surgeon' by medical practitioners who are not specialist surgeons would be in breach of the title protection provisions in the National Law.

There have been many submissions to this review advocating for the protection of the term 'surgeon', which would prevent non-specialist surgeons from using it. Proponents argue that this would better inform consumers and assist them to make safe choices when selecting a practitioner. However, whether the term 'surgeon' alone should be a protected title (and therefore only be permitted to be used by specialist surgeons) is currently under consideration by the Ministerial Council and outside the scope of this review. Therefore, the review makes no findings or recommendations about whether the term should be protected. The review's findings and recommendations are agnostic to the outcome of the Ministerial Council's process – they are intended to improve regulation of practitioners in cosmetic surgery, regardless of whether or not the title 'surgeon' is ultimately protected.

While the review wholeheartedly agrees that clarity for consumers about the training and qualifications of medical practitioners undertaking cosmetic surgery is essential, it does not consider that title protection alone provides enough clarity or sufficient protection to the public. The unique environmental factors found within the cosmetic surgery sector call for a more unique regulatory response.

In these circumstances, while the use of the practice endorsement model provided for in the National Law has its limitations and challenges, the review considers that Ahpra and the Medical Board should seek to establish an area of practice endorsement for cosmetic surgery. Under the National Law, the Medical Board may recommend that the Ministerial Council approve an area of practice as being an endorsed area of practice.[1] An endorsement recognises that a person has an extended scope of practice in a particular area because they have obtained a specific qualification in that area that has been approved by the Board. The program of study leading to the qualification also has to pass accreditation by an independent accreditation authority (in the case of medical practitioners, the Australian Medical Council (AMC)).

If an endorsement for cosmetic surgery was approved, it would be easy for consumers to identify practitioners who have an endorsement as the endorsement would be listed on the public register. Practitioners would be permitted to advertise themselves as having an endorsement for cosmetic surgery and those without an endorsement would be prohibited from claiming to hold one.

An accompanying public education campaign (which the review considers would be necessary) could then focus on educating consumers who were considering cosmetic surgery to 'make sure your doctor has an endorsement for cosmetic surgery'. The review considers that this would be a much simpler message to communicate than explaining surgical qualifications or specialist titles and would go a long way to address the existing confusion that consumers report about the training and qualifications of practitioners operating in this space.

Another benefit of endorsement is that it would set a clear minimum standard of training for practitioners providing cosmetic surgery. An accreditation standard for the program of study could be set at a sufficiently high level to ensure a program enables medical practitioners to have the necessary knowledge and skills to practise competently and safely. Only those training programs that are assessed as meeting the accreditation standard would be approved for the purposes of endorsement.

A program of study could be existing or newly developed. However, the review was not able to make findings about the suitability or unsuitability, or superiority or otherwise for cosmetic surgery practice of any existing qualifications. The question of appropriate qualifications is subject to substantial debate between competing groups and has significant consequences for market share. The endorsement process allows for the application of an objective and independent lens to these questions by the Medical Board and the AMC.

The review also considers that the Medical Board's *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* (the Cosmetic Guidelines) should be amended to provide more direction about the minimum training, qualifications and experience expected of medical practitioners providing cosmetic surgery (this is discussed in Chapter 4 – Influencing Practice).

[1] Section 15 of the National Law.

The review makes the following recommendations to address the identified issues:

Recommendations

1. The Medical Board seek to establish an area of practice endorsement for cosmetic surgery.
2. If an area of practice endorsement is approved for cosmetic surgery, Ahpra and the Medical Board, in consultation with other stakeholders, undertake a public education campaign to assist consumers to understand the significance of an endorsement.

Chapter 2: Management of notifications

One of Ahpra and the Medical Board's key functions is to receive and manage notifications about the performance, conduct and health of registered health practitioners, including notifications about cosmetic surgery matters. For Ahpra and the Medical Board to discharge this function it is critical that they are informed of serious concerns regarding the conduct and/or performance of medical practitioners who are undertaking cosmetic surgery. They must first receive a notification.

Consumers who have undergone cosmetic surgery are currently by far the largest source of notifications to Ahpra and the Medical Board about cosmetic surgery. However, the review found that Ahpra and the Medical Board face significant challenges when it comes to receiving and managing cosmetic surgery notifications. From a national perspective, the health complaints landscape is very complex with different systems operating in a number of different states and territories.[2] The overwhelming majority of people who made submissions to the review on this topic expressed the view that current complaints and notifications processes are not well understood by consumers.

The review also found that there appears to be an inherent misalignment between the expectations of consumers who make cosmetic surgery notifications and the outcomes that Ahpra and the Medical Board can achieve. Under the National Law, Ahpra and the Medical Board's sole focus when managing a notification is on the conduct, performance and health of the practitioner, including whether the practice is unsafe or below reasonably expected standards. At its heart, the notification process is between Ahpra and the Medical Board and the practitioner, and the consumer is merely the informant or witness. Ahpra and the Medical Board have no legislative power to achieve specific outcomes directed towards the consumer notifiers such as apologies, refunds, revision surgery or compensation. The review found that this appears to be both a source of confusion and disappointment for consumers.

Notwithstanding their reasonable efforts, the review found that Ahpra and the Medical Board's attempt to explain their role and manage notifier expectation about cosmetic surgery notifications has not been completely successful. This indicates that in the cosmetic surgery context (with its unique attributes) more should be attempted.

The review noted that Ahpra and the Australian Commission on Safety and Quality in Health Care are currently undertaking a joint project that aims to improve the consumer experience of making notifications about registered health practitioners. The review considers that this is valuable work and should assist in addressing some of the issues identified here.

Finally, the review noted situations where non-disclosure agreements (NDAs) had been employed by some practitioners which appeared to interfere with some consumers' understanding of their right to make a notification to Ahpra and the Medical Board, or to assist with an investigation. Ahpra advised the review that they believe that such NDAs would likely be unenforceable.

The review makes the following recommendations to address the identified issues:

[2] Including that Ahpra and the Medical Board does not deal with health, conduct and performance matters involving registered health practitioners in New South Wales (with the exception of advertising matters or where a person is claiming to be registered, specialised or endorsed when they are not).

Recommendations

3. Ahpra and the Medical Board continue their joint work with the Australian Commission on Safety and Quality in Health Care on improving the consumer experience of making health notifications in Australia.
4. Ahpra and the Medical Board consider:
   a) producing notifier educational material (with case examples) tailored specifically to cosmetic surgery matters including providing advice about:
      i. Ahpra and the Medical Board's role and the limit of their powers
      ii. pathways to HCEs and other complaint agencies that offer dispute resolution
   b) providing more specific advice (on the above matters) in initial correspondence to consumers who have made a notification about a cosmetic surgery matter
   c) making public their position in relation to practitioners' use of NDAs as a means to prevent consumers making a notification.

Fundamental to public safety in the cosmetic surgery sector is a strong reporting culture. This requires registered health practitioners and employers working within the sector to make notifications to Ahpra when it is necessary or appropriate. The National Law places an obligation on registered health practitioners, employers and health education providers to make a mandatory notification in certain circumstances, including where a practitioner forms a reasonable belief that another registered health practitioner is practising in a way that significantly departs from accepted professional standards and is placing the public at risk of harm.[3]

The review found that there is a significant underreporting of safety issues by registered health practitioners and employers in the cosmetic surgery sector. Most concerning was that no mandatory notifications appear to have been made about cosmetic surgery matters received between 1 July 2018 to 31 December 2021.[4] This compares very poorly against the yearly rate of mandatory notifications received for all registered health practitioners practising across all professions. For example, Ahpra and the National Boards' *2020/21 Annual Report* states that mandatory notifications made up 12.5% of all notifications received during that financial year, yet for cosmetic surgery it may be as low as 0%.

The review also noted that no mandatory notifications appear to have been received by Ahpra and the Medical Board from registered health practitioners about the various cosmetic surgery matters that have been reported in the media or subject to publicised class actions.

The review received a large number of submissions commenting on the issue of mandatory notifications. The most frequently mentioned barrier to mandatory reporting was fear, namely fear of:

- retaliation or hostility from other practitioners
- that making a notification will result in a job loss or otherwise adversely affect one's career
- litigation
- reputational damage or stigma
- being identified due to the lack of anonymity in making a notification.

Consistent feedback was also received about the challenge in determining whether the 'significant departure from accepted professional standards' threshold for a mandatory notification was met in cosmetic surgery matters when there is a lack of minimum standards for cosmetic surgery practice. This issue is addressed by a recommendation in 'Chapter 4 – Influencing Practice'.

[3] Sections 141, 142 and 143 of the National Law.

[4] Of the 177 notifications received between 1 July 2018 to 31 December 2021 and finalised by 31 December 2021 (this review's time period), none were mandatory notifications. It should be noted that it is possible that a mandatory notification(s) may have been made but not finalised in the review period (thus not captured as one of the 177 matters).

The review makes the following recommendations about these issues but notes that the ability to influence some of the barriers identified is likely to be beyond the control of Ahpra and the Medical Board:

Recommendations

5. Ahpra and the Medical Board review its educational material that is available to practitioners about mandatory and voluntary notifications and include more information about:
   a) notifications involving concerns that a practitioner may have placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards and is placing the public at risk of harm
   b) protections for notifiers and the ability to make a confidential mandatory notification or anonymous voluntary notification.
6. Ahpra and the Medical Board undertake a targeted education campaign in relation to making mandatory and voluntary notifications aimed at the cosmetic surgery sector and also the classes of practitioners/employers outside the sector who may subsequently treat cosmetic surgery patients (including emergency departments and their employees).

Once a notification is received, Ahpra works with the Medical Board to assess, investigate[5] and generally manage it. The Medical Board has the power, depending on the nature of the notification, to make determinations about a medical practitioner and impose certain sanctions or, in the most serious matters, refer the matter to a responsible (state or territory) tribunal who may determine the matter and impose sanctions.[6]

A large number of submissions received commented on the management of notifications. The most frequent suggestion for improvement was for Ahpra and the Medical Board to ensure that all notifications involve review by persons who have expertise in cosmetic surgery matters.

The review analysed Ahpra and the Medical Board's approach to managing cosmetic surgery notifications, with a focus on the methodology for risk assessment and investigation protocol. It undertook a detailed review of Ahpra and the Medical Board's handling of a sample of cosmetic surgery notifications received between 1 July 2018 to 31 December 2021 and finalised by 31 December 2021 (the review period).

The review found a significant variation in approach in managing these matters over the review period. The overall theme that arose from the sample review was the need for Ahpra and the Medical Board to take a consistent approach to analysing the notifications, applying the risk assessment methodology, identifying the key issue of the notification and making the necessary further enquiries.

The review acknowledges that notification management is a challenging function for Ahpra and the Medical Board, especially as the number of notifications received continues to increase. Ahpra and the Medical Board's resources are finite and stakeholder expectation is understandably high. In this environment the effective use of accurate risk assessment tools is critical.

The review found that some improvements to the way that cosmetic surgery notifications are assessed and investigated are necessary and makes the following recommendations aimed at enhancing the regulatory response to notifications:

[5] Not all notifications are investigated and many notifications are finalised at the assessment stage.

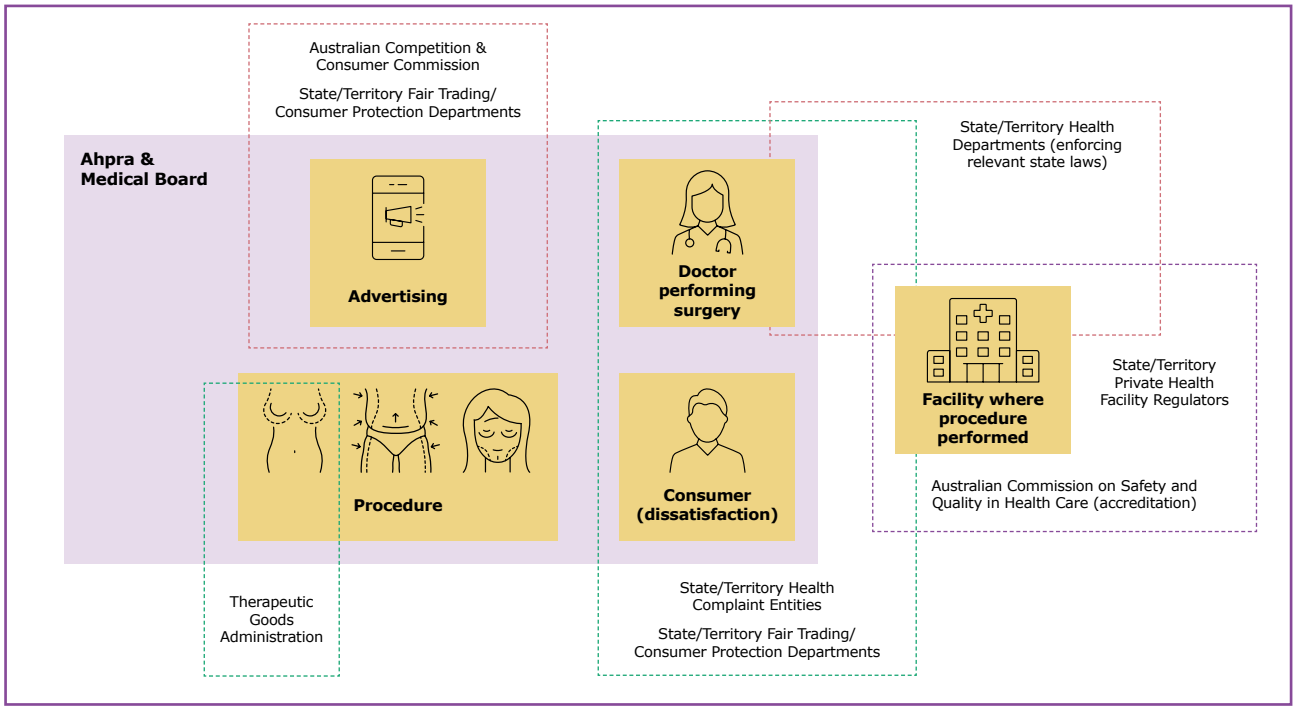
[6] Part 8 of the National Law.

Recommendations

7. Ahpra and the Medical Board:
   a) develop training and guidance material (for example, a manual) specifically about the management of cosmetic surgery notifications to supplement and support the current assessment/investigation processes (which may include what other open-source enquiries should be made and when). This should be directed towards ensuring that any specific key issues raised by the notification (either directly or indirectly) are consistently and appropriately considered and the risk assessment methodology is rigorously applied
   b) take further steps to enhance consistency in the management of issues raised in cosmetic surgery notifications, including for example, building up the specialist expertise of staff managing these notifications (whether in one team or across teams)
   c) ensure that where necessary key claims in a practitioner's submissions are scrutinised, including seeking corroborative evidence (for example, medical notes or GP records) and attempts are made to resolve key factual disputes (including seeking clarification from the notifier or other witnesses).

As already noted in this report, Ahpra and the Medical Board are part of a complex and multi-jurisdictional system that regulates cosmetic surgery in Australia (see figure 1). Therefore, to appropriately manage notifications that are received, Ahpra and the Medical Board need to be able to work effectively with other regulators.

Figure 1: Overlapping jurisdictions in cosmetic surgery regulation



The review considers that having a detailed working understanding of the roles and responsibilities of other regulators in this space is essential to ensure the most effective regulatory response to a notification. In the high-volume notifications environment where staff are under the pressure of managing competing priorities, it is not efficient or feasible to have to research these jurisdictional matters each time a certain type of notification is received.

While the review found no strong evidence of deficits in this space, there were some indicators that suggested more could be done. Ahpra currently does not have internal guidance material that clearly maps the various regulatory agencies, their roles, responsibilities and general powers in the cosmetic surgery sector. The complexity demands clear, documented guidance that is available to

all staff who may be involved in managing notifications. This indicated that there are opportunities to improve the flow of information between regulators at national, state and territory levels and the review makes the following recommendation to address the identified issues:

Recommendations

8. Building on the work undertaken by the review:
   a) Ahpra identify and clearly map the roles, responsibilities and powers of each regulator in the cosmetic surgery sector (including on a state-by-state basis) and produce a corporate document available to relevant staff; and
   b) once the mapping exercise is completed, Ahpra identify where any improvements are required to enhance the flow of information between these relevant regulators, including for example, identifying key contacts and/or where necessary entering into a memorandum of understanding or other agreement.

Chapter 3: Advertising regulation

The role and regulation of advertising in cosmetic surgery need to be understood in the broader context of regulation of cosmetic surgery practitioners, as discussed in various sections of this report. There is a lack of objective and unbiased information about the training and qualifications of practitioners in this sector, and cosmetic surgery lacks the protective measures found in other parts of the health system that inform consumers and direct them to qualified practitioners. The entirely elective nature of cosmetic surgery means that advertising plays a significant role in creating a desire or demand for these services which tends to distinguish it from other areas of health advertising. Finally, social media is extensively used as a tool to reach and influence consumer choice. The review considers that all these factors combined raise concerns about the impact of cosmetic surgery advertising and the need to ensure that it is well regulated.

Recent media reporting, academic literature and previous reviews have all raised concerns about this area, including the potential for cosmetic surgery advertising to mislead, noting that its primary intention is to sell, not educate. Research suggests a connection between social media use and the increasing incidence of body dysmorphia and other body image concerns (particularly among young women). In these circumstances, the review is particularly concerned with tactics employed by some practitioners, particularly on social media, including using images of models who are unlikely to have had cosmetic surgery to promote a particular surgical procedure, content that actively encourages people to pursue what is promoted as a socially accepted or perfect body type and the use of influencers to promote procedures.

Submissions to this review were highly critical of the advertising approach of some practitioners in this space and called for Ahpra and the Medical Board to do more. Consumer research undertaken as part of this review (including through an online survey) has highlighted the potential reach and influence of advertising in this sector and on the ability of consumers to make informed choices.

The review noted that Ahpra and the Medical Board's regulatory powers in this space are derived from both an advertising offence provision in the National Law and the ability to make codes and guidelines which set advertising standards and provide guidance about good practice for registered practitioners.

The review also noted that the advertising offence provision provides that a person must not advertise in a way that 'directly or indirectly encourages the [...] unnecessary use of regulated health services.' Purely aesthetic cosmetic surgery, by its very nature, is an elective procedure for which no clinical or functional need exists. In these circumstances there may be an argument that forms of advertising of cosmetic surgery may in effect be prohibited by section 133 of the National Law. The review considers that this is a complex legal question that could benefit from legal advice.

Recommendations

9. Ahpra obtain legal advice specifically about the application of section 133(1)(e) to cosmetic surgery and the extent to which it may effectively prohibit forms of advertising of cosmetic surgery.

The review found that Ahpra and the Medical Board's regulatory response is governed by a well-considered compliance and enforcement strategy which is predominantly focused on encouraging voluntary compliance. Although the strategy also provides for an escalated and a more forceful approach to high-risk advertising conduct, the review found that this tactic has not currently been deployed for high-risk cosmetic surgery advertising. In circumstances where there appears to be a cohort of practitioners who are knowingly and intentionally flaunting the advertising requirements, or who otherwise have little interest in voluntarily complying, proper application of the strategy would indicate the need to take a more forceful approach. Such an approach may include prosecuting practitioners pursuant to the offence provision or otherwise taking disciplinary action against them.

The review also found that while Ahpra does some proactive auditing of a sample of medical practitioners' advertising each year, it currently does not focus specifically on cosmetic surgery and only audits a limited number of practitioners. This approach is unlikely to meet current community expectation. While the review acknowledges that there are limits to what Ahpra and the Medical Board can do given the limits of their powers and finite nature of their resources, the review considers there would be benefit conducting a targeted audit project directed at cosmetic surgery advertising, which is provided for under the *Advertising compliance and enforcement strategy for the National Scheme* (the Strategy).

Recommendations

10. Ahpra and the Medical Board review their regulatory approach to advertising in the cosmetic surgery sector including by:
    a) ensuring that the risks posed by advertising in this sector are appropriately categorised within the risk framework set out in the *Advertising compliance and enforcement strategy for the National Scheme* so that stronger enforcement action is taken about high-risk matters (including, where appropriate, taking prosecutorial action in some matters)
    b) undertaking an industry-specific audit which should, among other things, inform the future proactive monitoring/auditing of activities in this space.

Extensive advertising guidance material has been published by Ahpra and the National Boards. Much of it has direct application to cosmetic surgery advertising. However, the review noted that Ahpra and the National Boards' *Guidelines for advertising a regulated health service* (Advertising Guidelines) tend to be limited to explaining the operation of the advertising offence provision.

The review sees no need to limit the advertising guidance material directed at registered practitioners to only what may amount to an advertising offence (noting that guidelines can also reflect the standards expected of professional peers and have regard to general community expectations). In the circumstances, the review considers that there would be benefit in refreshing and updating the Advertising Guidelines and/or producing additional material specifically about cosmetic surgery to clarify standards expected of practitioners.

The review also notes that having regard to the extensive use of social media advertising, technology is available to monitor and capture some advertising content in real time. This may potentially reduce the administrative burden of auditing and also increase the information available to Ahpra about practitioners of concern.

Recommendations

11. Ahpra and the Medical Board revise the Advertising Guidelines and/or produce additional material specifically about cosmetic surgery to clarify the standards expected of practitioners (including specific examples of inappropriate content or approaches) by addressing such areas as:
    a) avoiding the glamorisation and trivialisation of procedures including the downplaying of risk
    b) avoiding the use of images of models who have not undergone a cosmetic procedure(s) to promote a cosmetic procedure
    c) avoiding the promotion of procedures through the use of social media influencers
    d) avoiding the use of content that implies cosmetic surgery should be utilised to obtain an acceptable/ideal body type
    e) promoting the use of disclaimers
    f) limiting benefit statements to those that are objectively demonstrable/provable (that is, the physical changes – not claimed psychological or social benefit)
    g) limiting the filming and use of content that shows surgical procedures to educational purposes only and not for entertainment
    h) strengthening procedures for informed consent on the use of and storage of patients' before and after photos
    i) preventing the targeting of young or otherwise vulnerable groups with advertising (including through algorithms and other marketing technology).
12. Ahpra and the Medical Board consider the use of technology to assist in the monitoring/auditing of advertising in the sector.

Chapter 4: Influencing practice

National Boards, like the Medical Board, have the ability under the National Law to publish codes and guidelines. In this way they can seek to influence good medical practice by making their expectations clear to the practitioners it registers and also let the community know of the standard expected of doctors.

In 2016 the Medical Board issued *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* (the Cosmetic Guidelines), which apply to registered medical practitioners who perform cosmetic medical and surgical procedures regardless of the practitioner's registration type. The review considered whether the Medical Board's current Cosmetic Guidelines adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience.

The overwhelming feedback in submissions to the review was that the Cosmetic Guidelines are not adequate, should be strengthened, and specific changes are needed. General feedback included that more clarity or detail was needed to make the Medical Board's expectations clearer. The review received feedback from stakeholders about almost every section of the Medical Board's Cosmetic Guidelines.

The review concluded that while these guidelines set expectations about the majority of aspects relevant to the practice of cosmetic surgery, some areas have been overlooked and scope exists to provide more clarity and detail about other aspects.

Areas of the Cosmetic Guidelines specifically considered by the review included:

- **The definition of cosmetic surgery**: the review noted that it should be amended to remove the reference to 'boosting the patient's self-esteem' as being a purpose of the surgery, as no definitive and objective position can be reached about whether cosmetic surgery boosts self-esteem based on current available research.
- **Patient assessment, including psychological screening**: the review noted that screening for psychological issues is critical for cosmetic surgery patients to identify consumers for whom cosmetic surgery is not suitable. The review considers that the current

guidelines on preoperative screening should be strengthened and include reference to the use of a validated psychological screening tool to assess for underlying psychological conditions and documentation of the process and outcome.

- **Informed consent**: the review noted that ensuring consumers have access to accurate and sufficient information and are able to give fully informed consent before having a procedure is critical to ensuring public safety. The review considers that the current guidelines are generally comprehensive about consent matters but with relatively minor amendments could be improved including reference to:
  - ensuring that information is provided in a language understood by the consumer
  - providing the short- and long-term potential outcomes/complications
  - more comprehensive information about the total cost involved
  - more detail about the full range of complaints mechanisms available to the consumer.
- **Postoperative care**: the review noted that inadequate postoperative care in cosmetic surgery puts patients at risk and considered that more guidance is needed to ensure a high standard of care in relation to the care patients receive after their procedure.
- **Training and education**: the review noted that many stakeholders were critical of the generality of the wording in the Medical Board's current Cosmetic Guidelines about the Medical Board's expectations for training and qualifications for medical practitioners providing cosmetic surgery. It was noted that the guidelines state practitioners should have 'appropriate training' and 'necessary training' but does not provide any guidance as to what might be considered appropriate or necessary. If an endorsement is approved for cosmetic surgery, the review considers that the guidelines should be updated and strengthened to include endorsement as appropriate training. In the interim, the review also considers the Medical Board should strengthen the guidelines to provide more direction on the minimum training, expertise and experience expected of medical practitioners providing cosmetic surgery. The guideline should also articulate the importance of ongoing continuing professional development (CPD) in this area.

The review also makes observations about potential improvements to guidelines on cooling-off periods, video conferencing/telehealth and financial arrangements.

A number of submissions were received about the facilities where cosmetic surgery may be performed. The review found significant differences in approaches about which procedures can be performed in which facilities between different states and territories. This is a particular concern as there are risks to patients when cosmetic surgery is undertaken in facilities that are not appropriate for the level of risk of the procedure. The state-by-state variation in approach to facility regulation is a matter obviously outside of the control of Ahpra and the Medical Board. However, the review remains concerned that gaps in facility regulation potentially expose patient safety to undue risk. Therefore, the review considers that Ahpra and the Medical Board should take the opportunity to raise this issue and encourage jurisdictions to strengthen consistent facility regulation.

The review notes that the Medical Board is required to undertake wide-ranging consultation on any changes to guidelines and this will provide all stakeholders, including organisations, practitioners and consumers, an opportunity to provide further input on any proposed changes to the Cosmetic Guidelines.

Compliance by some practitioners with the Cosmetic Guidelines has also been identified as a significant issue of concern for many submitters. While there were some calls for Ahpra and the Medical Board to take a proactive approach and audit compliance with guidelines, the review considers they lack the formal powers to do so and thus such a role is outside of their legislative remit.

The review considers that there are other opportunities, however, for Ahpra and the Medical Board to address some compliance issues including through the management of notifications (discussed in 'Chapter 2 – Management of Notifications'), clarification of training and qualification requirements (discussed in this Executive Summary and 'Chapter 1 – Education, training and qualifications') and general practitioner education activities (discussed and recommended in this summary).

The review makes the following recommendations:

Recommendations

13. The Medical Board review, consult on and update its *Guidelines for medical practitioners who perform cosmetic medical and surgical procedures* to clarify expectations, including amending the following sections as detailed in 'Chapter 4 – Influencing Practice':
    a) definition
    b) section 2 – Patient assessment (including preoperative screening, cooling-off period, video consultations)
    c) section 4 – Consent (including informed financial consent)
    d) section 5 – Patient management (including sedation and anaesthesia, and postoperative care)
    e) section 8 – Training and experience
    f) section 11 – Facilities
    g) section 12 – Financial arrangements.
14. The Medical Board strengthen the Cosmetic Guidelines by reviewing where 'should' is used and consider using 'must' to make expectations clearer.
15. The Medical Board and Ahpra take on a role in seeking to facilitate reform in areas outside its powers and responsibilities where patient safety issues have been identified (for example, writing to the Ministerial Council recommending work be undertaken to develop a standardised national approach to health facility licensing and accreditation, including what types of cosmetic procedures can be done in each type of facility).
16. The Medical Board consider periodically publishing lessons learned in cosmetic surgery using deidentified data, outcomes of notifications and other information sources as an educative tool for practitioners and to further inform consumers.

Introduction

Context of review

On 30 November 2021, Ahpra and the Medical Board of Australia announced that they had commissioned an independent review of the regulation of health practitioners in cosmetic surgery.

Mr Andrew Brown[7] was appointed as the Independent Reviewer, to work with an Expert Panel comprising:

- Conjoint Professor Anne Duggan, Chief Medical Officer, Australian Commission on Safety and Quality in Health Care
- Mr Alan Kirkland, CEO, CHOICE
- Ms Richelle McCausland, National Health Practitioner Ombudsman.

The Independent Reviewer and the Expert Panel members, either individually or collectively, are referred to in this report as the review team or the review.

The review was commissioned in the wake of media reporting about cosmetic surgery that raised various concerns such as alleged serious hygiene breaches, patient safety issues, poor patient care, unsatisfactory surgical outcomes and aggressive and inappropriate marketing techniques with a heavy reliance on social media.

While the reporting highlighted issues about the practice of a small number of medical practitioners, it also raised concerns about the broader cosmetic surgery sector that required attention including:

- differing standards of education, training and experience of medical practitioners who perform cosmetic surgery
- confusion for consumers[8] about the titles that are used by medical practitioners (including cosmetic surgeon) and their scope of practice
- potential underreporting of safety issues in the sector
- the complex regulatory framework which exists between various state and national regulators and its overall responsiveness
- the role of social media and marketing tactics and their impact on consumer choices.

These concerns have arisen in a context in which cosmetic surgery has become commercialised in a way that differs from most other medical services. Medical practitioners in the sector market and advertise their services, and themselves, directly to the consumer in a competitive, commercial market. This has led to new entrepreneurial, corporate business models emerging.[9] Business models that provide financing for cosmetic surgery procedures have also emerged, further fuelling demand.

The size of the cosmetic surgery sector in Australia is significant but difficult to accurately quantify for a range of reasons. As it is not covered by Medicare or private health insurance, funding data is not available and there is no central reporting of procedures. There is also a range of medical practitioners providing cosmetic surgery, including across several specialties and registration types,[10] using a variety of titles and with varying levels of training and qualifications. These factors make it challenging for governments and regulators to accurately know the full size of the cosmetic surgery workforce or get a full picture of the number of unsuccessful procedures or procedures with serious adverse outcomes.

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7 Mr Brown has had 30 years' experience in the public sector, primarily in legal services, regulatory oversight and complaints management. He has extensive experience in public administration and designing and implementing effective and efficient regulatory and complaints management processes and is the former Health Ombudsman of Queensland.

8 This report uses several terms interchangeably when referring to people who have received, are considering receiving, or know someone who has received, cosmetic surgery. For example, the terms 'consumer', 'patient', 'member of the public' and 'community member' are all used, depending on the context.

9 E Swanson, 'The Commercialization of Plastic Surgery', *Aesthetic Surgery Journal*, 2013, 33(7):1065–1068, https://doi.org/10.1177/1090820X13500049; R Thiele, 'Ethical practice in plastic surgery', *Australasian Journal of Plastic Surgery*, 2019, 2(1):5–7, https://doi.org/10.34239/ajops.v2i1.145.

10 Under the Health Practitioner Regulation National Law, National Boards can grant a number of different types of registration to an eligible practitioner. These include general, specialist, limited, provisional, non-practising and student registration. These are discussed further later in this report.

It was in light of these issues and significant patient safety concerns that Ahpra and the Medical Board commissioned this independent review.

It is noted that media reporting has continued to raise concerns about the alleged performance and conduct of some medical practitioners in this sector.

Purpose – Terms of Reference

The purpose of this independent review was to examine the existing regulatory approaches and practices used by Ahpra and the Medical Board about medical practitioners undertaking cosmetic surgery. Within the context of the specific functions and responsibilities of Ahpra and the Medical Board, the review's focus was to include:

- examining patient safety issues in the cosmetic surgery sector, including considering how to strengthen risk-based regulation of practitioners in that sector
- ensuring that the regulatory approach of Ahpra and the Medical Board keeps pace with changes in that sector
- making recommendations about actions that will better protect the public.

The full Terms of Reference (ToR) for the review are provided at Appendix A.

It should be noted that while the review and consultation were titled *Independent review of the regulation of health practitioners in cosmetic surgery*, the final report is named *Independent review of the regulation of medical practitioners who perform cosmetic surgery* to better reflect the scope of the review and its recommendations.

Scope of the review

The review initially adopted the Medical Board's definition of cosmetic surgery.[11] The Medical Board has defined 'cosmetic medical and surgical procedures' as operations and other procedures that 'revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.' The focus of the review was on cosmetic surgical procedures that 'involve cutting beneath the skin'.

As the review progressed, a more succinct definition was adopted, namely, defining cosmetic surgery as operations that involve cutting beneath the skin to revise or change the appearance of normal bodily features where there is otherwise no clinical or functional need for the procedure.

This definition includes procedures such as breast implants, abdominoplasty (tummy tuck), rhinoplasty (nose surgery), surgical face lifts and liposuction. A range of other cosmetic treatments fall outside the scope of the review, as they do not cut beneath the skin, including cosmetic injectables (such as Botox and dermal fillers), laser skin treatments, dermabrasion and cryolipolysis (fat freezing), as do any procedures that either restore normal bodily features (such as reconstructive plastic surgery) or serve a clinical or functional purpose (such as breast reduction).

Also outside of the scope of this review were non-medical practitioners (both registered and unregistered) involved in the sector. The review acknowledges that a range of cosmetic procedures and treatments are provided by a range of registered practitioners (including, for example, dentists and registered and enrolled nurses) and unregistered providers. While these practitioners were outside the scope of this review, its findings and recommendations may have broader relevance and will be shared with other National Boards that regulate those professions.

Review process

The Review commenced on 17 January 2022.

Framework

The National Law sets out the range of powers and responsibilities Ahpra and the National Boards have when regulating health practitioners.

[11] While the Medical Board's definition of cosmetic surgery was adopted for the purpose of the review, the review recommends that this definition be amended (see 'Chapter 4 – Influencing Practice' for more details).

The review was structured around the following seven key areas of responsibility that Ahpra and the Medical Board have and the associated powers they may exercise (referred to as the seven key pillars) when regulating health practitioners who undertake cosmetic surgery:

1. Codes and guidelines
2. Management of notifications
3. Advertising restrictions
4. Title protections and endorsement for approved areas of practice
5. Cooperation with other co-regulators
6. Facilitating mandatory and voluntary notifications
7. Information to consumers.

Table 1 below shows how each of Ahpra and the Medical Board's specific powers and responsibilities about cosmetic surgery regulation relate to the scope and ToR for the review (noting that the fifth element of the ToR (patient safety risks) underpins all elements of the review).

Table 1 – Seven key pillars of the review

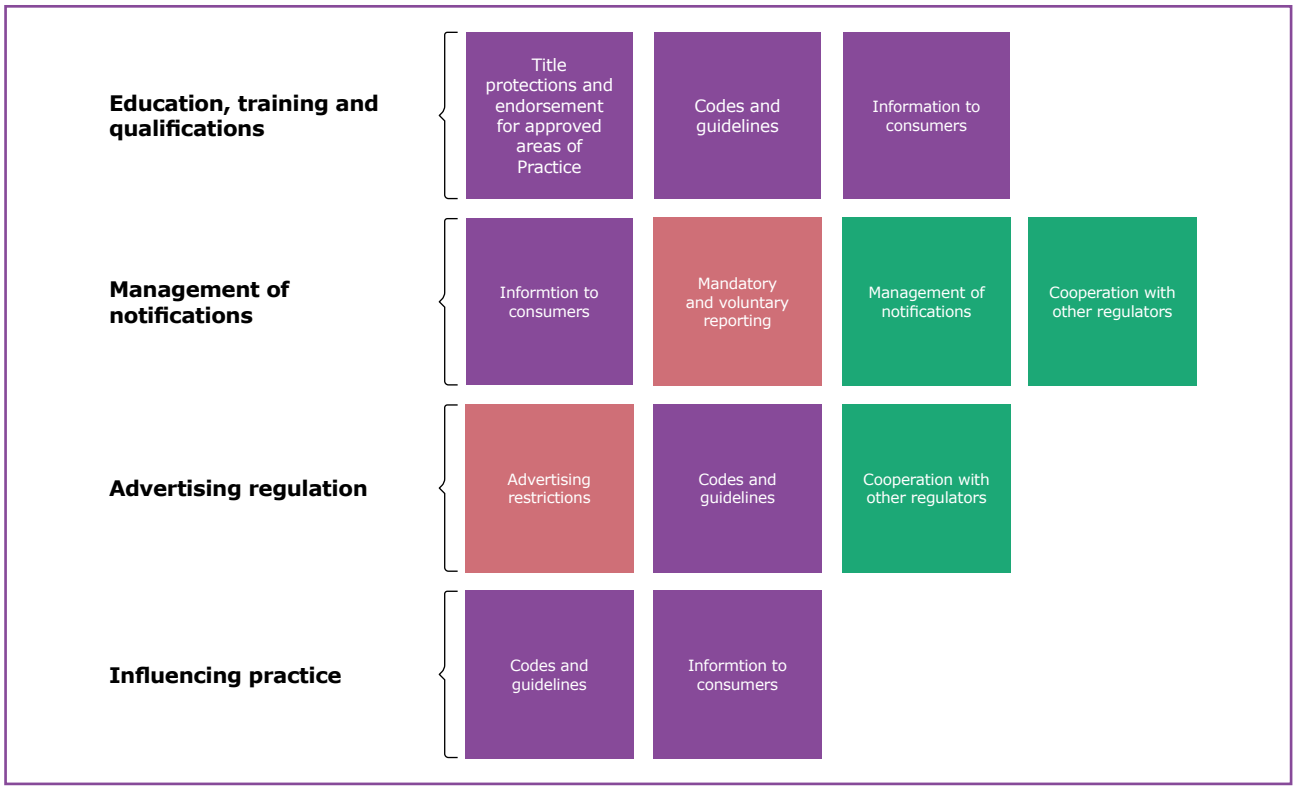
Ahpra/ Medical Board's specific responsibility and powers under the National Law	**Codes and guidelines**	**Management of Notifications**	**Advertising restrictions**	**Title protections and endorsement for approved areas of practice**	**Cooperation with other regulators**	**Mandatory and voluntary reporting**	**Information to consumers**
Relevant section of the National Law	Section 25(c) and 35(1)(c)(iii)	Part 8	Sections 35(1)(c)(iii), 39 and 133	Sections 13, 15, 98 and 119	Sections 27 and 32	Sections 140 to 145	Sections 24(c), 31, 35(1)(c)(iii) and 222 to 228
Terms of Reference Review and report on the regulatory role of Ahpra and relevant National Boards in cosmetic surgery with particular attention to its risk-based approach focusing on:	1a. Updates to codes of conduct and supporting guidance which aim to ensure that practitioners practise safely within the scope of their qualifications, training and experience.	1b. The methodology for risk assessment of cosmetic surgery notifications. 1c. the Ahpra investigation protocol.	1d. The management of advertising offences.	1e. Opportunities for changes, clarifications or further actions in relation to the current regulatory approach to protected titles.	2. The way Ahpra works with other system regulators to ensure clear roles and responsibilities and appropriate information flows in support of the broader regulatory framework which involves a range of state, territory and national regulators.	3. The best means available to strengthen the safety reporting culture within cosmetic surgery to address barriers to health professionals raising concerns when a practitioner has practised in ways that depart from accepted professional standards.	4.Strategies relevant to the role of Ahpra and National Boards as a regulator of the registered health professions, to reduce information asymmetry for consumers in order to inform safer choices and informed consent.
	5. Provide a contemporary view of current risks to patient safety in cosmetic surgery and how they should inform the work of Ahpra and relevant National Boards						

Many of the issues identified during the review, including feedback that was provided by submitters, crossed over or involved more than one pillar area. This report, and the review's recommendations, are structured around four key topics, to reflect the major themes that have emerged. These topics, which form individual chapters in the report, are:

1. Education, training and qualifications
2. Management of notifications
3. Advertising regulation
4. Influencing practice.

The pillar areas relevant to each topic/chapter are illustrated in Figure 2 and will be discussed in the corresponding chapters.

Figure 2: Report structure



Information gathering

The first stage of the review involved gathering information from Ahpra and the Medical Board. This included meetings with key personnel, including the Ahpra Chief Executive Officer and the Medical Board Chair. The purpose of these initial discussions and information gathering was to understand the context for the review and to be briefed on Ahpra and the Medical Board's current practices, particularly about the management of notifications, regulation of advertising and information for consumers.

The reviewer was provided with key Ahpra and Medical Board documents, including:

- Medical Board's code of conduct, *Good medical practice: a code of conduct for doctors in Australia*
- Medical Board's *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*
- Ahpra and National Boards' *Guidelines for advertising a regulated health service*
- Ahpra and National Boards' *Guidelines: Mandatory notifications about registered health practitioners*
- Ahpra and National Boards' *Regulatory Guide*
- Ahpra and the National Boards' *Advertising compliance and enforcement strategy for the National Scheme.*

In addition, research was undertaken and considered, including:

- literature published on the regulation of cosmetic surgery in various jurisdictions, including Australia, New Zealand, United Kingdom, Canada, United States of America and France
- Australian and international published literature on the use of social media and advertising, particularly about cosmetic surgery
- mapping of the multi-jurisdictional system that regulates cosmetic surgery in Australia
- tribunal and Board decisions and case studies related to cosmetic surgery notifications.

Public consultation

The second stage of the review was a public consultation phase. This involved publishing a consultation paper and an invitation for written submissions from stakeholders, including medical practitioners, colleges, professional associations and members of the public. A survey aimed at consumers (or potential consumers) of cosmetic surgery was also released.

The public consultation stage ran for six weeks from 4 March to 14 April 2022.

Details of how the consultation stage was promoted and publicised (including the consultation paper and consumer survey) are provided at Appendix B.

Consultation paper seeking submissions

The purpose of the public consultation paper was to seek views and information from a range of stakeholders about Ahpra and the Medical Board's regulation of medical practitioners who perform cosmetic surgery in Australia.

The consultation paper was structured around the seven key pillars of Ahpra's and the Medical Board's responsibility and powers (referred to above). Among other things, the paper provided a brief explanation of each pillar and asked a number of questions about each.

The full set of consultation questions is provided at Appendix C.

Stakeholders were:

- invited to make written submissions which addressed some or all of the consultation questions
- invited to include any evidence or examples to support their responses
- advised that they could make a submission in confidence
- advised that submissions, other than those made in confidence, would be published on the Ahpra website.

Submissions that did not request confidentiality will be published on the Ahpra website, alongside this report. In publishing those submissions that did not request confidentiality, some submissions have been redacted to remove any information which could be personal, sensitive, potentially offensive or defamatory in nature.

The call for submissions on 4 March 2022 resulted in 249 submissions from:

- 12 consumers/patients
- 41 organisations
- 149 medical practitioners
- 3 other registered health practitioners
- 44 other individuals.

Of the 249 submissions received, 88 submissions (35%) were template submissions, which were identical or with only slight variations or tailoring of information.

These figures are further set out in Table 2.

Table 2: Submissions received

Submission category	Template submissions received	Non-template submissions received	Total submissions received
Consumers/patients	0	12	12
Organisations	0	41	41
Medical practitioners	51	98	149
Other registered health practitioners	1	2	3
Other individuals	36	8	44
Total	88	161	249

Further information and analysis of submission data are included in the relevant sections of the report.

A list of submissions received is provided at Appendix D. Where a submission was received in confidence, this is noted, and the submitter's name is withheld, and the submission has not been published.

Consumer survey

An anonymous online survey was designed and made available specifically for consumers, including those who had had cosmetic surgery or who may be considering having a procedure, and members of the public were encouraged to participate. Consumers were also advised that they were welcome to answer the consultation questions in the consultation paper.

The survey was open from 4 March to 14 April 2022, as part of the public consultation stage, and valid responses were received from 595 respondents. Analysis of survey responses is included in the relevant sections of this report.

More information about the survey is provided at Appendix E.

Targeted consultation

The third stage of the review involved targeted consultation.

Technical Advisory Group

The review appointed a Technical Advisory Group, which comprised clinicians from a range of specialties and areas of practice. One of the roles of this group was to produce technical guides[12] for some of the most common cosmetic surgical procedures, namely:

- abdominoplasty
- breast augmentation
- facelift
- female genital cosmetic surgery
- liposuction.

The primary purpose of the technical guides was to generally inform the review about key clinical aspects of a number of common cosmetic surgical procedures.

The guides were not intended to be prescriptive clinical standards or best practice standards. Rather, the guides covered key categories and considerations that an eminent group of practitioners, with a range of specialisations and expertise, considered to be necessary for safe practice, such as:

- surgical risk profile
- potential complications of the procedure
- preoperative care factors (e.g. patient risk factors, psychosocial factors, consent)
- facilities (what type of facility should the procedure be undertaken in)
- anaesthesia requirements
- assistance during a procedure (what other practitioners should be present)
- postoperative care, including discharge instructions and when admission to an overnight facility should be considered
- record keeping.

In the future, the guides may also assist Ahpra and the Medical Board when next updating or reviewing the existing *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*. Any update or review of the Guidelines would include wide-ranging consultation with medical practitioners and other stakeholders.

The guides may also be a future reference resource for Ahpra and the Medical Board when assessing and investigating notifications about cosmetic surgery matters, including to assist in the identification of 'red flags' that may require further consideration, and to provide general information to assist in the identification of potential professional performance issues.

Membership of the Technical Advisory Group is detailed in the Acknowledgements section.

[12] At the time of publication, work on the technical guides was still underway. This work will continue.

Consumer Reference and Advisory Group

The review also appointed a Consumer Reference and Advisory Group, which included consumer organisations as well as representatives with expertise in marketing and psychosocial aspects of cosmetic surgery.

The group provided advice to the review on key policy issues relevant to consumers, including:

- informed consent
- advertising and social media
- expectations relating to titles, training and qualifications
- complaints and reporting culture.

Membership of the Consumer Reference and Advisory Group is detailed in the Acknowledgements section.

Consumer focus groups

The Consumers Health Forum of Australia (CHF) was engaged to conduct two small consumer focus groups. One group was conducted with people who had had cosmetic surgery, and the other group was with people who were considering cosmetic surgery.

Both groups were asked questions about:

- how they selected (or would select) a doctor to perform cosmetic surgery
- advertising
- consent and expectations around cosmetic surgical procedures
- understanding of complaints processes.

Those participants who gave permission to publish their name, or part of their name, are listed in the Acknowledgements section.

Extracts of focus group comments and analysis of their responses are included in the relevant sections of this report.

More information in relation to the consumer focus groups is provided at Appendix F.

Stakeholder meetings

In addition, the reviewer met with a range of key stakeholders to explore key issues relevant to the review. A summary of stakeholder meetings is provided at Appendix G.

Acknowledgements

The review is grateful for the over 800 contributions received to the review, including from people who have had or are considering cosmetic surgery, consumer advocacy bodies, medical practitioners who provide cosmetic surgery, specialist medical colleges that provide accredited training, professional organisations that represent practitioners, other regulators and medical indemnity insurers.

Many submitters made thoughtful suggestions and offered potential solutions aimed at promoting patient safety. All contributions were considered, and many have informed the review's findings.

The independent reviewer would like to thank the review's Expert Panel members, who generously and voluntarily contributed their expertise: Conjoint Professor Anne Duggan (Chief Medical Officer, Australian Commission on Safety and Quality in Health Care), Mr Alan Kirkland (CEO, CHOICE) and Ms Richelle McCausland (National Health Practitioner Ombudsman).

The review would also like to acknowledge the contributions of the review's two advisory groups.

The Technical Advisory Group members (in alphabetical order) were:

- Dr Tim Brown (Specialist plastic surgeon)
- Dr Timothy Edwards (Specialist plastic surgeon and Incoming President, Australian Society of Aesthetic Plastic Surgeons)
- Dr Dan Kennedy (Specialist plastic surgeon and President, Australian Society of Plastic Surgeons)

- Dr Adrian Lim (Specialist dermatologist and nominated representative of the Australasian College of Dermatologists)
- Dr Debra O'Brien (Specialist emergency physician and Medical Board of Australia member and representative)
- Adjunct Associate Professor Elissa O'Keefe (Registered Nurse and Nurse practitioner, and nominated representative of the Nursing and Midwifery Board of Australia)
- Dr Annette Pantle (Specialist medical administrator and Medical Director, Medical Council of New South Wales)
- Dr Peter Roessler (Specialist anaesthetist, and nominated representative of Australian and New Zealand College of Anaesthetists)
- Dr Magdalena Simonis (Specialist general practitioner, and nominated representative of the Royal Australian College of General Practitioners)
- Associate Professor Kellee Slater (Specialist general surgeon, and nominated representative of the Royal Australasian College of Surgeons)
- Mr Patrick Tansley (Medical practitioner, and President, Australasian College of Cosmetic Surgery and Medicine)
- Dr Garth Thomas (Specialist anaesthetist, and Ahpra Clinical Adviser (Medicine)).

The Community Reference and Advisory Group members (in alphabetical order) were:

- Ms Pip Brennan (nominated by Health Consumers' Council Western Australia)
- Mr Philip Cullum (nominated by Consumers' Federation of Australia)
- Ms Jordan Frith (nominated by Consumers Health Forum of Australia, Youth Forum)
- Dr Paul Harrison (Deakin University, Department of Marketing, Deakin Business School)
- Ms Joanne Muller (nominated by Consumers Health Forum of Australia)
- Dr Toni Pikoos (Clinical Psychologist)
- Mr Emiliano Zucchi (Ethnic Communities' Council of Victoria).

The reviewer also wishes to thank all the consumer focus group participants, both named and unnamed here. Those participants who gave permission to publish their name, part of their name, or pronouns (where requested), (in alphabetical order) were:

- Phebe Bowden
- Marg Fagan
- Melissa Gibson
- Lana
- Rebecca Langman
- Isabelle Sheppard (they/them)
- Ricki Spencer
- Brian Stafford
- Tammy Taylor.

And finally, the reviewer would like to thank Ahpra and the Medical Board of Australia. The reviewer is grateful to Martin Fletcher (Chief Executive Officer) and Dr Anne Tonkin (Medical Board Chair) for having the courage and conviction to voluntarily subject the operations of Ahpra and the Medical Board to transparent scrutiny in an effort to improve their regulatory performance in this space and ultimately protect the community.

The review has also been well supported by a small team of Ahpra staff who worked tirelessly to provide high quality policy and secretariat support. The review would like to acknowledge the significant contribution made by the following Ahpra staff (in alphabetical order):

- Kym Daly
- Sarah Harper
- Kirsten Hibberd
- Peter Knapp
- Kerryn Rozenbergs.

The reviewer would also like to thank Dr Garth Thomas (Ahpra Clinical Adviser, Medicine) for contributing a significant amount of time to provide clinical input to the review.

In addition, Ahpra staff and the Medical Board were very responsive to the reviewer's requests and cooperated fully throughout the review, providing detailed written briefings, access to relevant data, as well as information about Ahpra and the Medical Board's processes and procedures. The review is most grateful for this support.

Disclaimer

The review focuses upon key issues of concern within the cosmetic surgery sector and the report contains various criticisms. Notwithstanding this, it is acknowledged that many practitioners working within this sector are well trained, highly skilled, very ethical and extremely professional practitioners who always have patient safety at the forefront. Observations, comments and/or findings by the review in this report should not be taken to reflect or represent this group of practitioners.

Further, any observations, comments and/or findings in this report are not directed at any specific practitioner. Notwithstanding that a practitioner may fall within a certain class or group discussed in this report, no specific view is expressed about their overall ability or competency to perform cosmetic surgery or whether their conduct is unethical or unsafe. Conclusions about any individual practitioner can only be made after the full consideration of all the individual aspects of their practice and antecedents. This has not occurred in relation to any individual practitioner as part of this review and therefore, no view has been expressed, or should be taken to have been expressed, about any individual.

Recommendations

1. The Medical Board seek to establish an area of practice endorsement for cosmetic surgery.
2. If an area of practice endorsement is approved for cosmetic surgery, Ahpra and the Medical Board, in consultation with other stakeholders, undertake a public education campaign to assist consumers to understand the significance of an endorsement.
3. Ahpra and the Medical Board continue their joint work with the Australian Commission on Safety and Quality in Health Care on improving the consumer experience of making health notifications in Australia.
4. Ahpra and the Medical Board consider:
   a) producing notifier educational material (with case examples) tailored specifically to cosmetic surgery matters including providing advice about:
      i. Ahpra and the Medical Board's role and the limit of their powers
      ii. pathways to HCEs and other complaint agencies that offer dispute resolution
   b) providing more specific advice (on the above matters) in initial correspondence to consumers who have made a notification about a cosmetic surgery matter
   c) making public their position in relation to practitioners' use of NDAs as a means to prevent consumers making a notification.
5. Ahpra and the Medical Board review its educational material that is available to practitioners about mandatory and voluntary notifications and include more information about:
   a) notifications involving concerns that a practitioner may have placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards and is placing the public at risk of harm
   b) protections for notifiers and the ability to make a confidential mandatory notification or anonymous voluntary notification.
6. Ahpra and the Medical Board undertake a targeted education campaign in relation to making mandatory and voluntary notifications aimed at the cosmetic surgery sector and also the classes of practitioners/employers outside the sector who may subsequently treat cosmetic surgery patients (including emergency departments and their employees).
7. Ahpra and the Medical Board:
   a) develop training and guidance material (for example, a manual) specifically about the management of cosmetic surgery notifications to supplement and support the current assessment/investigation processes (which may include what other open source enquiries should be made and when). This should be directed towards ensuring that any specific key issues raised by the notification (either directly or indirectly) are consistently and appropriately considered and the risk assessment methodology is rigorously applied
   b) take further steps to enhance consistency in the management of issues raised in cosmetic surgery notifications, including for example, building up the specialist expertise of staff managing these notifications (whether in one team or across teams)
   c) ensure that where necessary key claims in a practitioner's submissions are scrutinised, including seeking corroborative evidence (for example, medical notes or GP records) and attempts are made to resolve key factual disputes (including seeking clarification from the notifier or other witnesses).
8. Building on the work undertaken by the review:
   a) Ahpra identify and clearly map the roles, responsibilities and powers of each regulator in the cosmetic surgery sector (including on a state-by-state basis) and produce a corporate document available to relevant staff; and
   b) Once the mapping exercise is completed, Ahpra identify where any improvements are required to enhance the flow of information between these relevant regulators, including for example, identifying key contacts and/or where necessary entering into a memorandum of understanding or other agreement.
9. Ahpra obtain legal advice specifically about the application of section 133(1)(e) to cosmetic surgery and the extent to which it may effectively prohibit forms of advertising of cosmetic surgery.

10. Ahpra and the Medical Board review their regulatory approach to advertising in the cosmetic surgery sector including by:
    a) ensuring that the risks posed by advertising in this sector are appropriately categorised within the risk framework set out in the *Advertising compliance and enforcement strategy for the National Scheme* so that stronger enforcement action is taken about high-risk matters (including, where appropriate, taking prosecutorial action in some matters)
    b) undertaking an industry-specific audit which should, among other things, inform the future proactive monitoring/auditing of activities in this space.
11. Ahpra and the Medical Board revise the Advertising Guidelines, the Cosmetic Guidelines and/or produce additional material specifically about cosmetic surgery to clarify the standards expected of practitioners (including specific examples of inappropriate content or approaches) by addressing such areas as:
    a) avoiding the glamorisation and trivialisation of procedures including the downplaying of risk
    b) avoiding the use of images of models who have not undergone a cosmetic procedure(s) to promote a cosmetic procedure
    c) avoiding the promotion of procedures through the use of social media influencers
    d) avoiding the use of content that implies cosmetic surgery should be utilised to obtain an acceptable/ideal body type
    e) promoting the use of disclaimers
    f) limiting benefit statements to those that are objectively demonstrable/provable (that is, the physical changes – not claimed psychological or social benefit)
    g) limiting the filming and use of content that shows surgical procedures to educational purposes only and not for entertainment
    h) strengthening procedures for informed consent on the use of and storage of patients' before and after photos
    i) preventing the targeting of young or otherwise vulnerable groups with advertising (including through algorithms and other marketing technology).
12. Ahpra and the Medical Board consider the use of technology to assist in the monitoring/auditing of advertising in the sector.
13. The Medical Board review, consult on and update its *Guidelines for medical practitioners who perform cosmetic medical and surgical procedures* to clarify expectations, including amending the following sections as detailed in 'Chapter 4 – Influencing Practice':
    a) Definition
    b) Section 2 – Patient assessment (including preoperative screening, cooling-off period, video consultations)
    c) Section 4 – Consent (including informed financial consent)
    d) Section 5 – Patient management (including sedation and anaesthesia, and postoperative care)
    e) Section 8 – Training and experience
    f) Section 11 – Facilities
    g) Section 12 – Financial arrangements.
14. The Medical Board strengthen the Cosmetic Guidelines by reviewing where 'should' is used and consider using 'must' to make expectations clearer.
15. The Medical Board and Ahpra take on a role in seeking to facilitate reform in areas outside its powers and responsibilities where patient safety issues have been identified (for example, writing to the Ministerial Council recommending work be undertaken to develop a standardised national approach to health facility licensing and accreditation, including what types of cosmetic procedures can be done in each type of facility).
16. The Medical Board consider periodically publishing lessons learned in cosmetic surgery using deidentified data, outcomes of notifications and other information sources as an educative tool for practitioners and to further inform consumers.

Chapter 1: Education, Training and Qualifications

Introduction

One of the most consistent themes to arise during this review relates to the issue of the education, training, qualifications and experience of practitioners undertaking cosmetic surgery, or more specifically the absence of any minimum standards about these matters. Most previous reviews undertaken in Australia, and in other similar jurisdictions, have highlighted this as a concern. Submissions received as part of this review overwhelmingly raised it as an issue. Feedback from consumers (through the consumer survey and focus groups) emphasised that these are important matters to them and that they rely heavily upon what they are told by their doctors about their training, qualifications and experience.

Some media reporting, which has focused on the alleged conduct of a small number of practitioners, has raised serious concerns about the alleged adequacy of the training and qualifications of some practitioners in this sector and the consequent risk to patients. A number of class actions are also on foot that allege significant harm by inadequately trained practitioners. The review notes that no formal disciplinary processes against practitioners who have been the subject of recent media reporting or class actions have concluded and as such currently no findings of unsatisfactory professional performance or professional misconduct have been made.

Notwithstanding the lack of formal findings in those matters, it is clear that there are no universal minimum standards for training, qualifications and experience for cosmetic surgery practitioners in Australia. As will be discussed in this and other chapters, the Medical Board's codes and guidelines place the onus on the individual medical practitioner to ensure they practise within their skills, knowledge and competence, but without reference to any minimum standards or other more specific guidance. In these circumstances, it is possible in Australia for any medical practitioner to offer and perform invasive cosmetic surgical procedures without having undertaken appropriate training or having amassed sufficient supervised experience to reach an acceptable level of competency.[13] Therefore, the opportunity for unqualified and inexperienced practitioners to perform invasive cosmetic surgical procedures and potentially cause substantial harm to consumers continues to exist, and the environment in which cases such as those reported in the media allegedly occurred, still prevails.

Against this background consumers are largely left on their own when it comes to selecting a practitioner to perform cosmetic surgery. Often they are required to sift through a plethora of advertising and marketing material, to seek to understand various titles and try to make sense of numerous qualifications, all in an attempt to identify a qualified and competent practitioner. This is an unacceptable situation.

As will be discussed in this chapter, while the problem is easy to identify and define, the solutions are much more complex and controversial. They are complex because the National Law, governing Ahpra and the Medical Board's powers and responsibilities, is based largely on a title protection model (it seeks to regulate what a practitioner is allowed to call themselves) and less on a model that directly regulates scope of practice (what medical practitioners are allowed to do). The solutions are controversial because they require navigating some disputed territory that is at the core of a very public battle between groups representing those medical practitioners who are within the Royal Australasian College of Surgeons (RACS) (and in particular have a plastic surgery subspecialty) and those who are outside RACS.

However, notwithstanding the complexity and controversy surrounding this issue, the review through its recommendations, urges Ahpra and the Medical Board to do all they can to address the issue of training, qualifications and experience in the sector. As will be discussed in this chapter, while the use of the endorsement practice model provided for in the National Law has its limitations and challenges, the review considers that Ahpra and the Medical Board should seek to establish an area of practice endorsement for cosmetic surgery. The review also considers that the Medical Board's guidelines on cosmetic surgery should be amended to provide more direction about the minimum training, qualifications and experience expected of medical practitioners

[13] While this may amount to a breach of the relevant codes and guidelines, the absence of any universal minimum standards about training and qualifications makes proving such a breach difficult.

providing cosmetic surgery (discussed in more detail in Chapter 4 – Influencing Practice). These steps, followed by a public education campaign, should go a long way to address the confusion that currently exists for consumers and ultimately promote a safer cosmetic surgery sector.

Previous reviews

The regulatory approach to cosmetic surgery has been subject to numerous reviews both within Australia and in other similar jurisdictions. While suggesting different solutions to the problem, a universal theme in the overwhelming majority of these reviews has been to highlight the lack of clarity around what training and qualifications a medical practitioner should possess to undertake cosmetic surgery.

In 1999 a report to the then NSW Minister for Health[14] made the observation that:

> *Any registered medical practitioner can do cosmetic surgery. There are no mechanisms to protect patients from unskilled and inexperienced people or to assist consumers to make judgments about the levels of competence of practitioners.*

The report noted that many of the submissions to that review:

> *[...]supported a process to give the public reasonable confidence that a person claiming to be skilled in a particular procedure meets minimum standards of competency and quality.*

Over 20 years later, this review has found that nothing has really changed on this issue.

A report to the Australian Health Ministers' Conference in 2011[15] reached a similar position noting that:

> *While cosmetic medical and surgical procedures are undertaken by some medical practitioners who have completed advanced specialist surgical or medical training, current regulatory provisions allow any registered medical practitioner to set up in practice and call themselves a cosmetic surgeon or physician, conveying the impression that they are specifically qualified or specialise in the area.*

The report concluded that cosmetic surgery should only be provided if the medical practitioner 'has appropriate training, expertise and experience in the procedure'.

In 2013, when Queensland's then Health Quality and Complaints Commission (HQCC)[16] reviewed the complaints they had received about cosmetic procedures, they observed that:

> *The cosmetic surgical and medical procedures examined in this report are mostly performed by medical practitioners, including plastic surgeons, cosmetic surgeons, cosmetic doctors, general practitioners (GPs), dermatologists, ophthalmologists (eye surgeons), otolaryngologists (ear, nose and throat specialists) and oral and maxillofacial surgeons.*

On the issue of qualifications to perform cosmetic procedures, the HQCC expressed the view that:[17]

> *[...] there is a need for guidelines or standards outlining minimum training and accreditation requirements for medical practitioners performing cosmetic procedures. The issue is whether the practitioner has the appropriate expertise, skills, experience and competence in the procedures they are performing.*

More recently in 2018, the NSW Committee on the Health Care Complaints Commission[18] reported that:

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[14] Health Care Complaints Commission (HCCC), *The Cosmetic Surgery Report – Report to the NSW Minister for Health*, HCCC, 1999, p22.

[15] Australian Health Ministers' Conference (AHMC), *Cosmetic Medical and Surgical Procedures – A National Framework*, AHMC, 2011, p5. (An inter-jurisdictional Working Group tasked with identifying, and reviewing the adequacy of, consumer safeguards in relation to cosmetic medical and surgical procedures.*) [This report made various recommendations specifically to Ahpra/Medical Board some of which were implemented but others were not].*

[16] Health Quality and Complaints Commission (HQCC), *Great expectations: A spotlight report on complaints about cosmetic surgical and medical procedures in Queensland*, HQCC, 2013, p6.

[17] HQCC, *Great expectations: A spotlight report on complaints about cosmetic surgical and medical procedures in Queensland*, p9.

[18] Parliament of New South Wales, Committee on the Health Care Complaints Commission, *Cosmetic Health Service Complaints in New South Wales*, Report 4/56, 2018, p9 and p50.

Major cosmetic procedures which involve cutting beneath the skin might be performed by someone who has little or no experience in the procedure.

And further:

The Committee heard concerns from various inquiry participants that, at present, any doctor can call themselves a 'cosmetic surgeon'. For example, the Committee learned that this can range from doctors who are trained in other areas such as General Practitioners, Cardio-thoracic surgeons or Anaesthetists who are now working as a cosmetic surgeon or have an interest in this area. Doctors describing themselves as cosmetic surgeons might also be specialist general surgeons.

In 2021, the Ministerial Council in undertaking a Regulation Impact Statement (RIS) consultation regarding the use of the title surgeon, also reached the conclusion that:

[...] there is no legal requirement for 'cosmetic surgeons' to undergo further or advanced surgical training in order to describe themselves as such [...] [and that] […] the surgical training that a self-described 'cosmetic surgeon' has received may vary widely and be far less comprehensive than that received by accredited specialist surgeons.[19]

Finally, it is worth referring to work undertaken overseas, and particularly in the United Kingdom. The United Kingdom has a very similar registration and specialisation process as Australia and has also been struggling to find ways to better regulate cosmetic surgery. Various reviews and reports undertaken in the United Kingdom over the last two decades identified similar issues about practitioner qualifications and made various recommendations for improvement.[20] A significant review in 2013[21] led by Professor Sir Bruce Keogh KBE identified the very same issue that has been discussed here, namely:

There is a clear need for accredited training standards to be set for cosmetic procedures so that patients can be assured that the person carrying out an intervention has the appropriate training. The Review Committee wants to see an end to the possibility of an unscrupulous practitioner being able to mislead the public as to their skills and experience, and of training providers offering poor quality training courses for practitioners.

Notwithstanding various recommendations made in the Keogh Report, subsequent reviews in the UK have continued to identify the same problem and/or continue to recommend that it be addressed.[22]

Ahpra and the Medical Board's powers

Before unpacking the various issues related to training and qualifications, it is first necessary to briefly outline the way that registration and titles are regulated under the National Law and the different categories of medical practitioners operating in this sector.

Registration types, qualifications and titles

Ahpra and the Medical Board are responsible for registering medical practitioners. The registration types for medicine are provisional, limited, general, specialist and non-practising. A practitioner's type of registration is published on the Ahpra public register.

The Ministerial Council has approved a list of specialties, fields of specialty practice and specialist titles. Specialist registration can be granted to medical practitioners who have been assessed by the Australian Medical Council (AMC) accredited specialist college as being eligible for fellowship of that college (and thus in that specialty). Medical practitioners with the necessary qualifications in

[19] Health Council, Use of the title 'surgeon' by medical practitioners in the Health Practitioner Regulation National Law - Consultation Regulation Impact Statement, Department of Health, 2021, p28.

[20] UK National Care Standards Commission, *Report to the Chief Medical Officer for England on the Findings of Inspectors of Private and Cosmetic Surgery Establishments in Central London*, 2003; Department of Health, *Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer*, 2005.

[21] Department of Health, Review of the Regulation of Cosmetic Interventions – Final Report, 2013, p20.

[22] For example, the Nuffield Council on Bioethics Report, *Cosmetic Procedures: ethical issues*, 2017, p55 *'… there is no legally defined set of activities constituting 'the practice of medicine' that may only be performed by a doctor. Concern has been expressed that there is therefore nothing to prevent a person without appropriate qualifications treating patients under the title of, for example, "aesthetic surgeon".'*

the approved specialties are included on the public register and their specialist title is protected by law.

There are 86 specialist titles associated with 23 specialties and 64 fields of specialty practice. Practitioners who have met the eligibility requirements for surgical practice outlined, are able to use one or more of the 11 specialist surgical titles approved by the Ministerial Council.

National Boards can also 'endorse' the registration of suitably qualified practitioners in an area of practice (if Health Ministers have approved an area of practice endorsement). A practitioner's endorsement is published on the Ahpra public register.

Title protection

The National Law's title protection model, with very few exceptions, regulates what practitioners may call themselves, rather than specifying what they can and cannot do.

Individuals who are not registered health practitioners or do not hold specialist registration or an endorsement to practise in a particular area of practice, must not 'hold themselves out' as a registered specialist or claim to be qualified to practise in a recognised specialty.

Disciplinary action may be taken against a registered practitioner who knowingly or recklessly claims to hold specialist registration or be qualified to practise as a specialist health practitioner in a recognised specialty which the practitioner does not hold.[23] A person may be prosecuted for an offence if they use a title, name, initial, symbol, word or description that indicates, or could be reasonably understood to indicate, the person is a specialist or is authorised or qualified to practise in a recognised specialty.[24] The same title protections apply to endorsement; a registered practitioner must not knowingly or recklessly claim to hold an endorsement or to be qualified to hold an endorsement that the practitioner does not hold.[25]

The title 'surgeon' is part of a number of specialist titles (for example, 'specialist plastic surgeon' and 'specialist orthopaedic surgeon') but there is no standalone title 'surgeon' that is protected by the National Law. Cosmetic surgery is not recognised as a medical specialty.[26] There are no training programs specifically for cosmetic surgery accredited by the AMC and any available qualifications and training in cosmetic surgery have not been approved by the Medical Board.

As a result the title 'cosmetic surgeon', a commonly used term in the cosmetic surgery sector, irrespective of the level of training and qualifications of the practitioner, is not a protected title. Therefore, it is unlikely that the use of this title by medical practitioners who are not specialist surgeons would be in breach of the title protection provisions in the National Law.

Whether the term 'surgeon' alone should be a protected title (which would prevent its use by practitioners who had not completed an AMC accredited program) is currently under consideration by the Ministerial Council.[27] Consideration of whether 'surgeon' should be protected and whether cosmetic surgery should be established as a specialty with a specialist title (which would require approval by Health Ministers, and where necessary, legislative amendment) are outside the scope of this review. The review's findings and recommendations are agnostic to the outcome of the Ministerial Council's process – they are intended to improve the regulation of practitioners in cosmetic surgery, regardless of whether or not the title 'surgeon' is ultimately protected.

Practitioner obligations – Codes and guidelines

The Medical Board can issue codes and guidelines to make its expectations clear and describe good practice. There is some guidance in the Medical Board's current code of conduct, *Good medical practice: a code of conduct for doctors in Australia*, and the *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*, about practitioner competence and training.

[23] Sections 118 and 119 of the National Law.

[24] Sections 118 and 119 of the National Law.

[25] Sections 118 and 119 of the National Law.

[26] A previous attempt by the then Australasian College of Cosmetic Surgery (ACCS) to have cosmetic surgery recognised as a medical specialty was unsuccessful for a number of reasons.

[27] The consultation period has closed and a Decision Regulation Impact Statement will be approved by Ministers and released to the public in 2022–23, see https://engage.vic.gov.au/medical-practitioners-use-title-surgeon-under-national-law.

The Medical Board's code of conduct sets out the standards of professional conduct the Medical Board expects. In section 3, Providing good care, it states good medical practice is:

> *3.2.1 Recognising and working within the limits of your competence and scope of practice.*
>
> *3.2.2 Ensuring you have adequate knowledge and skills to provide safe clinical care.*

The Medical Board's Cosmetic Guidelines provide specific guidance for medical practitioners who perform cosmetic medical and surgical procedures. On training and experience, the current Cosmetic Guidelines state:

> *8.1 Procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure and deal with all routine aspects of care and any likely complications.*
>
> *8.2 A medical practitioner who is changing their scope of practice to include cosmetic medical and surgical procedures is expected to undertake the necessary training before providing cosmetic medical and surgical procedures.*

There is also a Medical Board registration standard for continuing professional development (CPD) that requires medical practitioners who are engaged in any form of practice to participate regularly in CPD that is relevant to their scope of practice to maintain, develop, update and enhance their knowledge, skills and performance to ensure that they deliver appropriate and safe care.[28]

The above publications, issued pursuant to the National Law, establish a system that places the obligation on the practitioner to ensure that they work within their own capabilities. This system appears to function adequately in most areas of medical practice. However, as will be discussed later, the cosmetic surgery sector is somewhat unique and it is largely left to the practitioner themselves to determine whether they have undertaken appropriate training and have the necessary expertise and experience.

Cosmetic surgery, registration type and specialty registration

Medical practitioners undertaking cosmetic surgery generally fall into three broad categories and then several sub-categories. The categories are based on whether their training includes surgical training and whether the training program they completed is accredited by the AMC (and approved by the Medical Board).

The first broad category comprises medical practitioners who have specialist registration in a surgical specialty, having successfully completed a relevant AMC-accredited training program and been assessed by the relevant specialist medical college as being eligible for fellowship. This category can then be further subdivided into practitioners who have undertaken their training in:

- the subspecialty area of plastic and reconstructive surgery (plastic surgeons), or
- another surgical subspecialty area, such as otolaryngology (head and neck surgery also referred to as an ENT surgeon), oral and maxillofacial surgery or general surgery.

The training undertaken in these categories varies based on a practitioner's particular subspecialty but these training programs are all accredited by the AMC, and approved by the Medical Board. The accredited surgical training programs are provided by a specialist medical college – RACS[29] for many surgical subspecialties or, for oral and maxillofacial surgery, the Royal Australasian College of Dental Surgeons (RACDS).[30] Having successfully undertaken the relevant AMC-accredited training program (which usually takes five to six years) the practitioners can apply for specialist registration that is then listed on the Ahpra public register. Their approved specialist titles include the word 'surgeon' (other than specialist urologists), and therefore the full specialist titles are also protected under the National Law. Most plastic surgeons are represented by the Australian Society of Plastic Surgeons (ASPS) and/or the Australasian Society of Aesthetic Plastic Surgeons (ASAPS).

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[28] Medical Board of Australia, Registration standard: Continuing professional development, 2016.

[29] The surgical and education (SET) training program in plastic and reconstructive surgery is administered and overseen by the Australian Society of Plastic Surgeons (ASPS). As per the service agreement between the ASPS and RACS, the ASPS provide administrative support to the RACS Australian Board of Plastic and Reconstructive Surgery.

[30] To be eligible for the training program for oral and maxillofacial surgery, practitioners must be dual qualified as a medical practitioner and a dental practitioner.

The second broad category of medical practitioners who undertake cosmetic surgery comprises medical practitioners who have specialist registration in a specialty that is generally considered to include a significant surgical component, again having successfully completed an AMC-accredited training program. This category includes the recognised specialties:

- ophthalmology
- obstetrics and gynaecology.

These training programs are accredited by the AMC, and approved by the Medical Board, and are provided by the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) respectively. Practitioners' specialist registration is listed on the public register, but their protected specialist titles do not include the word 'surgeon'.

In both these categories, some of the specialties and subspecialties (and their training) are specific to a body region or part. For example, otolaryngology – ear, nose and throat and ophthalmology – the eye.

The third broad category comprises medical practitioners who are neither a specialist surgeon, nor a specialist considered to have a significant surgical component. This broad category can be further divided into practitioners who have:

- specialist registration but in a non-surgical field, such as specialist dermatologists
- specialist registration as a general practitioner
- general registration only.

While practitioners in this third category may have undertaken some form of surgical training, it is not a surgical training program that has been accredited by the AMC. It is also possible that some practitioners may have little to no surgical training beyond their internship rotations.

Practitioners in this third category may be listed on the register as having, for example, specialist registration as a dermatologist or general practitioner and others will be shown as having general registration only, and any specific surgical training is not listed on the register. Some practitioners in this category are represented by the Australasian College of Cosmetic Surgery and Medicine (ACCSM). Some of these practitioners refer to themselves as a 'cosmetic surgeon'.

Table 3 summarises the categories of medical practitioner who perform cosmetic surgery in Australia.

Table 3: Cosmetic surgery practitioners

Specialist surgeons (with AMC-accredited training)		**Specialists with AMC-accredited surgical training component**		**Practitioners without AMC-accredited surgical training**		
Plastic surgeons	Other specialist surgeons for example Otolaryngologists and Urologists	Ophthalmologists	Obstetricians and gynaecologists	Non-surgical specialists for example Dermatologists	Specialist general practitioners	General registrants
RACS	RACS	RANZCO	RANZCOG	ACD, for example	RACGP, ACRRM	
Most plastic surgeons are represented by the ASPS and/or ASAPS				Some practitioners in this category are represented by the ACCSM and/or may have received (non-accredited) surgical training from the ACCSM. ACCSM also represent some specialist surgeons.		

What can Ahpra and the Medical Board do about the problem?

Having identified that a key problem in the sector relates to a lack of specificity around the training and qualifications of practitioners undertaking cosmetic surgery, the pertinent question for the review is what powers do Ahpra and the Medical Board have to seek to address it? The review identified three potential areas that also align with the review's terms of reference (the first area is solely within Ahpra and the Medical Board's control, the second requires approval by the Ministerial Council and legislative amendment and the third requires Ministerial Council approval):

- codes and guidelines
- title protection
- the endorsement model.

Codes and guidelines issued by the Medical Board impose an obligation upon a medical practitioner who undertakes cosmetic surgery to ensure they have 'appropriate training, expertise, and experience to perform the procedure and deal with all routine aspects of care and any likely complications'. However, none of this guiding documentation provides any detail about what that training, expertise and experience should look like. As will be discussed in detail in 'Chapter 4 – Influencing Practice', the review recommends that the Medical Board's *Cosmetic Guidelines* should be amended to provide more direction about the minimum training, qualifications and experience expected of medical practitioners providing cosmetic surgery.

As mentioned above, the issue of **title protection**, or more specifically, whether the term 'surgeon' alone should be a protected title (and thus only be permitted to be used by specialist surgeons) is currently under consideration by the Ministerial Council and outside the scope of this review. Although the issue of title protection, where relevant, will be discussed, the review makes no recommendations about whether the term should be protected. As stated above, the review's findings and recommendations are agnostic to the outcome of the Ministerial Council's process – they are intended to improve regulation of practitioners in cosmetic surgery, regardless of whether or not the title 'surgeon' is ultimately protected.

The potential application of **the endorsement model** to the regulation of cosmetic surgery warrants careful consideration and is therefore addressed in detail.

The endorsement model

The Medical Board may recommend that the Ministerial Council approve an area of practice as being an endorsed area of practice.[31] Once an area of practice endorsement is approved, the Medical Board may endorse the registration of a medical practitioner as being qualified to practise in an approved area if the practitioner: holds an approved qualification or another substantially equivalent qualification; and complies with an approved registration standard relevant to the endorsement.[32] Therefore, an endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have completed a specific qualification in that area that is approved by the Board.

For cosmetic surgery, this would require the approval of the Ministerial Council of 'cosmetic surgery' as an area of practice for which the registration of a medical practitioner may be endorsed.[33] The process would require the accreditation authority for medicine, the AMC, to develop and consult on *accreditation standards* and then accredit one or more relevant program(s) of study. The accreditation standards and programs of study would need to be approved by the Medical Board for the purposes of endorsement of registration.[34]

The accreditation standard would define the requirements that education providers and their programs of study would need to meet to ensure those who complete the program are suitably qualified and skilled to practise. Once a program of study was accredited, the program and the education provider would be regularly reviewed by the AMC to ensure they continue to meet the accreditation standards.

A relevant *registration standard*, which would define the requirements for granting endorsement of registration, would need to be developed by the Medical Board, consulted on, and approved by the Ministerial Council.[35] If the area of practice endorsement were approved, medical practitioners who had completed an accredited program of study leading to the award of an approved qualification for endorsement of registration, would be able to apply to the Medical Board for endorsement. If granted, the endorsement would be published on the practitioner's registration on the public register (see Figure 3).

[31] Section 15 of the National Law.

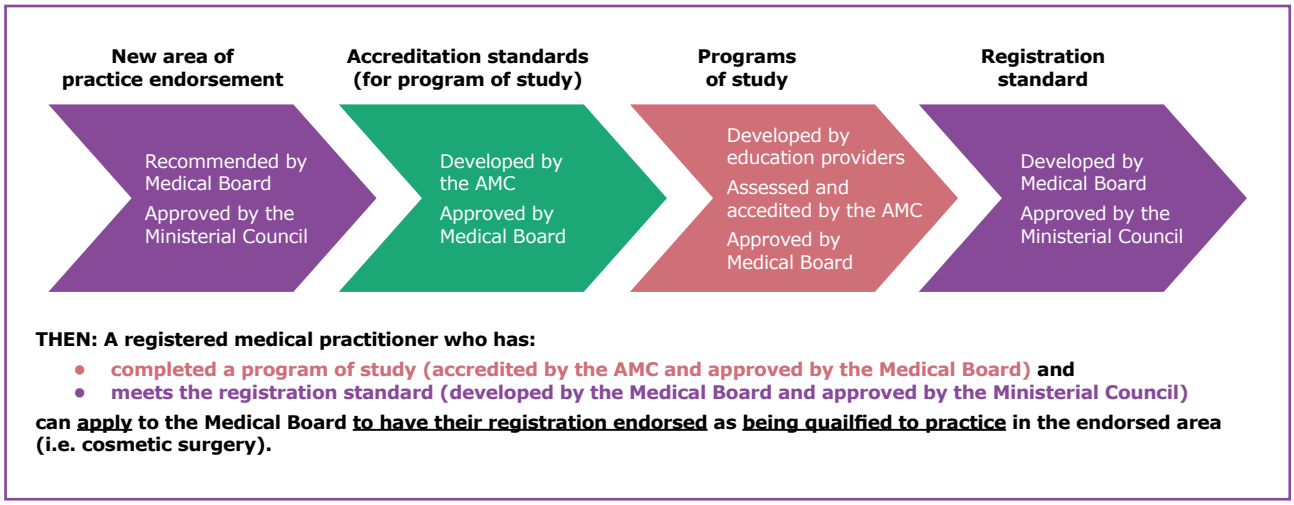
[32] Section 98(1) of the National Law.

[33] Section 15 of the National Law.

[34] Section 35(1) of the National Law.

[35] Section 12(1)(b) of the National Law.

Figure 3: Endorsement process



There could be multiple approved qualifications and pathways to endorsement (it would not need to be limited to one approved qualification). Any existing or new education provider could apply for an existing or new program of study to be accredited against the standards.

All medical practitioners are required to participate regularly in CPD that is relevant to their scope of practice to maintain professional currency, and support them to maintain, improve and broaden their knowledge, expertise and competence. Practitioners with an endorsement who were practising in the area of cosmetic surgery would more explicitly be required to ensure that their CPD included activities related to cosmetic surgery. Registered medical practitioners are randomly selected for audit of their compliance with the CPD requirements.

An endorsement would not prohibit other medical practitioners from providing cosmetic surgery but would set a minimum standard of training for practitioners with an endorsement. Disciplinary action could be taken against a practitioner who claimed to hold, or be qualified to hold, an endorsement that they do not hold.[36]

Stakeholder feedback

The consumer perspective

In the consumer survey,[37] when asked 'how important are a doctor's qualifications to you?', 78% of all respondents selected 'very important'. Other responses to this question included:

- 19% who selected 'if they are a doctor offering cosmetic surgery, I assume they are qualified'
- 18% who selected 'if they have qualifications listed, I assume they are qualified to perform cosmetic surgery'.

When asked 'how would you/did you find what qualifications your doctor had?', not many said that they would look (19%), or did look (9%), the practitioner's qualifications up on the Ahpra public register:

- 53% selected 'information on the doctor's website'
- 26% selected 'the doctor told me during my consultation'
- 11% selected 'social media'
- 10% selected 'I would be satisfied with what the doctor told me during the consultation'.

More information about the survey responses about doctor selection is provided in 'Chapter 3 – Advertising Regulation'.

Free text comments from the survey also provided interesting insights into this area. Survey respondents' comments included:

[36] Section 119 of the National Law.

[37] Consumers could select multiple responses when answering survey questions – totals equal more than 100%.

- *The doctor marketed themselves as a surgeon, but only later did I realise they had no formal qualification or training in surgery. Only later did my GP explain the difference between a plastic surgeon and cosmetic surgeon*
- *At the time I got the surgery I did not know about Ahpra and that my doctor was just a GP and [had] no formal surgical qualifications*
- *The use of letters after the doctors [name] is confusing*
- *I should have done more research but you just assume that they are qualified to do the job*
- *Didn't realise the doctor wasn't a plastic surgeon. Didn't realise they hadn't had specialist training, it looked like they had from the website and qualifications*
- *I definitely felt misled that this person had qualifications to perform this procedure but upon reflection after this was all complete I realised that he was only a medical doctor not [a] specialist. I will be more vigilant in future.*

The focus groups undertaken as part of this review also provided consistent responses on this topic. Although only a very small sample of people were engaged (total of 12), comments from the participants tended to reiterate the concerns that have been identified elsewhere, including statements such as:

- *If they haven't had the training to perform these surgeries, they shouldn't be performing them. I don't think the onus should be on the consumer to know the difference*
- *You hear the word surgeon, and you make an assumption*
- *I don't think we knew at the time specifically, plastic versus cosmetic surgeon. I don't think those were words that we were actually aware of. I don't know what the actual letters are after the name [...]*
- *[On acronyms and post-nominals used by doctors to describe their qualifications] As an ordinary individual, you don't know what all those things mean. They're meaningless*
- *Protection for consumers, shouldn't just be the consumers' responsibility. We need the system to put in place the protections.*

The importance of training and qualifications to consumers is understandable and demonstrated in the consumer feedback. There appears to be a heavy reliance by consumers on what they are told by the practitioner about qualifications and experience. It is only natural to expect that a lack of clarity in the area of practitioner training and qualifications translates into confusion for consumers.

Submissions

Given the findings of previous reviews, it is unsurprising that the review received strong and consistent feedback in submissions from all types of stakeholders on the importance of training for medical practitioners providing cosmetic surgery for patient safety and to enable consumers to make informed choices.

Summary of submissions about codes and guidelines

There was much feedback in submissions about section 8: 'Training and experience' in the Medical Board's Cosmetic Guidelines. Many organisations and medical practitioners noted that the Guidelines state that 'procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure', but do not specify what training would be considered to be appropriate. For example, the ASPS stated:

> *[...] the guidelines do not adequately address the issues relevant to the current and future practice of cosmetic surgery and contribute to safe practice. In these guidelines there is no reference to what the appropriate scope, qualifications, training or experience should be for someone performing cosmetic surgery.*

Most stakeholders suggested that appropriate training be defined or specified, and/or that minimum qualifications be mandated for a medical practitioner to be able to provide cosmetic surgery. Many practitioners who made submissions were emphatic on this issue, stating that the Guidelines' use of the term 'appropriate training' was 'vague', 'too woolly' and 'inadequate'. A specialist plastic surgeon considered that on training, 'the current guidelines are confused at best and misleading at worst'.

In their responses to the code and guidelines questions, generally organisations did not suggest how appropriate training should be defined in the Cosmetic Guidelines, although there was feedback about appropriate qualifications for those providing cosmetic surgery from many, in the consultation questions about endorsement. Practitioner submitters put forward a number of qualifications and training programs as training that would be appropriate to be specified in the Guidelines. These included training in core surgical competencies (through the accredited specialist medical college RACS) and/or training in specific cosmetic procedures.

There is more detailed discussion of section 8 of the Medical Board's Cosmetic Guidelines, including the need to amend it, in 'Chapter 4 – Influencing Practice'.

Summary of submissions about endorsement

There was significant feedback from stakeholders about training and qualifications for medical practitioners providing cosmetic surgery in relation to endorsement. Organisations, registered medical practitioners, other registered health practitioners and individuals provided feedback. Almost all organisations that made a submission provided feedback about endorsement, qualifications and/or titles, as did more than 120 medical practitioners.

Feedback was received from medical practitioners who provide cosmetic surgery and from those who do not. Practitioners who made submissions included specialist plastic surgeons, other specialist surgeons, other specialists including specialist general practitioners and practitioners who have general registration only. Feedback was also received from organisations and practitioners who made confidential submissions – their feedback was considered as part of the review, but is not specifically outlined in this report.

There was a variety of views ranging from strong support to strong objection as to what extent establishing an endorsement for cosmetic surgery addresses issues in the sector. Of those stakeholders expressing support for an endorsement, it was commonly with caveats, predominantly around who would be eligible and which qualifications would be required.

Notably, of those organisations who were explicit in their response, the ASPS and the ASAPS do not support endorsement, the ACCSM supports establishing an endorsement; and RACS did not make a specific submission but confirmed they endorsed the ASPS view on training and endorsement. More detail about the ASPS and ASAPS submissions is provided below.

Many organisations, including most of the specialist medical colleges who made submissions, did not provide a specific response as to whether or not they supported endorsement, rather making comments about the importance of patient safety and ensuring practitioners are appropriately trained and qualified. The Australasian College of Dermatologists (ACD) thought endorsement had 'some merit in principle'. Some organisations and medical practitioners focused on linking titles to specified qualifications without expressly giving a view on endorsement. Some stakeholders suggested that endorsement, if established, would need to be combined with other reforms. A few pointed out that there would need to be significant public education for consumers to explain what an endorsement means.

Of the medical practitioners who commented on endorsement, over 50 used a template submission that included support for endorsement. Some added their own text to the template response. Of those who provided unique submissions, there was support for endorsement from over 20 medical practitioners including some specialist plastic surgeons, other specialist surgeons, other specialists, specialist general practitioners, and general registrants. However, support was predominantly linked to specific qualifications/practitioners. For example, some submitters supported a cosmetic surgery endorsement for specialist plastic surgeons only.

Those who supported endorsement suggested that it would ensure medical practitioners have appropriate training in cosmetic surgery and enable consumers to identify which medical practitioners have had formal training in cosmetic surgery.

Some medical practitioners made it very clear that they did not support an endorsement – a specialist plastic surgeon said it's 'a ridiculous suggestion' and a specialist otolaryngologist said it's 'a terrible idea'. However, they gave different reasons, the first practitioner was concerned that it trivialises the skills and training for surgery, while the second suggested the problem with the proposal was determining who decides who gets the endorsement.

Other reasons cited as to why endorsement was not supported were because surgery should only be done by specialist surgeons and endorsement (and any new training programs) is not needed

as there is already a specialist training program for surgeons. Some suggested endorsement would further confuse consumers.

Many stakeholders who clearly opposed endorsement or who were not explicit in support or opposition, still provided a response to the consultation question - *Which program of study (existing or new) would provide appropriate qualifications?* Stakeholders listed many different qualifications as appropriate for a cosmetic surgery endorsement including:

- Fellowship of the Royal Australasian College of Surgeons (FRACS) Plastic surgery
- FRACS Plastic surgery, plus additional cosmetic surgery training
- any of the nine FRACS surgical subspecialties
- FRACS, plus additional cosmetic surgery training
- FRACS or fellowship of the other specialties that have a surgical training component – Fellowship of the Royal Australian and New Zealand College of Ophthalmologists (FRANZCO), Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG), Fellowship of the Royal Australasian College of Dental Surgeons Oral and maxillofacial surgery (FRACDS OMS), and some included Fellowship of the Australasian College of Dermatologists (FACD) as having surgical training component
- a new AMC-accredited cosmetic surgery training program developed by relevant accredited specialist medical colleges
- a new cosmetic surgery training program under the auspices of RACS
- Fellowship of the Australasian College of Cosmetic Surgery and Medicine (FACCSM)
- international cosmetic surgery fellowship equivalent.

Some stakeholders suggested that endorsement and the appropriate qualifications must be specific to a region of the body. For example, endorsement for cosmetic blepharoplasty would be open to practitioners with FRACS Plastic surgery or FRANZCO only.

There was much feedback about 'automatic endorsement' or exemption from needing an endorsement to provide cosmetic surgery. For example, the Australian Medical Association (AMA) suggested practitioners with a FRACS Plastic surgery qualification would not need an endorsement. Some medical practitioners, including specialist plastic surgeons, other specialist surgeons and medical practitioners without specialist registration, suggested that no specialist plastic surgeon should automatically get an endorsement for cosmetic surgery based solely on their FRACS Plastic surgery qualification.

While many medical practitioners suggested that only their own qualification was appropriate (for example a specialist plastic surgeon suggesting FRACS Plastic surgery was the only appropriate qualification or a practitioner who has a FACCSM[38] suggesting FACCSM was the only appropriate qualification), a small number listed several qualifications as appropriate (their own plus others).

The practitioners who suggested that FACCSM was the most appropriate qualification for an endorsement were mainly specialist general practitioners and general registrants. Many of these submitters had been awarded this fellowship.

Some stakeholders suggested further thinking needs to be done around endorsement. Several noted the concurrent proposal by Health Ministers about title protection. Some practitioners listed some of the difficulties that will be faced if an endorsement was established, including deciding whether to have a 'grandfathering'[39] provision.

The position of RACS/ASPS/ASAPS and ACCSM

Resolving the issue of training and qualifications is controversial. A conflict exists between key organisations that, on the one side, represent practitioners who are fellows of RACS, and more specifically hold a plastic surgery subspecialty, namely the ASPS and the ASAPS and, on the other side, an organisation that represents practitioners who are not fellows of RACS, namely the ACCSM. While all these organisations are supportive of more clarity about training and

[38] FACCSM is Fellowship of the Australasian College of Cosmetic Surgery and Medicine. The college has two training programs leading to FACCSM (Surgical) and FACCSM (Medical). The college, and its training programs, is not accredited by the AMC.

[39] A provision under which some form of old/existing requirements would continue to apply to some practitioners while new requirements will apply to future applicants.

qualifications, there is heated debate over the detail, such as what the training and qualifications should be, who should provide it and the mechanisms that Ahpra and the Medical Board should use to achieve the necessary clarity. While their respective arguments focus on patient safety, one cannot ignore that the by-product of their positions impacts on their potential market share and in this respect their diametrically opposed views appear well entrenched.

While their conflict can be described as intense and very public, it must be acknowledged that each of these organisations has provided significant support (including their time and resources) to this review and their dealings with the review team and each other during this process have been appropriate and respectful. The review is most grateful for their involvement.

As many of the issues that these organisations have raised in their submissions are pertinent to the issue of training and qualifications and the use of the endorsement model, it is useful to briefly summarise their arguments.

ASPS and ASAPS[40]

The ASPS does not support the establishment of an area of practice endorsement for cosmetic surgery. The ASPS are concerned that rather than protecting the public, endorsement is likely to increase public confidence in endorsed practitioners who are not qualified as specialists. They state that cosmetic surgery is still 'real' surgery and needs to be performed by those with recognised surgical qualifications. Their arguments include that an endorsement would fail 'to recognise the core skills in anatomy, pathology, physiology, wound management, complication management and psychological assessment that underpin a specialist training in surgery'. Further, they maintain that there is a significant risk that the public will equate an endorsement with specialist training which would be misleading.

The ASPS regards RACS as the only legitimate provider of surgical training in Australia and the only appropriate qualification (for cosmetic surgery) is the fellowship of RACS (FRACS), which is awarded to those who have successfully completed the five-year RACS surgical education and training program (or are specialist international medical graduates granted FRACS via the specialist pathway).

The ASPS also considers that protecting the title 'surgeon' is critical to addressing the current issues in cosmetic surgery as patients have a perception that practitioners who use the title 'surgeon' have undertaken specific surgical training, 'which in fact is not necessarily the case'.

The ASAPS also do not support the establishment of an area of practice endorsement for cosmetic surgery. The ASAPS view is based on cases they refer to in their submission of patient harm by practitioners who are not specialist surgeons, and the lack of demonstrable evidence of patient benefit of endorsement. The ASAPS is concerned about 'removing (the) statutory safeguards' of 'AMC-accredited surgical training and Ahpra registration as a specialist surgeon' and 'substituting them with a system that endorses unregistered surgeons who haven't achieved (these) professional standards'. They suggest that endorsement would act as an official 'tick of approval' for unaccredited practitioners to undertake invasive surgery and add to consumer confusion.

The ASAPS regards the existing five-year AMC accredited program of plastic surgery delivered by RACS as providing appropriate skills and qualifications to practise cosmetic surgery. They consider that the practice of cosmetic surgery is also within the scope of practice of specialist otolaryngologists, general surgeons, urologists, ophthalmologists and gynaecologists.

Noting that the ACCSM have suggested that their own surgical training program would be an appropriate future endorsement qualification, the ASAPS indicated in their submission that the ACCSM two-year training program and its surgical exams are not approved (accredited) by the AMC. However, they suggest that any medical practitioner (who is not a specialist surgeon) who wishes to practise invasive cosmetic surgery could 're-train and upskill to the Australian standard in surgery' by successfully completing the AMC-accredited specialist training in surgery.

The ASAPS suggest that 'misleading and confusing titles' such as 'cosmetic surgeon' pose a major risk to patients and that, to address the problem, Ahpra should require that all medical practitioners only use the title associated with their medical registration. Those with general registration should be permitted to use only 'medical practitioner' and only those with specialist

[40] RACS endorsed the ASPS submission (with two caveats around post-nominals and listing registration type).

surgical registration could use a title 'specialist surgeon'. The ASAPS suggest that this will enable patients to make informed choices.

ACCSM

The ACCSM strongly supports the establishment of an area of practice endorsement for cosmetic surgery. The ACCSM considers that endorsement will protect the public by ensuring that all medical practitioners offering cosmetic surgery have met independently established core and specific training and competency requirements. The ACCSM argue that 'evidence exists that [harm] is caused from practitioners both with and without advanced surgical training (including plastic surgeons) and/or who are practising outside their scope of competence'. Further, consumers would be able to easily identify practitioners with an endorsement, as the endorsement would be listed on the public register. They state that it must apply to all medical practitioners undertaking cosmetic surgery.

As to which programs of study (existing or new) would provide appropriate qualifications, the ACCSM states that it is 'the only medical college in Australia which provides education and training leading to Fellowship specifically in cosmetic medicine and surgery' and thus the 'surgical Fellowship of ACCSM would be considered an appropriate qualification'. The ACCSM submit that other qualifications, such as FRACS (Plastic surgery), would not meet the accreditation standards for endorsement in cosmetic surgery but those practitioners could undertake additional training and activities to be eligible for endorsement. They argue that the AMC accreditation reports of RACS and its training program, FRACS (Plastic surgery), suggest that there is a deficit in the plastic surgery training program about aesthetic cosmetic surgical training.

The ACCSM's view is that title protection in isolation will not protect patients, and it may give 'false reassurance' that a doctor with the title 'surgeon' is qualified to perform cosmetic surgery.

Observations and analysis

In essence the ASPS and the ASASP argue that endorsement is not necessary as there already exists a tried and tested system of specialist training and registration in Australia, underpinned by independent accreditation by the AMC. The training is long, robust, extensive, builds upon a foundational basis and is a system that the public can, and does, have confidence in.

While the review considers there is significant merit to this argument, the practice of cosmetic surgery in Australia poses new and unique challenges. The cosmetic surgery sector has become somewhat of a market disrupter. It sits outside existing health system frameworks and challenges the traditional specialist registration model. Medicare item numbers are not available for purely aesthetic cosmetic surgery and therefore general practitioners are generally not involved in recommending treatment or directing patients to specialist surgeons. Likewise, purely aesthetic cosmetic surgery is not offered by the public health system or covered by private health insurance, again bypassing systems that fit within the specialist model.

Other areas of practice also have other systems that provide quality assurance of practitioners' training and standards. For example, the Australian Commission on Safety and Quality in Healthcare's National Safety and Quality Health Service Standards for facility accreditation require that practitioners providing colonoscopy must have training certified by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) comprising representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and RACS.[41] To maintain practice, colonoscopists must be recertified every three years. There are no equivalent professional bodies setting universal standards for cosmetic surgery.

The net result is that the existing traditional systems that tend to ensure that patients access appropriately qualified medical practitioners do not necessarily apply in cosmetic surgery. Therefore, specialist title protection may not be enough to ensure community safety in this area.

One of the limitations of the argument of the groups that represent specialist plastic surgeons is that the risk to the public is all about what a practitioner calls themselves. They contend that if you can protect the title 'surgeon' and restrict the use of other terminology, then a consumer is

[41] Gastroenterological Society of Australia (GESA), *Credentialing*, GESA website, n.d., accessed 20 July 2022.

properly informed and can make safe choices. The linchpin of their argument is, as the ASAPS state, 'patients must be able to make choices in an open and transparent market'.

The review wholeheartedly agrees that clarity for consumers about the training and qualifications of medical practitioners is essential. However, the review considers that title protection, or title protection alone, does not provide enough clarity or sufficient protection to the public and more needs to be done.

While many practitioners who are not specialist surgeons employ the term 'cosmetic surgeon', a number of practitioners who offer and perform cosmetic surgery do not. It does not take much online searching to find practitioners who are already voluntarily complying with the 'surgeon' title protection model by avoiding use of the term. They are instead using such terms as 'cosmetic doctor' or 'cosmetic proceduralist'. In fact, the review has found that some have changed the terminology they use in very recent times. The review considers that a medical practitioner, through a professional-looking website and other marketing material, still has the ability to present themselves as being appropriately qualified and experienced to undertake cosmetic surgical procedures even without using the term 'surgeon'. No evidence has been presented to indicate that stopping the use of the title 'surgeon' will prevent all consumers from using the services of unqualified and inexperienced practitioners and it is logical to expect that some consumers still will.[42]

In their submission, ASAPS go to great lengths to spell out a rule-based system about how a practitioner, who is not a specialist surgeon, should be able to represent themselves. These include that:

- general registrants must use the term 'medical practitioner'
- only practitioners in recognised specialties can use the title of that specialty[43]
- all practitioners be prohibited from using any titles that fall outside the regulated list of protected titles
- all practitioners must declare their registration status and official Ahpra title as part of the consent process
- all practitioners should be 'obliged to openly disclose the[ir] registration status and official Ahpra title to the patient during the first consultation'
- only the practitioner's registered title be used in advertising, marketing and other information provided to patients
- 'post nominal letters, abbreviations and qualifications obtained from non-AMC accredited private institutions should not be used by a registered medical practitioner'
- steps be taken to cease being permitted to refer to a 'shopping list' of experience that is not from the 'only independently verified source of qualifications in the Ahpra register'.

While this is a commendable attempt to try and improve transparency, the review considers that a number of these are impractical, unproven and potentially unenforceable. It is also quite possible that attempts to restrict and control terminology could further confuse consumers.

Another concern with the position that title protection alone is the solution, is that it does not address the question of the adequacy of training of other surgical specialists (who are not plastic surgeons[44]) who may undertake cosmetic surgery. The review accepts that, through their extensive training, the baseline competency of any specialist surgeon is likely to be very high. It may also be accepted that for some surgeons whose specialty/subspecialty are specific to a body region, their training and experience to undertake cosmetic surgery on that region is sufficient. However, for example, while a specialist otolaryngologist (head and neck surgeon) may have undertaken sufficient training to perform a rhinoplasty,[45] without undertaking further training, does the same apply to them performing breast augmentation? Similar questions apply to general

[42] The review is not suggesting that any specific practitioner who is using terminology discussed in this paragraph is not qualified or experienced. Such a determination could only be made after carefully examining an individual's training, qualifications and experience.

[43] This is already provided for under the National Law.

[44] The ACCSM have submitted that even the RACS plastic surgery specialty training program does not adequately train plastic surgeons in aesthetic cosmetic surgery.

[45] Nose surgery which aims to reshape or repair the nose, which may be undertaken for functional reasons and/or cosmetic reasons.

surgeons who have not undertaken further training specifically in cosmetic surgery. Title protection would not stop them advertising a full range of cosmetic procedures to consumers as a qualified 'surgeon'.

The endorsement model as a potential solution

All this points to more needing to be done than only addressing specialist title protection (if that is what the Health Ministers ultimately decide to do). As has been noted above, and is discussed in detail in 'Chapter 4 – Influencing Practice', the review also recommends that the Medical Board's Cosmetic Guidelines be amended to provide more direction about minimum training, qualifications and experience. While amendments to the guidelines can be implemented more quickly than title protection and/or an endorsement model and are a step in the right direction, the Medical Board will be limited in the amount of detail and specificity that can be provided in the guidelines about these matters. This, in turn, will limit the overall effectiveness of amendments to the guidelines as a standalone solution to this problem (see Chapter 4).

As the problem calls for a more substantial response, the review considers that as imperfect as it may be, endorsement provides an additional tool that Ahpra and the Medical Board should attempt to utilise.

While the ACCSM submission supports the endorsement model, it goes beyond that, arguing that:

- the ACCSM's surgical fellowship program is an appropriate qualification for the approved endorsement training program
- the RACS Plastic surgery program does not sufficiently train surgeons to undertake aesthetic cosmetic surgery.

The review does not make any findings about either of these two propositions.

The review is not in a position to make any findings about the ACCSM surgical training program's appropriateness as a qualification for endorsement. The review team lacks the expertise, has not had access to, or the opportunity to consider the curriculum, nor had the time to reach such a conclusion. The ASAPS in their submission, correctly noted that in 2014, in assessing a 2008 application to establish cosmetic surgery as a new medical specialty, the AMC identified a number of concerns with some aspects of the then Australasian College of Cosmetic Surgery (ACCS) program.

As cosmetic surgery is not a recognised medical specialty, there has been no accreditation assessment of any education and training programs to determine if the program produces graduates with the knowledge, skills and professional attributes to practise in Australia. In the case of the ACCS, its capability as an education provider has not been assessed against accreditation standards. While different criteria may be applied to a program for endorsement as opposed to specialist recognition, these issues would need to be further explored.

Should the endorsement model be pursued, and the ACCSM, or any other training provider, seek to apply for accreditation of their training program as an approved qualification, it would then be up to the AMC to assess the program against the relevant accreditation standards and decide whether it meets those standards. The AMC would provide the accreditation report to the Medical Board who would then decide whether or not to approve the program of study as providing a qualification for the purposes of endorsement. Therefore, this review makes no finding or recommendation about the suitability of the ACCSM program.

The review also makes no findings about the ACCSM's allegation that the RACS plastic surgery training program is deficient in its aesthetics training component. While there are references in AMC reports (including in its 2017 report[46]) to potential gaps and a deficit in the experience available in this space, subsequent reports refer to steps being taken to address these issues. Additionally, on the question of overall patient safety, both the ASPS and ASAPS make a very strong case for the benefits of a rigorous program that strongly grounds practitioners in the fundamental aspects of surgery.

[46] Australian Medical Council (AMC), *Accreditation Report: The Training and education programs of the Royal Australasian College of Surgeons*, AMC, 2017.

Should the endorsement model be pursued, the ASPS and ASAPS may also submit that the RACS plastic surgery program is an appropriate training program for cosmetic surgery endorsement. Questions as to whether the program has addressed earlier identified gaps could then be considered by the AMC as part of the endorsement accreditation process. RACS could also seek accreditation of a new education and training program in cosmetic surgery.

Finally, the review believes that the consideration of endorsement is separate to, and not dependent on, the outcome of the concurrent consideration of title protection of 'surgeon' by Health Ministers. The endorsement model could operate with or without 'surgeon' title protection.

Benefits and limitations of the endorsement model

In considering whether the endorsement provisions in the National Law may be an appropriate mechanism to employ, the review is well aware that there are both benefits and limitations of endorsement. Many stakeholders raised these in their submissions.

One of the key benefits of endorsement is that it should help address the existing confusion that consumers report about the training and qualifications of practitioners operating in this space. Stakeholders provided much feedback that the current Ahpra public register provides no information about a practitioner's qualifications specifically in cosmetic surgery. If an endorsement was approved, it would be easy for consumers to identify practitioners who have an endorsement as the endorsement would be listed on the public register, along with their registration type. Practitioners would be permitted to advertise themselves as having an endorsement for 'cosmetic surgery' (or however the approved endorsement is worded). Disciplinary action could be taken if a practitioner who did not have an endorsement on their registration, claimed to have an endorsement or claimed to be qualified to hold endorsement.

An accompanying public education campaign (which would be necessary) could then focus on educating consumers who were considering cosmetic surgery to 'make sure your doctor has an endorsement for cosmetic surgery'. Public education campaigns could help consumers more easily find practitioners who have undertaken recognised cosmetic surgery training, rather than the current situation where consumers must wade through a variety of post-nominals and creative descriptions of cosmetic surgery 'courses' and 'workshops'.

Another benefit of endorsement is that it would set a clear minimum standard of training for practitioners providing cosmetic surgery. The review notes the concerns of some stakeholders that an endorsement 'trivialises' surgical training and undermines the existing 'rigorous standards' of accredited surgical specialty training programs. However, this is not necessarily so and would be dependent on the rigour and standard of the approved training program(s) that lead to endorsement. The standard would need to be set at a sufficiently high level to ensure a program enables medical practitioners to have the necessary knowledge and skills to practise competently and safely in the approved area of practice. The accreditation and approval process could consider any prerequisite or pre-entry requirements.

The accreditation standards would outline the standard required and the accreditation authority (the AMC) would assess programs of study against the approved accreditation standards. Only those training programs that are assessed as meeting the accreditation standard can be approved for the purposes of endorsement. It is up to the Medical Board and the AMC to determine the appropriate standard.

For these reasons, the review is not able to make findings about the suitability or unsuitability, or superiority or inferiority for cosmetic surgery practice of any existing qualifications. The question of appropriate qualifications is subject to substantial debate between competing groups and has significant consequences for market share. Another advantage of the endorsement process is that it applies an objective and independent lens to resolving these questions.

The review acknowledges that there are limitations associated with endorsement. The need to 'enforce' Board standards and guidelines was repeatedly raised as a concern by stakeholders. 'Enforcing' compliance with endorsement is not dissimilar to the current title protection, that is practitioners who do not have an endorsement cannot claim to be endorsed or to be qualified to hold endorsement.

The existence of an endorsement would still not prevent a practitioner who does not have an endorsement from practising in the area of cosmetic surgery. However, the endorsement model would provide more clarity for consumers and make it easier for them to identify a practitioner

who may not be appropriately qualified, especially if supported by a public education campaign as noted above.

The review also notes the difficulties that will be associated with implementing an area of practice endorsement. In addition to developing a registration standard, accreditation standards and assessing training programs against the accreditation standards, 'grandparenting' provisions for current practitioners practising in this area will need to be considered.

There will be practitioners who have gained qualifications before that qualification was accredited for endorsement, as well as practitioners who have many years of experience but who do not have an approved qualification required for endorsement. The process for determining whether they are eligible for endorsement will need to be determined and this will be challenging. As one specialist physician put it in their submission, 'grandfathering in people is the road to hell'.

Similarly, if an area of practice endorsement is approved, there would likely be overseas-trained practitioners who seek to have their overseas qualifications recognised for endorsement. There will also be practitioners who do not have training in and/or practice in, the full area of practice, for example, practitioners who only provide one type of cosmetic procedure or procedures for one body region.

That cosmetic surgery is an area of rapid change, with new procedures constantly emerging, adds another layer of complexity when determining which practitioners would be eligible for endorsement.

The review acknowledges there will be costs involved in establishing an endorsement, and funding will need to be determined. The review understands that funding sources may include accreditation of education providers' programs of study on a cost-recovery basis and application fees for practitioners seeking an endorsement on their registration.

The review absolutely recognises the complexities of establishing an area of practice endorsement. It is dependent on approval by the Ministerial Council as well as extensive work required by Ahpra and the Medical Board and its accreditation authority, the AMC, including the development of an accreditation standard. Any existing and/or new programs of study would need to be established and approved. It also requires a Medical Board registration standard. The National Law requires Boards to undertake wide-ranging consultation and there would need to be consultation with, and input from, multiple stakeholders including the specialist colleges, societies, other colleges and education providers. That the key professional bodies have diametrically opposing views will make this more challenging.

As noted earlier, change such as this is more likely to succeed if accompanied by a public education campaign to inform consumers about endorsement and what it means. However, there would be costs associated and it may be outside the National Scheme's remit to use registrant fees[47] to fund widespread education campaigns for consumers seeking cosmetic surgery. Ahpra and the Medical Board may like to consider which other stakeholders, including government bodies, professional organisations and consumer groups could be involved in a public education campaign.

The endorsement model will not be able to be implemented quickly and the review makes other recommendations that may be implemented in the shorter term (including amending the Cosmetic Guidelines). Endorsement is a long-term solution. However, if a process such as this does not commence soon then there is a real possibility that the unsatisfactory situation that was identified over 20 years ago, will continue to exist for another 20 years, with more and more practitioners, with varying degrees of training, qualifications and experience, entering the sector each year.

Recommendations

1. The Medical Board seek to establish an area of practice endorsement for cosmetic surgery
2. If an area of practice endorsement is approved for cosmetic surgery, Ahpra and the Medical Board, in consultation with other stakeholders, undertake a public education campaign to assist consumers to understand the significance of an endorsement.

[47] The National Scheme is funded by practitioners' registration fees.

Postscript: Registration standards about scope of practice

The National Law[48] provides for the ability of a National Board to develop and recommend to the Ministerial Council (for approval) what is described as 'registration standards' about 'the scope of practice of health practitioners registered in the profession'. This is a somewhat curious provision as the overall regulatory model under which the National Law is based is title protection.

Ahpra and the National Boards have not developed any guidance material about this provision and it has not been widely used. The review understands that such a standard has only been used by the Dental Board of Australia and it essentially just provides that dental practitioners must only perform dental treatment 'for which they have been educated and trained' and 'in which they are competent'.[49] The Dental Board's *Scope of practice registration standard* is linked to its *Guidelines for scope of practice*. The guidelines go further and, for example, broadly discuss the scope of practice for other practitioners in the dental practice division who are not dentists (for example, dental hygienists and dental prosthetists) and also identifies classes of dental specialists.[50]

The National Law does not contain any provisions that specifically detail the consequence of breaching a registration standard about scope of practice. This is different, for example, to the title-use protection provisions that create an offence for situations where a registered practitioner claims to hold a specialist registration or endorsement when they do not. There also is not a specific provision in the National Law that would link the standard to the public register. However, like codes and guidelines, a registration standard is admissible in disciplinary proceedings[51] 'as evidence of what constitutes appropriate professional conduct or practice for the health profession'.

It is not clear to the review the extent to which a registration standard about scope of practice could be used in the context of cosmetic surgery. However, it may bear further consideration. It is hard to imagine that it could be effectively used without having also established an area of practice endorsement for cosmetic surgery. It may, however, be that such a standard could integrate well with the endorsement model. Having established cosmetic surgery as an area of practice endorsement, and having approved the relevant training program(s), it may be possible to supplement the approach with a registration standard that specifies that only practitioners who have a cosmetic surgery practice endorsement should undertake cosmetic surgery.

Whether this provision could operate this way would require further investigation and legal advice. It would also require broader policy considerations as using a standard to regulate specific scope of practice within a health profession would represent a major shift in regulatory approach.

Given the uncertainties in this area, the review makes no particular recommendations about its use.

Should the endorsement model recommendation be accepted and implemented, there would be benefit in Ahpra and the Medical Board considering if and how a registration standard about scope of practice could apply to further strengthen regulation of cosmetic surgery and specifically whether it could supplement the endorsement model to enhance its effectiveness in this sector.

[48] Section 38(2)(b) of the National Law.

[49] Dental Board of Australia, *Scope of practice registration standard*, 2022.

[50] Dental Board of Australia, *Guidelines for scope of practice*, 2022.

[51] Section 41 of the National Law.

Chapter 2: Management of Notifications

Introduction

One of Ahpra and the Medical Board's key functions is to receive and manage notifications about the performance, conduct and health of registered medical practitioners, including notifications about cosmetic surgery matters. The Medical Board also has the power, depending on the nature of the notification, to make determinations about a medical practitioner and impose certain sanctions or, in the most serious matters, refer the matter to a responsible (state or territory) tribunal who may determine the matter and impose sanctions.[52]

The effective discharge of this function involves three key interrelated elements, namely:

- Ahpra and the Medical Board have to be able to receive notifications
- once received, notifications have to be appropriately managed and responded to (including through assessment and/or investigation and determination)
- appropriate management often involves effectively cooperating with other coregulators.

Each of these three elements will be discussed separately in this chapter.

This chapter examines the significant challenges faced by Ahpra and the Medical Board when it comes to facilitating the receipt of cosmetic surgery notifications. It notes that from a national perspective, the health complaints landscape is very complex with different systems operating in different states and territories. It also discusses what appears to be an inherent misalignment between the expectations of consumers who make cosmetic surgery-related notifications and the outcomes that Ahpra and the Medical Board can achieve.

Finally, it notes that while other registered health practitioners may be well positioned to witness and identify concerning performance and conduct by practitioners performing cosmetic surgery, a range of barriers appear to impede the making of notifications. While many factors are largely beyond the control of Ahpra and the Medical Board, and effective solutions are challenging, the review makes some recommendations directed towards enhancing the information available to both consumer and practitioner notifiers.

This chapter also outlines the review's analysis of Ahpra and the Medical Board's approach to managing cosmetic surgery notifications, with a focus on the methodology for risk assessment and investigation protocol. As will be discussed, notification management is a challenging function for Ahpra and the Medical Board, especially as the number of notifications received continues to increase. Ahpra and the Medical Board's resources are finite and stakeholder expectation is understandably high. In this environment the effective use of accurate risk assessment tools is critical. The review considers that some improvements to the way that cosmetic surgery notifications are assessed and investigated are necessary and makes recommendations aimed at enhancing the regulatory response to notifications.

Finally, this chapter examines the complex and multi-jurisdictional system that regulates cosmetic surgery in Australia and notes, that to appropriately manage notifications that are received, Ahpra and the Medical Board need to be able to work effectively with other regulators. As a detailed working knowledge of the various regulatory agencies, their roles, responsibilities and general powers in the cosmetic surgery sector is essential, the review recommends that Ahpra develop and capture this information for use by its staff who manage notifications.

Receiving notifications

For Ahpra and the Medical Board to discharge their responsibilities it is critical that they are informed of serious concerns regarding the conduct and/or performance of medical practitioners who are undertaking cosmetic surgery, namely they must first receive a notification about these matters.

Consumers who have undergone cosmetic surgery are obviously a critical stakeholder group and key source of notifications. However, registered health practitioners or health facilities should be an another very important source of notifications. Each of these two source groups will be examined separately as they involve different issues.

[52] Part 8 of the National Law.

Consumer notifiers

Ahpra may receive notifications directly from consumers. To effectively facilitate the making of notifications, consumers need to be aware of the notification process, and the notifications process needs to be accessible. Both these concepts are closely interrelated.

Consumers who have undergone cosmetic surgery are currently by far the largest source of notifications to Ahpra and the Medical Board about cosmetic surgery. For example, of the 177 notifications received by Ahpra between 1 July 2018 to 31 December 2021 (and finalised by 31 December 2021), all came from people who had had cosmetic surgery (or from someone else on their behalf).

The nature of the concerns raised by consumers in the notifications included:

- issues with the communication style of the practitioner
- consumers being dissatisfied with the results of a procedure
- allegations of substantially unacceptable outcomes
- complaints about infections, complications and other adverse effects.

The review acknowledges that for some consumers the outcomes of the surgery (whether or not the practitioner may have been at fault) have had a devastating impact on them including physically, psychologically and financially. Some consumers have borrowed money to have cosmetic surgery and when they required further revision procedures, were unable to afford it. Similar experiences have been relayed through the consumer feedback processes provided for this review.

Ahpra and the Medical Board's approach to accessibility

In Ahpra's outward-facing material, notifications are described as 'concerns' or 'complaints'. Notifications can be made by telephone (via a 1300 number) Monday to Friday between 9am and 5pm, through an online portal, by email or post. Ahpra uses the National Relay Service (for people who are deaf or have a speech impairment) and the Translating and Interpreting Service (for people who speak a language other than English). Ahpra has also provided some of its notifications material in five languages other than English. The online portal, which operates as an interactive online notification form, requires a notifier to complete a significant number of fields, but flows in a logical manner, contains reasonable instructions (including drop-down menus) and includes on each page the 1300 telephone number should the notifier need assistance. An educational video is also provided on the website which seeks to explain Ahpra's role and function, the limitations of their remit and how to make a notification. Generally speaking, in these circumstances the review considers that the mechanisms available to make a notification facilitate reasonable consumer accessibility.

Stakeholder feedback

The Senate Inquiry found that consumers lack clarity about where to make a complaint if they are dissatisfied with the treatment they received from a medical practitioner, and this is not unique to cosmetic surgery.[53]

The overwhelming majority of people who made submissions to the review on this topic expressed the view that current complaints and notifications processes are not well understood by consumers. They said consumers do not know where to go to make a complaint if they are dissatisfied with their cosmetic surgery, and they do not understand the limits of Ahpra and the Medical Board's powers.

Around half of the submitters who commented on this issue stated that practitioners should be required to provide information to consumers on how to make a complaint if dissatisfied, including information on the different avenues for complaints and the different escalation points.

Interestingly, even though the majority of submitters indicated that consumers lacked awareness of the notifications process, around three-quarters of all survey respondents stated that if they had surgery and something went wrong, they would make a complaint to Ahpra. While this potentially

[53] Senate Community Affairs References Committee, *Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law*, April 2022, accessed 30 June 2022.

suggests a higher actual level of awareness of the notifications process among consumers than what is perceived, the survey sample may have been biased towards a more informed consumer (based on the way it was promoted) and also, being a survey associated with Ahpra and the Medical Board, it is likely to be self-educating.

Despite the reported levels of awareness among survey respondents, some respondents stated that while they were not happy with their procedure, they did not make a complaint. Reasons for not making a complaint included:

- feeling no action would be taken
- the process being too difficult
- not knowing where to make a complaint
- feeling embarrassed
- not being able to get the outcome they want.

A further potential complication raised by stakeholders was the use by some practitioners of non-disclosure agreements (NDAs) or confidentiality agreements. Some survey respondents and submitters referred to the use of NDAs to prevent them from making a notification.

Observations/Analysis

While the notifications process appears reasonably accessible, the review considers that overall awareness of and accessibility is hampered by two significant challenges, namely: the complex notifications and complaint landscape that is split between national and state/territory agencies; and the limitation of Ahpra and the Medical Board's powers and remit about consumer notifications.

Notifications/complaints landscape

As a national organisation, Ahpra operates within a federal system which sees each state and territory (rightly) having established a separate health complaints entity (HCE). The powers and responsibilities of the state/territory HCEs vary. Nationally the notifications and complaints landscape is complex.

In New South Wales, Ahpra and the Medical Board play no role in receiving and managing notifications about health, performance or conduct of medical practitioners,[54] including cosmetic surgery concerns, and all matters are managed by the Health Care Complaints Commission (HCCC) or the Medical Council of New South Wales when referred by the HCCC.

In Queensland the Office of the Health Ombudsman (OHO) is the single point of contact for all health-related complaints/concerns (and as such Ahpra has no role in receiving concerns directly from consumers). The role of taking disciplinary action about a practitioner's performance and conduct is shared between the OHO and the Medical Board, with the OHO retaining the most serious matters. In the remaining states and territories, the Medical Board (alone) undertakes the role of disciplining registered practitioners and the health complaints entities' (HCE) role with individual registered practitioners is more focused on dispute resolution, although most have investigative powers and may produce investigation reports.[55] The consumer nature of cosmetic surgery also potentially enlivens other regulatory or complaints handling agencies such as the Australian Competition and Consumer Commission (ACCC) and state-based consumer protection agencies in some cases.

HCEs provide clear information about their jurisdictions (including on their websites), cooperate closely with Ahpra about the notifications they receive (including through a joint consideration process) and adopt a 'no wrong door approach' to seek to ensure that complaints/notifications are redirected from their agency to the correct place. However, the complaints and regulatory landscape for a consumer wishing to raise a concern about a medical practitioner performing cosmetic surgery is still potentially daunting and complicated.

[54] With the exception of advertising matters or where a person is claiming to be registered, specialised or endorsed when they are not.

[55] Most HCEs also play a significant role in managing complaints about unregistered health providers pursuant to the Code of Conduct for Unregistered Health Care Workers.

Ahpra/Medical Board's powers and remit

Adding to complexity and the challenge for consumers when seeking to comprehend the landscape, is the specific role and powers of Ahpra and the Medical Board related to consumer notifications. In addition to managing notifications about the health of a practitioner, Ahpra and the Medical Board's main focus is on the conduct and performance of the practitioner, including whether it is unsafe, is placing the public at risk, is of a standard below that which should be reasonably expected or indicates the practitioner may not be suitable to hold registration. At its heart, the action is between the Medical Board/Ahpra and the practitioner, and the consumer is merely the informant or witness.

The National Law makes no provision for specific outcomes directed towards consumer notifiers. There is no ability for the Medical Board to pursue and obtain individual consumer outcomes such as apologies, refunds, revision surgery or compensation. Some of the language used by Ahpra in its outward-facing material (such as referring to notifications as 'complaints') may tend to give consumers the impression that it is a complaints agency with corresponding functions.

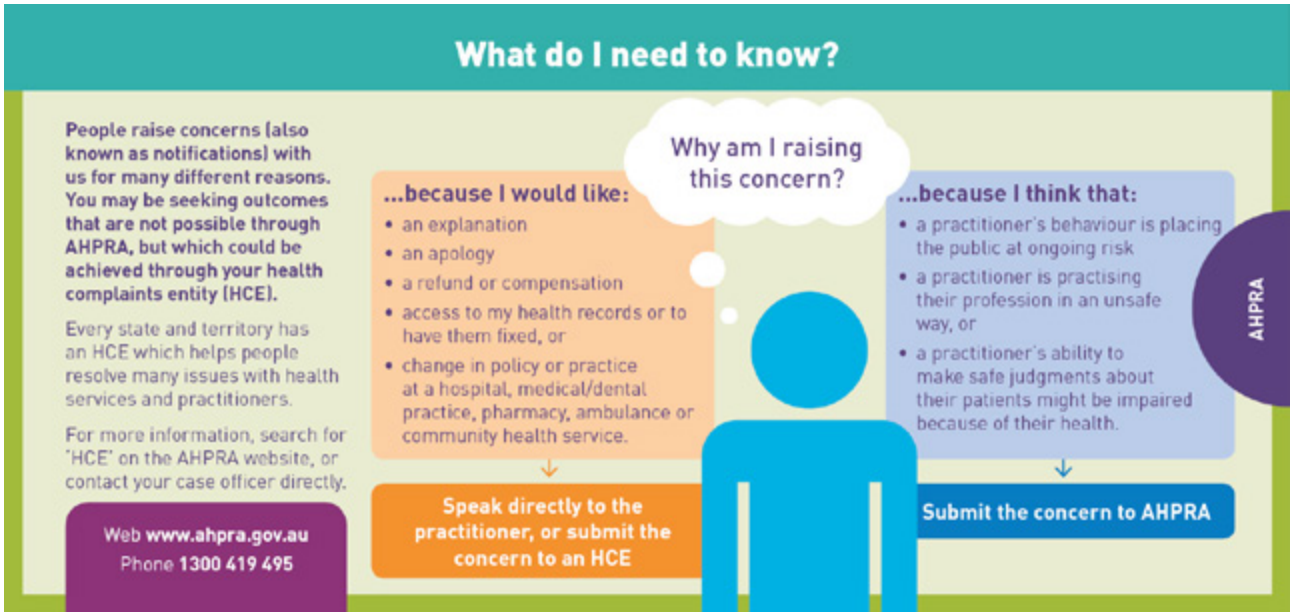
As discussed in more detail below, the review analysed a sample of 35 notifications (out of the 177 matters received by Ahpra and the Medical Board between 1 July 2018 to 31 December 2021, and finalised by 31 December 2021). All of these notifications were made by either the consumer of the cosmetic surgery or on their behalf. While not necessarily the only reason they made a notification, in the majority of these cases the consumers were seeking some form of recompense (either a refund, the cost of reversionary surgery or even compensation). Such consumers are always likely to be dissatisfied with the handling of their matter, as such outcomes cannot be achieved through the notifications process. This dissatisfaction is perhaps aptly summed up by a survey respondent who stated:

> *AHPRA is a waste of time for patients unlucky enough to have had a bad experience and needing to report it. Patients need refunds and sometimes compensation for suffering and bad outcomes that can't be rectified.*

The review met with the state/territory Health Commissioners (who run the HCEs) and discussed their potential management of cosmetic surgery-related complaints. Most (but not all) offer a dispute resolution service for such matters. Some will undertake this work concurrently (while the performance and conduct of the practitioner is under consideration by the Medical Board) and others will wait for that process to be concluded (which may be hampered by delay). One HCE has established an arrangement with their state consumer protection department to refer matters there in some circumstances. The review considers that Ahpra could do more to outline to consumer notifiers the alternative complaint pathways available to them.

In this context, Ahpra in its outward-facing material has the unenviable task of trying to explain to consumer notifiers both the complex federally segmented complaints systems as well as the limitations of their remit. When first reviewing this material, including for example the online video, it is easy to be critical of their approach which seems to focus more on what they cannot do compared to what they can. However, after appreciating the numerous challenges in this space, the review considers this approach is reasonable. For example, the online material makes various references to the inability to obtain refunds and compensation and the online complaint form requires the notifier to indicate in which state/territory the health service was delivered and when either New South Wales or Queensland is selected, a link to those agencies is provided. Correspondence provided to people who have made a notification includes a brief fact sheet style postcard (see Figure 4 below) which reiterates what Ahpra and the Medical Board can and cannot do.

Figure 4: Factsheet postcard included in correspondence to notifiers



However, notwithstanding their reasonable efforts, it appears that Ahpra and the Medical Board's attempt to explain their role and manage notifier expectation about cosmetic surgery notifications has not been completely successful. In the cosmetic surgery context (with its unique attributes) more should be attempted.

The review is aware that Ahpra and the Australian Commission on Safety and Quality in Health Care (ACSQHC) are currently undertaking a joint project that aims to improve the consumer experience of making a health complaint in Australia. This project is exploring the consumer experience of making a health complaint and identifying areas in which Ahpra and/or the ACSQHC can help consumers to navigate the complaints processes. The review considers that this is valuable work and should assist in addressing some of the issues identified.

Practitioners themselves can also play a role in raising consumer awareness of the notification and complaints processes by providing information in this regard to their patients. This issue is further discussed in 'Chapter 4 – Influencing Practice'.

The review also considers that consumer expectations may be more effectively managed by providing more information to consumers, specifically in the cosmetic surgery context. For example, a tailored online landing page and educational collateral (for example, fact sheets and FAQs) specifically directed at consumers who have concerns about cosmetic surgery matters may improve their understanding of the notifications process as it relates to cosmetic surgery matters and where they should take their concerns. Among other things, advice should be provided about:

- Ahpra and the Medical Board's role and powers (including what they can and cannot do with the aid of cosmetic surgery examples)
- the pathways to HCEs and other complaint agencies that offer dispute resolution.

There is also a case for providing more specific information and advice upfront in the initial correspondence sent to consumers who have made a notification. While the postcard referred to above is useful, it may be overlooked. Further, the postcard does not provide tailored information and therefore cannot respond to the specific concerns raised by the notifier. More information could be provided in the body of the correspondence about these matters. In doing this, more value is added by Ahpra in their interactions with consumers, even when consumers do not get the outcomes they are seeking from Ahpra and the Medical Board.

In implementing these two recommendations, Ahpra should seek to collaborate with the HCEs to confirm the appropriate referral pathways as they relate specifically to cosmetic surgery matters.

Finally, the review is concerned with the alleged use of NDAs by practitioners when seeking to resolve consumer disputes. While it is not unreasonable for them to be used to seek to limit a consumer's ability to bring a civil action when settling a formal legal claim, the review questions both their appropriateness and overall legality when they seek to prevent the involvement of a

regulator (such as Ahpra and the Medical Board) which has a legal responsibility to act in the interests of community protection. The review sought information from Ahpra on this matter and was advised that Ahpra shares the view that NDAs that seek to limit a consumer's ability to make a notification would not be legally enforceable. In these circumstances, the review considers that there would be value in Ahpra publishing its position in relation to the use of NDAs as a means to prevent consumers making a notification. This information would be useful to both practitioners and consumers.

Recommendations

3. Ahpra and the Medical Board continue their joint work with the Australian Commission on Safety and Quality in Health Care on improving the consumer experience of making health notifications in Australia.
4. Ahpra and the Medical Board consider:
   a) producing notifier educational material (with case examples) tailored specifically to cosmetic surgery matters including providing advice about:
      i. Ahpra and the Medical Board's role and the limit of their powers
      ii. pathways to HCEs and other complaint agencies that offer dispute resolution
   b) providing more specific advice (on the above matters) in initial correspondence to consumers who have made a notification about a cosmetic surgery matter
   c) making public their position in relation to practitioners' use of NDAs as a means to prevent consumers making a notification.

Practitioner notifiers

Fundamental to public safety is a strong reporting culture. This requires registered health practitioners and employers working within the cosmetic surgery sector to make notifications to Ahpra when it is necessary or appropriate.

In many cases, various kinds of registered health practitioners are well positioned to observe the conduct and performance of a medical practitioner undertaking cosmetic surgery. Registered and enrolled nurses are often employed by the practitioner or the facility in a perioperative capacity where the surgery is being undertaken. Anaesthetists are often present during the surgery. Medical practitioners who work in accident and emergency departments of both public and private hospitals may subsequently treat people who have experienced complications from surgery. In many cases health service organisations, such as hospitals, employ these practitioners and have robust incident reporting systems. Other surgeons are engaged to undertake revision surgery, at times, correcting mistakes made by the practitioner who undertook the original surgery.[56]

Ahpra and the Medical Board's powers and responsibilities

The National Law places an obligation on registered health practitioners, employers and health education providers to make a mandatory notification in certain circumstances.[57] For example, a mandatory notification is required if a practitioner forms a reasonable belief that another registered health practitioner is practising in a way that significantly departs from accepted professional standards and is placing the public at risk of harm.[58] Other concerns that may require the making of a mandatory notification (depending on the risk of harm to the public) relate to a practitioner who may have an impairment, have been intoxicated while practising; or have engaged in sexual misconduct.[59]

[56] ASAPS in their submission state: 'ASAPS members are frequently called upon to treat avoidable life-threatening complications and sub-standard aesthetic results following cosmetic surgery …' (p2).

[57] Sections 141, 142 and 143 of the National Law.

[58] Ahpra, Guidelines: *Mandatory notifications about registered health practitioners*, March 2020, accessed 7 July 2022, p7.

[59] Ahpra, Guidelines: *Mandatory notifications about registered health practitioners*.

While it is not an offence under the National Law to fail to make a mandatory notification, Ahpra and the National Boards do have the power to take disciplinary action against a practitioner who fails to make a mandatory notification when required.[60]

Where a registered health practitioner may not be obliged to make a mandatory notification (as the test outlined in the National Law[61] may have not been reached), they are still able to make a voluntary notification which also enhances public safety.

Ahpra and the National Boards have published detailed *Guidelines: Mandatory notifications about registered health practitioners* that explain the requirements of this aspect of the National Law and aim to support individuals to decide whether they need to make a mandatory notification. Ahpra's website provides various information and resources to explain the obligations and the process including videos, case studies, fact sheets, FAQs and a resource kit. However, as will be discussed below this material focuses more on impairment, intoxication and sexual misconduct than practising in an unsafe manner. Like consumers, practitioner notifications can be made by telephone, through an online portal, by email or post. The online portal is the same online form as for consumers; however, check boxes and dropdown menus narrow its application to being a practitioner notification. Therefore, it generally appears accessible to practitioners.

Mandatory reporting in the cosmetic surgery context

The review holds concerns that there is a significant underreporting of safety issues by registered health practitioners and employers in the cosmetic surgery sector. The reasons for this view are twofold.

Firstly, no mandatory notifications appear to have been made about the 177 notifications received about cosmetic surgery matters between 1 July 2018 to 31 December 2021 (and finalised by 31 December 2021). Ahpra and the National Boards' *Annual Report 2020/21* states that mandatory notifications made up 12.5% of all notifications received during that financial year. While it is possible that a mandatory notification(s) may have been made but not finalised in the review period (thus not captured as one of the 177 matters), if the ratio of mandatory to voluntary notifications for cosmetic surgery matters was similar to the average in all matters, one would expect approximately 22 mandatory notifications relating to cosmetic surgery, not zero.

Secondly, and more anecdotal in nature, very few, if any, notifications have been received by Ahpra and the Medical Board from registered health practitioners about the various cosmetic surgery matters that have been reported in the media or subject to publicised class actions. Many of these matters are currently only allegations, and findings of fact have not yet been made. However, if there is substance to many of the allegations, it is concerning that more mandatory or voluntary notifications were not made.

Research

Research indicates that, notwithstanding that mandatory reporting in Australia has a further reach than in other countries including New Zealand, the United States and Canada, it is not without its limitations.[62] This 2014 research about mandatory notifications in Australia, which included data from every registered health profession and all but one jurisdiction, found that nearly two-thirds of reports of notifiable conduct received by Ahpra in the period studied were about perceived departures from accepted professional standards, especially about clinical care. In addition, 80% of notifiers were from the same health profession as the practitioner about whom they made the notification.[63] This pattern does not appear to be evident with cosmetic surgery notifications.

Another study, undertaken prior to the commencement of the National Scheme, identified four barriers to reporting, namely: uncertainty or unfamiliarity with the legal requirement to report; fear of retaliation; lack of confidence that appropriate action would be taken; and loyalty to colleagues and a general culture against reporting.[64]

[60] Section 141(3) of the National Law.

[61] Section 144 of the National Law.

[62] M Bismark, M Spittal, T Plueckhahn and D Studdert, 'Mandatory reports of concern about the health, performance and conduct of health practitioners', *Medical Journal of Australia*, 2014; 201 (7): 399–403, doi.org:10.5694/mja14.00210.

[63] Bismark et al., 'Mandatory reports of concern about the health, performance and conduct of health practitioners'.

[64] C DesRoches, R Sowmya, J Fromson, R Birnbaum, L Lezzoni, C Vogeli and E Campbell, 'Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues.' *JAMA* 2010; 304:187–193. doi:10.1001/jama.2010.921.

Stakeholder feedback – Submissions

Around 70 submitters to the review commented on the issue of mandatory notifications. While the majority of these indicated that current guidelines adequately explain a practitioner's mandatory reporting obligations, they also identified a number of barriers that prevent practitioners from making notifications. The most frequently mentioned barrier to mandatory reporting was fear, namely fear:

- of retaliation or hostility from other practitioners
- that making a notification will result in a job loss or otherwise adversely affect one's career
- of litigation
- of reputational damage or stigma.

One medical practitioner said:

> *The main reason why health practitioners do not make notifications is the fear of jeopardizing our futures in the industry if we report against colleagues. This has been demonstrated multiple times whereby whistle blowers ultimately lost training positions or chances of getting into training after reporting is made. This is not limited to the cosmetic surgery sector.*

The second most frequently mentioned barrier was the lack of anonymity in making a notification, and that the practitioner about whom the notification was made would find out the name of the notifier. Submitters stated that this reinforced their fears about making a mandatory notification. This barrier was mentioned by just under one-fifth of submitters.

The third most frequently mentioned barriers were the culture in the industry and the perceived difficulties or lack of confidence in Ahpra's management of the notification process. On culture, submitters described a 'poor reporting culture' in cosmetic surgery and in the medical profession more broadly that was underpinned by power imbalances in workplaces and fear. For example, the Australian College of Nurse Practitioners raised 'The culture of the cosmetic surgery industry, that reinforces image and financial reward over patient safety and best practice.'

On the notification process, and Ahpra's management of notifications, the ASAPS said:

> *Practitioners do not have confidence in Ahpra to either prosecute a complaint or protect the whistle blower.*

The AMA said:

> *Many doctors describe the notification process as overly bureaucratic and at times counterintuitive – this fear and lack of belief in that the system is fair is itself a deterrent.*

A number of submitters also stated that they were uncertain about when to make a notification, as there are no minimum standards for cosmetic surgery.

The OHO said:

> *The main barrier to the reporting of mandatory notifications by other healthcare practitioners is a lack of understanding of professional standards that apply to cosmetic surgery [...] how do health practitioners identify substandard service or services that are a significant departure from accepted professional standards, when there are no accepted professional standards?*

The ASAPS said:

> *The Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations related to impairment, intoxication and sexual misconduct. But does not adequately explain 'significant departure from accepted professional standards' because Ahpra has not explicitly stated nor defined what accepted professional standards in cosmetic surgery are.*

The views of many submitters are neatly summarised by this statement from a medical indemnity insurer:

> *There are barriers to all health practitioners making notifications and these exist across all specialties and professions, not only health practitioners involved in cosmetic surgeries. These include:*
>
> - *Lack of clarity as to what constitutes accepted professional standards and a significant departure from those standards.*

- *Lack of understanding about mandatory notification obligations and the process, including what occurs with the notification after the notifier makes it and how much information (including the identity of the notifier) will be made apparent to the practitioner/health facility*
- *Fear that reporting colleagues including supervisors and people in the same team, may have an impact on the health practitioner's job and working relationships.*

Most submitters who commented on the barriers to mandatory reporting also made suggestions for improvement. The main themes were:

- allowing practitioners to make notifications anonymously
- requiring all complications from cosmetic surgery to be reported
- setting minimum standards for cosmetic surgery against which a practitioner's performance could be assessed to determine if the threshold for mandatory reporting has been met.

Observations and analysis

Notwithstanding that other registered health practitioners are in a unique position to observe and identify medical practitioners undertaking cosmetic surgery who pose a risk to public safety, reporting is problematic. Unfortunately, many of the identified barriers are significant, and the ability of Ahpra and the Medical Board to influence them is limited.

While submitters generally considered that the information provided by Ahpra and the Medical Board concerning mandatory notifications is sufficient, a closer review of the online material reveals that while it is discussed in the relevant guidelines[65] and some FAQ, other informative material (such as online videos and case study examples) is focused on the making of mandatory notifications about impairment, intoxication and sexual misconduct and not the ground involving practising in a way that significantly departs from accepted professional standards and placing the public at risk of harm.

Much has been made by submitters about the fear of repercussions against a practitioner who makes a notification about another. The review notes that certain legislative protections are provided to notifiers and processes exist for a practitioner to make a confidential or anonymous voluntary notification or a confidential mandatory notification.

It was not clear from the submissions whether or not submitters were aware of the protections currently afforded to practitioners by the National Law. Section 237 of the National Law provides protection from civil, criminal and administrative liability, including defamation, for people who make notifications in good faith. The National Law further clarifies that making a notification is not a breach of professional etiquette or ethics, or a departure from accepted standards of professional conduct but rather is consistent with professional conduct and a practitioner's ethical responsibilities. There would be value in addressing these issues in greater detail in the general information that is available to practitioners.

The National Law does not contain whistle-blower style protection from reprisals, for example making it an offence to take reprisal action against a notifier. The review also notes that a 2019 review by the National Health Practitioner Ombudsman (NHPO), *Review of confidentiality safeguards for people making notifications about health practitioners* recommended that Ahpra should seek an amendment to the National Law to make it an offence to harm, threaten, intimidate, harass or coerce a notifier. This review supports this position. The review was advised that Ahpra has written to Health Ministers about the NHPO report and recommendations.

[65] Ahpra and National Boards, *Guidelines: Mandatory notifications about registered health practitioners*, March 2020, accessed 7 July 2022.

Recommendations

5. Ahpra and the Medical Board review its educational material that is available to practitioners about mandatory and voluntary notifications and include more information about:
   a) notifications involving concerns that a practitioner may have placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards and is placing the public at risk of harm
   b) protections for notifiers and the ability to make a confidential mandatory notification or anonymous voluntary notification.

Consistent feedback was received about the challenge in determining whether the 'significant departure from accepted professional standards' threshold for a mandatory notification was met in cosmetic surgery matters. Submissions indicated that greater detail about the minimum standards for cosmetic surgery would reduce uncertainty in this space. This issue is addressed by a recommendation in 'Chapter 4 – Influencing Practice'.

Finally, the particularly low to non-existent notification rate in the cosmetic surgery sector tends to indicate that more targeted information and education may be required. There would be value in undertaking a targeted education campaign in this space.

Recommendations

6. Ahpra and the Medical Board undertake a targeted education campaign in relation to making mandatory and voluntary notifications aimed at the cosmetic surgery sector and also the classes of practitioners/employers outside the sector who may subsequently treat cosmetic surgery patients (including emergency departments and their employees).

Managing notifications

Ahpra and the Medical Board's powers and responsibilities

Part 8 of the National Law governs the Medical Board's powers and responsibilities to manage and respond to notifications. Ahpra works with the Medical Board to assess, investigate and generally manage notifications that are received. Not all notifications are investigated, and many matters are finalised after assessment. Where some form of regulatory action needs to be taken, ultimately, the seriousness of the conduct or performance of the subject of the notification will determine whether the Medical Board deals with it themselves or whether it is referred to a state or territory tribunal.

The management of notifications may include one or more of the following actions and sanctions, determined on a case-by-case basis:[66]

a) assessing the notification to determine whether it is a matter that requires any regulatory action
b) investigating a practitioner, or requiring a practitioner to undergo a health or performance assessment
c) taking immediate action about a practitioner (on an interim basis) to protect the public or in the public interest, including suspending their registration
d) cautioning a practitioner (which is a warning to a practitioner about their conduct or the way they practise)
e) imposing conditions on a practitioner's registration (or accepting an undertaking) that requires the practitioner to do something or stop doing something

[66] Part 8 of the National Law.

f) referring the matter to the responsible tribunal if a practitioner's behaviour constitutes professional misconduct. Tribunals can take a range of actions, including cancelling a practitioner's registration.

Ahpra's *Regulatory Guide: An Overview* 2020[67] provides a very succinct summary of the notification management process that is applied. Relevant extracts from the Guide are quoted below.

Preliminary assessment

Upon receipt of a notification about a health practitioner (or a student), Ahpra must refer the notification to the applicable Board(s) for preliminary assessment. In some circumstances, Ahpra may refer notifications to the police and/or other national or state-based regulatory bodies.

A Board must, within 60 days after receiving a notification, conduct a preliminary assessment and decide:

- whether or not the notification is about a person who is a health practitioner or a student registered in a health profession for which the Board is established
- whether or not the notification relates to a matter that is a ground for notification, and
- whether or not it is a notification that could also be made to a health complaints entity.

A Board may decide, at the preliminary assessment stage, to take no further action regarding the notification if:

- the notification is frivolous or vexatious
- it is not practicable for the Board to investigate
- the person to whom the notification relates has not been, or is no longer, registered in a health profession
- the subject matter of the notification has already been dealt with adequately by the Board
- the subject matter of the notification is being dealt with, or has already been dealt with, by another entity, or
- the health practitioner to whom the notification relates has taken appropriate steps to remedy the subject matter of the notification and the Board reasonably believes no further action is required about the notification.

If a Board believes that it is necessary to take further action about the notification it may:

- start an investigation into the practitioner
- consider taking immediate action about the practitioner
- consider cautioning the practitioner, which is a warning to a practitioner about their conduct or the way they practise
- consider imposing conditions (or accepting an undertaking) from a practitioner that requires the practitioner to do something or stop doing something
- require the practitioner to undergo a health or performance assessment
- refer the practitioner to a hearing by a panel, or
- refer the practitioner to a responsible tribunal.

[67] More detail on how Ahpra and the National Boards manage notifications about the health, performance and conduct of practitioners is outlined in Ahpra's *Regulatory Guide: An Overview*, 2000, accessed 12 July 2022.

Investigations

Powers of an investigator

Investigators appointed under the National Law have various statutory powers to obtain evidence and information relevant to an investigation, including:

- powers requiring a person to provide information, answer questions or produce documents, and
- powers permitting the investigator to search places (such as a practitioner's residence, or place of practice) and seize objects or documents.

Potential outcomes of investigation

[If an investigation is conducted] at the conclusion of an investigation, the investigator must provide the relevant Board with a written report (which includes the investigator's findings and their recommendations about any action to be taken).

The Board will then consider the investigator's report and decide whether or not to take further action about the matter. Further action might include:

- referring the matter to another entity (such as a health complaints entity)
- taking immediate action
- directing the practitioner to undergo a health or performance assessment
- taking relevant action under section 178 of the National Law (such as cautioning the practitioner, imposing conditions or accepting an undertaking)
- referring the matter to a panel, or
- referring the matter to a responsible tribunal.

Referral to the responsible tribunal

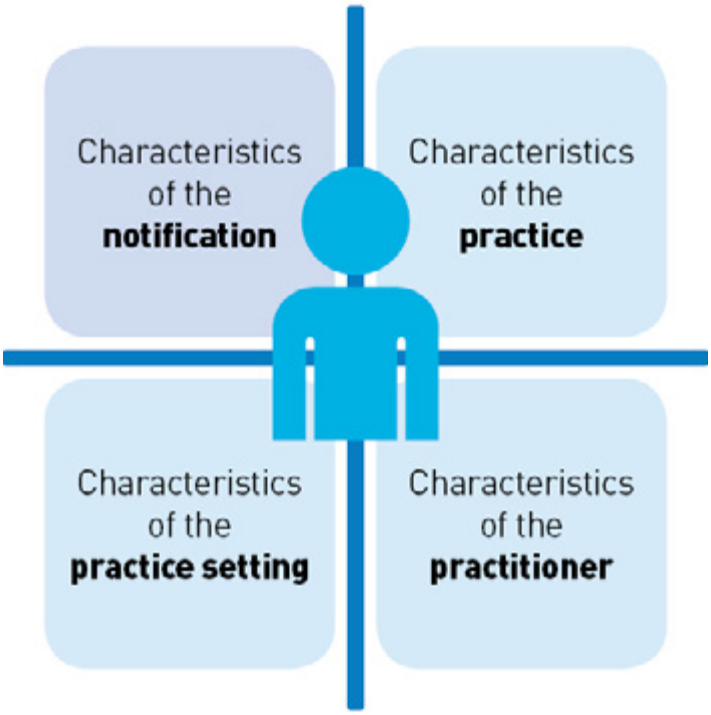
A Board must refer a matter to a responsible tribunal if it forms a reasonable belief that:

- a practitioner has behaved in a way that constitutes professional misconduct, or
- a practitioner's registration was improperly obtained because the practitioner or someone else gave the Board information or a document that was false or misleading in a material particular.

When assessing a notification about a medical practitioner, Ahpra and the Medical Board use a risk-based assessment methodology to assess risks that the individual practitioner might pose. The **characteristics** considered when assessing risk of the practitioner (as detailed in Figure 5 below) include the:

- specific concerns raised regarding the knowledge, skill or judgement possessed, or care exercised, by the practitioner is below a reasonable standard
- type of practice engaged in, including the inherent risk and any relevant standards or guidelines
- practice setting, including the vulnerability of patient group and whether the practitioner has access to professional peers and support
- practitioner themselves, including their regulatory history and the actions they have taken in response to the concern.

Figure 5: Risk assessment methodology



Clinical advisers to the Medical Board, who are registered medical practitioners, provide clinical input on the assessment (including risk assessment) and management of notifications about medical practitioners. Based on the information obtained in a notification, or from a pattern of notifications, an Ahpra clinical adviser firstly undertakes an assessment to consider whether the knowledge, skill or judgement possessed, or care exercised, by the practitioner is below a reasonable standard.

Following the initial clinical screening, further consideration is given to the notification, practice and setting, as well as the characteristics of the practitioner, to determine if the matter relates to a low, medium, or high clinical risk. This risk rating then informs next steps and helps determine whether a matter needs to progress to investigation.

Ultimately, following the assessment and/or investigation process, determinations can be made about the notification and where necessary and appropriate sanctions can be taken against the practitioner. The seriousness of the conduct or performance matter that is the subject of the notification will dictate whether it is the Medical Board or a panel of the Board or a state or territory tribunal that determines the matter and issues sanctions.

The Medical Board has the power to take immediate action at any time against a practitioner where it reasonably believes that interim regulatory action is necessary to protect the public from a serious risk, or is otherwise in the public interest.[68] Immediate action includes suspending the practitioner or imposing conditions on the practitioner's registration or accepting enforceable undertakings from the practitioner – all on an interim basis.

While the Medical Board has the ability to suspend registration on an interim basis (by taking immediate action), only a tribunal can suspend on a substantive basis or cancel registration.

Ahpra and the Medical Board's focus is to identify notifications that indicate a registered health practitioner is practising in unsafe or unprofessional ways. 'Protection of the public' is the paramount consideration[69] when managing notifications and deciding the appropriate regulatory or disciplinary action to take. According to Ahpra, protecting the public means protecting the public from, among other things:

[68] Sections 155 to 159A of the National Law.

[69] In 2019, Health Ministers issued *Policy Direction 2019-01: Paramountcy of public protection when administering the National Scheme* to Ahpra and National Boards, accessed 26 July 2022.

- *practitioners who engage in unethical, or unlawful, conduct*
- *practitioners who practise in an unsafe or incompetent manner, and*
- *a culture of sub-standard practice from which harm may flow.*[70]

The role of Ahpra and the Medical Board is protective, not punitive, which means when deciding on an appropriate sanction, Ahpra advise that the following factors are considered:

- *specific deterrence*
- *general deterrence*
- *protection of / confidence in the profession*
- *maintenance of professional standards*
- *rehabilitation*
- *insight*
- *remorse*
- *evidence of good character*
- *level of experience*
- *delay*
- *personal circumstances*
- *disciplinary history*
- *impact on complainant/victim*
- *impact on patient community.*[71]

Depending on the nature and circumstances of the individual case, 'some of these principles or factors will be given more or less weight than others (or not considered at all)'.

As has been discussed above, the notification process has not been designed to be restorative or compensatory. Achieving individual rectification for consumer notifiers is beyond the powers of Ahpra and the Medical Board. This factor, combined with the non-punitive nature of the system, means that even where Ahpra and the Medical Board have handled a notification in the most appropriate manner, some consumers may be left feeling disappointed and let down by the process.

In New South Wales, these functions are undertaken by the Medical Council of New South Wales and the HCCC, and not Ahpra and the Medical Board. In Queensland, the Office of the Health Ombudsman is the single point of contact for all health service complaints and notifications in that state and may undertake most of these functions themselves or refer a notification to Ahpra and the Medical Board to manage.

Submissions

Around 70 submissions commented on the management of notifications. Submitters were asked what changes are needed to the management of notifications, and why. The most frequently mentioned suggestion was for Ahpra and the Medical Board to ensure that all notifications about cosmetic surgery matters involve review by a person or persons who have expertise in cosmetic surgery matters. Submitters suggested a range of ways this could be achieved – for example, through establishment of a technical advisory group, use of a peer review process, engagement of clinical advisers who have expertise in cosmetic surgery, and/or having the same Ahpra staff deal with all notifications about cosmetic surgery so that they can develop expertise in this subject area.

A medical indemnity insurer indicated support for:

- *increasing Board/Ahpra's expertise in handling cosmetic surgery matters. This could be achieved through*
- *use of dedicated Ahpra staff for all cosmetic surgery notifications*
- *a dedicated Board committee to assess cosmetic surgery notifications*

[70] Ahpra, Regulatory Guide: An Overview, 2020.

[71] Ahpra, Regulatory Guide: An Overview, 2020.

- *internal education on the cosmetic surgery environment, key risks and emerging trends*
- *earlier involvement of appropriate experts*
- *closer, ongoing engagement with peak surgical bodies*
- *mechanisms to obtain advice from leading specialists to assist Board/committee decisions on complex notifications or in considering broader, systemic issues.*

Another issue raised by some stakeholders during the review was the existence of civil litigation against cosmetic surgery practitioners (at times alleging significant issues of malpractice), which is disconnected from the notifications process. In some significant matters such as class actions no notification is made, meaning that Ahpra and the Medical Board have no visibility of the concerns raised. One stakeholder did however make the point that most civil claims are publicly available and searchable online.

Review of notifications

The review was required to enquire and report on Ahpra and the Medical Board's approach to managing cosmetic surgery notifications, with a focus on the methodology for risk assessment and investigation protocol. The focus of the review in this area was to identify any potential areas for improvement and recommend where changes may be necessary to the assessment and investigation approach to cosmetic surgery notifications.

For this reason, the review undertook a detailed review of Ahpra and the Medical Board's handling of a sample of cosmetic surgery notifications.

Ahpra was asked by the review to interrogate their case management system for the 2018/19, 2019/20, 2020/21 financial years to identify cosmetic surgery-related notifications about medical practitioners. As the focus was on how Ahpra and the Medical Board managed those notifications, it was necessary for the notifications considered by the review to have been finalised. Therefore, the data parameters for the notifications review were cosmetic surgery-related notifications about medical practitioners received between 1 July 2018 to 31 December 2021, and finalised by 31 December 2021.

With these specific parameters, the data reviewed will not have captured every cosmetic surgery notification received about a medical practitioner during the relevant time period, as some matters may not have been finalised by 31 December 2021.

Ahpra's system does not include any specific searchable fields for cosmetic surgery matters such that an automated search can be run. Identifying the matters required keyword searching and filtering results through a manual review of case information.

Initially a total of 271 notifications were identified. However, it was necessary to undertake a further manual data cleansing exercise to remove notifications that were out of scope (e.g. notifications about cosmetic procedures such as injectables and laser treatments). This process left a total of 177 matters that were considered to be in scope.

Data

The 177 notifications related to 114 medical practitioners. 137 of the notifications were finalised at the Assessment stage, 27 proceeded to Investigation and 13 were finalised by other means. No immediate action was taken and none proceeded to a tribunal.

Only four of the 177 notifications resulted in any formal regulatory action being taken against the practitioner. In one case conditions were imposed and in three other cases cautions were issued to the practitioner. In the remaining 173 notifications, no adverse findings were made against the practitioner with:

- no further action being taken in 107 of the notifications,
- the matter being retained by HCE or referred to another agency in 66 of the notifications.

Having regard to the above data, the rate of regulatory action taken in cosmetic surgery notifications about medical practitioners was **2.3%** (4 cases out of 177). This compares (for the same time period) to a regulatory action rate of **8.0%** of the total notifications received about all medical practitioners and **5.4%** of the total notifications received about surgeons. Therefore, the regulatory action rate for cosmetic surgery notifications is approximately one quarter of the rate for all medical practitioners and half the rate of all surgeons.

Table 4 details the type of registration/specialisation of the practitioners subject to the notifications.

Table 4: Cosmetic surgery notifications by registration/specialisation type

Practitioner	Number of notifications	Number of practitioners
Plastic surgeons	100	56 (1 caution)
General registrants	19	18
General practitioners	18	10 (1 conditions imposed)
Other surgeons (for example, Otolaryngologist)	17	14 (2 cautions)
General surgeons	17	13
Dermatologists	5	2
Other	1	1
Total	177	114

There are several reasons for caution about seeking to draw any definitive conclusions from this data about any of the cohorts of medical practitioners in this table, including about their performance or even their likelihood of being the subject of a notification.

Firstly, the fact that a notification is made against a practitioner does not of itself indicate any wrongdoing, malpractice or substandard performance. Only four of the 177 matters involved an adverse finding against the practitioner, with no adverse finding made in the remaining 173 matters. At its highest, without an adverse finding, a consumer notification is merely an indication that the notifier is dissatisfied with some aspect of the practitioner's treatment of them which is a subjective measure. It does not necessarily indicate what some have referred to as a 'botched' surgery and such a description in the circumstances is misleading.

Secondly, not all conduct and practice concerns result in a notification being made. None were mandatory notifications by other registered practitioners who may have observed serious safety breaches. Some matters subject to media reporting or class actions (some which allege some serious failings on the part of practitioners) were not the subject of a notification. Therefore, these 177 notifications are an incomplete list of potential concerns about practitioners in this sector.

Finally, without knowing the total populations of practitioners in these cohorts who undertake cosmetic surgery, it is not possible to establish any kind of reliable rate. A notification rate[72] (which contextualises the results based on total population) would be the only way to reliably start comparing cohorts. Those populations are uncertain and difficult to reliably identify.

Take for example plastic surgeons – 56 practitioners had notifications made about them during this time, which is the largest number of all the cohorts. However, they are likely to be the largest single group of medical practitioners operating in this space. There are 531 specialist plastic surgeons registered in Australia[73] but, not all perform aesthetic cosmetic surgery. The ASAPS states on their website that they represent 300 specialist plastic surgeons, which may indicate that 300 of the 531 practise some form of aesthetic cosmetic surgery.[74] There may also be some plastic surgeons not represented by ASAPS who still undertake this work. Therefore, the total potential population is somewhat uncertain and likely to be somewhere between 300 and 531. If the population is 300, for example, the notification rate for plastic surgeons would be 19%. If it was 500 it would be 11%.

If this is compared to the cohort of general registrants and general practitioners undertaking cosmetic surgery, as is detailed in the table above, a total of 28 practitioners in these groups were subject to notifications. However, identifying the total population of practitioners in this cohort undertaking cosmetic surgery is extremely difficult. The review undertook various open source and other enquiries in an attempt to identify this population (including identifying those that advertise online, may be represented by industry organisations, or were subject to notifications). A total of 87 practitioners were identified but this is not likely to be definitive.[75] If, for example, the total was 87, then the notification rate would be 32%.

[72] A notification rate is a very subjective measure of consumer dissatisfaction.

[73] Medical Board of Australia, Registration data table – March 2022. This number includes NSW medical practitioners.

[74] This number includes NSW medical practitioners. See https://aestheticplasticsurgeons.org.au/asaps-who-we-are/

[75] This number includes NSW medical practitioners.

These examples illustrate the difficulty in trying to draw any conclusion about the competence, skill and overall performance of any particular cohort from the notifications data.

Data sample and review

A sample of 35 notifications was selected for detailed review. The 35 notifications related to 26 practitioners (11 plastic surgeons, seven other surgeons (for example, specialist otolaryngologist) and eight practitioners with either general registration or specialist registration as a general practitioner). Of these 35 notifications, 28 were finalised after assessment and seven proceeded to investigation. Regarding outcomes, 31 notifications resulted in no further action, three practitioners received cautions and one had conditions imposed.

Documentation for each of these notifications was examined by the review team, including the notification itself and associated material provided by the notifier, risk assessment documentation, internal clinical advice, external independent clinical advice (where obtained), practitioner submissions, medical records (where obtained), assessment and investigation reports and Medical Board decisions.

Findings

In undertaking the notifications review, the review team had the benefit of carefully examining all supplied material about a manageable number of notifications without any significant time constraints. In this respect the review team's work was undertaken in a somewhat artificial environment which was far removed from the realities of a busy regulatory agency.

In the 2020/21 financial year Ahpra received a total of 10,147 notifications and the Medical Board managed 5,516 matters involving medical practitioners (requiring them to balance various competing demands and prioritising and managing various risks). The review team's consideration of these matters was also focused specifically on identifying opportunities for improvement and so was undertaken through a particularly critical lens.

The notification review undertaken by the review team identified a number of opportunities for improvements to the assessment and notification approach in cosmetic surgery matters.

Significant variation in approach in managing these matters was demonstrated over the three-year period. The overall theme arising from this exercise was the need for Ahpra and the Medical Board to take a consistent approach to analysing the notifications, applying the risk assessment methodology, identifying the key issue of the notification and making the necessary further enquiries.

The review considers that the risk assessment methodology is an appropriate tool to apply to cosmetic surgery notifications. The proper application of the tool to each case should appropriately identify risk and inform further action. However, in some cases reviewed, the risk assessment tool could have benefited from more rigorous and consistent application.

Examples of the problematic application of the tool to some cases included:

- lowering the risk rating without properly documenting the rationale
- not completing all the quadrants of the risk assessment framework
- taking an inconsistent approach to some risk indicators and failing to place appropriate weight on others (for example, notifications history).

The key issues that were identified in the sample review including suggested improvements are detailed in this Table 5.

Table 5: Key issues identified in notifications review

Issue	Suggestion for improvement
It was unclear whether the extensive notification history of some practitioners was given sufficient weight in either the risk assessment process or overall management of the matter (however, it is noted that there are challenges in placing weight on notifications that resulted in a NFA).	Ensure that the practitioner's notification history is properly considered in the risk assessment process. Where a practitioner has an extensive notifications history the notification may warrant increased scrutiny and/or investigation.
There was a possible over-reliance on the practitioner submissions in some cases without scrutinising key issues or determining whether there is evidence to corroborate the practitioner's claims (for instance, records or GP referral).	Ahpra/the Medical Board should ensure that (where necessary) claims by a practitioner on key issues should be tested including considering whether there is evidence to corroborate the practitioner's claim.
In some matters where there was a factual dispute on a key issue(s), further enquiries were not made by Ahpra to seek to clarify it.	At times there will be a need to go back to the notifier and seek clarification or obtain information from other witnesses.
Where notifiers have sought second opinions or reversion surgery from another practitioner (often a specialist plastic surgeon), information from that practitioner was not always sought or where it is provided not given enough weight.	Where a consumer has attended another practitioner for a second opinion/revision, consideration should be given to requesting their notes or opinion. Where this information is provided, it should be carefully considered.
Some assessments did not address all key issues of complaint (for example the inadequacy of the facility the procedure was undertaken in or the use of anaesthetic).	Care needs to be taken that notifications are not characterised too narrowly and all key issues are considered.
The reasons documented in some Board decisions were very brief and failed to address all key issues raised in the notification.	All key issues raised in the notification should be addressed in Board decisions.
Ahpra and the Medical Board rarely seem to refer to the Cosmetic Guidelines in their assessments/decisions (even though this document is meant to set expectations for cosmetic surgery practice).	The Medical Board's Cosmetic Guidelines should be used more explicitly to guide the assessment of whether a practitioner's conduct or performance is below the standard expected.
There was not a consistent approach to considering the qualifications and experience of a practitioner who had undertaken invasive cosmetic surgery without any obviously relevant qualifications.	Where a practitioner on the face of the notification does not appear relevantly qualified, their qualifications and experience should be examined. In some cases it may be necessary to put a practitioner to proof on claims in their CV.
In some cases there was a failure to obtain and or consider before and after photos which may have assisted in determining whether the outcome was unsatisfactory and whether consumer dissatisfaction was justified.	In cases that allege unsatisfactory outcomes, before and after photos (if taken) should be obtained by Ahpra and considered by an internal clinical adviser.
In cases involving unsatisfactory outcomes or complications, in some cases preoperative documentation and consent forms were not obtained and reviewed.	Preoperative information and consent documentation should be carefully considered in notifications alleging unsatisfactory outcomes or complications.
In some cases the risk assessment methodology was not robustly or consistently applied.	Ensure that the risk assessment methodology, including proper consideration of each risk quadrant, is appropriately applied to each case.

Having regard to these issues, and noting a number of the pertinent issues identified by stakeholders, the review considers that some enhancements to the way that Ahpra and the Medical Board manage cosmetic surgery notifications is necessary.

For example, should Ahpra and the Medical Board considered that there is a risk of inconsistency in the approach by the various state/territory medical boards when determining these matters, and this cannot be addressed through training etc., consideration should be given to establishing a national specialist committee of the Medical Board to handle cosmetic surgery notifications.

The review also acknowledges the overall volume of notifications across all registered practitioners that are received by Ahpra and the National Boards. Managing such high-volume work is an extremely challenging and unrelenting exercise. Ahpra and the National Board's resources are finite. Community and stakeholder expectation is high and it is a reality of complaints and notification management that such expectations are rarely met. It is also a reality that Ahpra and the Medical Board do not have the resources to investigate every notification it receives. In this environment, accurate and effective risk assessment tools are critical and so is their appropriate application.

In implementing recommendations, it will be necessary to balance the action that needs to be taken with the resources available and competing priorities of the agency.

Finally, a number of stakeholders expressed concern that Ahpra and the Medical Board do not appear to have visibility of civil litigation (which may allege unsafe practice) that may have been brought against a practitioner, including class actions. The review considers that it would be unreasonable to expect Ahpra and the Medical Board to constantly monitor all civil claims lodged across state and territory jurisdictions against all medical practitioners. However, when considering cosmetic surgery notifications that raise certain performance issues, there may be some benefit in

undertaking some open-source enquiries that may identify significant legal proceedings.

Recommendations

7. Ahpra and the Medical Board:

a) develop training and guidance material (for example, a manual) specifically about the management of cosmetic surgery notifications to supplement and support the current assessment/investigation processes (which may include what other open source enquiries should be made and when). This should be directed towards ensuring that any specific key issues raised by the notification (either directly or indirectly) are consistently and appropriately considered and the risk assessment methodology is rigorously applied

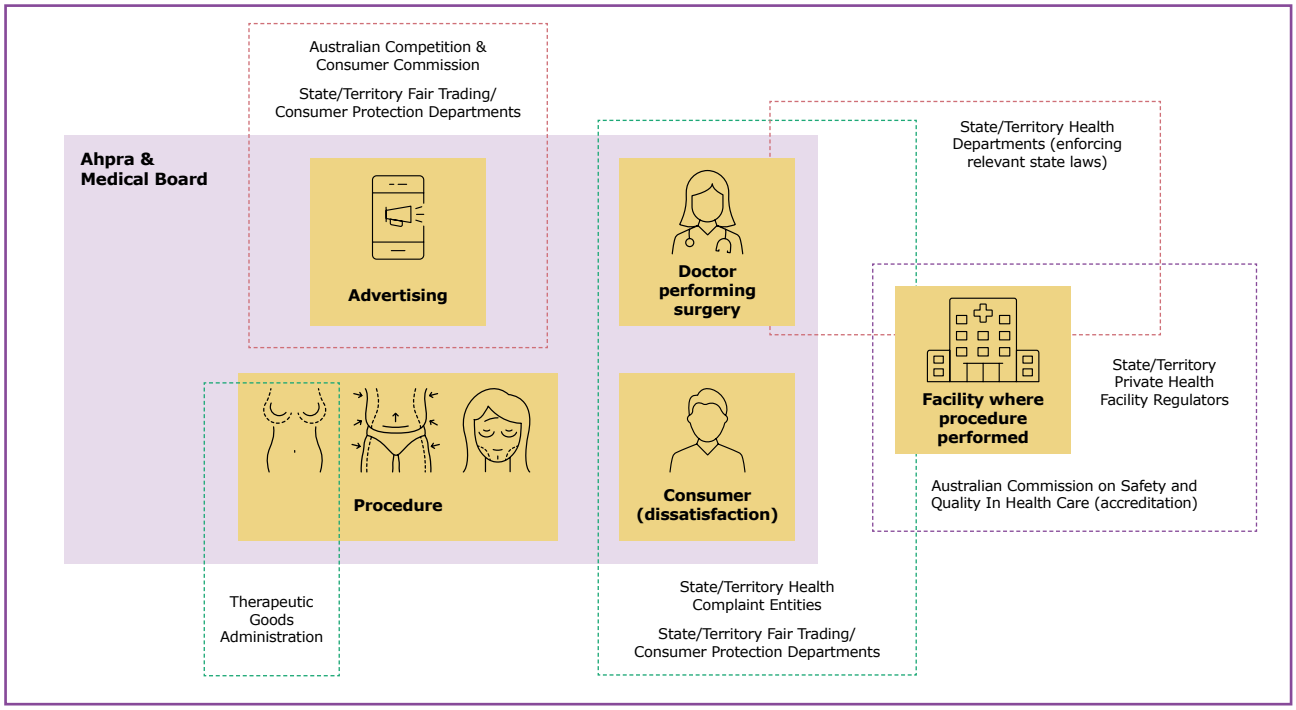
b) take further steps to enhance consistency in the management of issues raised in cosmetic surgery notifications, including for example, building up the specialist expertise of staff managing these notifications (whether in one team or across teams)

c) ensure that where necessary key claims in a practitioner's submissions are scrutinised, including seeking corroborative evidence (for example, medical notes or GP records) and attempts are made to resolve key factual disputes (including seeking clarification from the notifier or other witnesses).

Cooperation with other regulators

While this review focuses on Ahpra and the Medical Board's role and responsibilities, it must be noted that Ahpra and the Medical Board are one part of a complex and multi-jurisdictional system that regulates cosmetic surgery in Australia. Some aspects of regulation in this space are national, while others are state and territory-based (see Figure 6). Each regulator plays an important role in overseeing elements of the cosmetic surgery sector and protecting the public from harm. Other patient safety frameworks exist that provide additional important safeguards in the cosmetic surgery sector.

Figure 6: Overlapping jurisdictions in cosmetic surgery regulation



Other agencies that play a regulatory role

HCEs

As has been mentioned above, each state and territory has an independent health complaints entity with powers to investigate complaints about health services and health professionals, which may include cosmetic surgery and cosmetic surgeons. These organisations play a central role in the health complaints landscape and are readily accessible to health consumers.

The review is satisfied that effective information-sharing arrangements (including a legislated joint consideration process)[76] currently exist between Ahpra and the Medical Board and the various HCEs to ensure the referral of matters between the agencies and to allow the appropriate organisation to deal with a concern about a registered medical practitioner.[77] However, as has been recommended, Ahpra should improve the amount of information available to dissatisfied cosmetic surgery consumers about available complaint resolution pathways. This will require further engagement with the HCEs about their specific treatment of cosmetic surgery complaints.

State and territory laws and requirements about cosmetic surgery

Some states and territories have placed restrictions or requirements on the provision of cosmetic surgery in their jurisdiction. In some jurisdictions, the law requires that some cosmetic surgical procedures be performed in licensed facilities. However, these requirements are unique to each jurisdiction and are not necessarily consistent across Australia.[78] In addition, regulations do not necessarily stipulate which practitioners must perform certain procedures.

For example, since 2008, Queensland has prohibited the performance of cosmetic procedures on children, unless it is in the 'best interests of the child'.[79] Also in Queensland, regulations prescribe that certain surgical procedures such as breast augmentation or reduction, liposuction (specified volume), abdominoplasty and various implants, must be performed in certain facilities such as a day hospital.[80]

New South Wales regulation requires that cosmetic surgery involving general or other defined anaesthesia and certain cosmetic surgery procedures (regardless of type of anaesthesia) such as breast augmentation, liposuction (specified volume) and abdominoplasty must be performed in a licensed private health facility.[81]

In Victoria, surgical procedures involving general or high dose local anaesthesia and liposuction procedures involving removal of 200 ml or more of lipoaspirate must be performed in a registered hospital or day procedure centre.[82]

In the Australian Capital Territory regulation requires that defined cosmetic procedures only be performed in licensed hospitals or day procedure facilities approved to perform public health risk procedures.[83]

In addition, some states have provisions in state legislation about lotteries, which prohibit offering cosmetic surgical procedures as a prize or reward. For example, New South Wales includes in its definition of 'prohibited prizes' the 'provision of cosmetic surgery or other similar procedure the main purpose of which is to improve personal appearance or self-esteem.'[84]

Regulation of private health facilities

Many of the private facilities where cosmetic surgery is performed are licensed by state and territory health authorities. State and territory licensing laws require these facilities to meet a

[76] Section 150 of the National Law.

[77] This was also confirmed by the submission made by the OHO.

[78] Appendix H details the arrangements in place in each state and territory.

[79] *Public Health Act 2005* (Qld) div 11 ch 5A.

[80] *Private Health Facilities Regulation 2016* (Qld) reg 3(2).

[81] *Private Health Facilities Regulation 2017* (NSW) regs 3–4.

[82] *Health Services (Health Service Establishments) Regulations* 2013 (Vic) reg 6(c)(i) and (v).

[83] *Public Health (Health Care Facility) Code of Practice* 2021 (No1) (ACT) s3.2; *Public Health (Health Care Facility) Risk Declaration* 2021 (No1) (ACT) sch 1.

[84] *Lotteries and Art Unions Act 1901* (NSW), see definition of 'prohibited prize' in section 2A.

range of standards, including infection control, resuscitation and other clinical infrastructure, and credentialling and scope-of-practice processes for clinical staff working in them.

State and territory authorities are also responsible for compliance and enforcement of these licensing laws, including inspections and removal of licences for those found to be significantly breaching standards.

Private hospitals are also licensed in each state and territory.

National standards for accreditation of health facilities

The Australian Commission on Safety and Quality in Health Care (ACSQHC) leads and coordinates national improvements in health care safety and quality. Key functions of the ACSQHC include developing national safety and quality standards, including the National Safety and Quality Health Service (NSQHS) and National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards and implementing national model accreditation schemes, such as the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.

The primary aim of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision. The ACSQHC expects that all services, including practices providing cosmetic surgery and cosmetic medicine, comply with either the NSQHS or NSQPCH Standards.

The AHSSQA Scheme provides for the national coordination of accreditation processes. The awarding of accreditation is intended to provide assurance to the community that an accredited health service organisation meets expected patient safety and quality standards and the necessary systems and processes are in place to reduce the risk of harm to patients.

All public and private hospitals and day procedure services are required to be accredited to the NSQHS Standards.

Of particular relevance, is the Clinical Governance Standard (standard one), in both the NSQHS and NSQPCH Standards. The standard requires that organisations' safety and quality systems ensure that patient safety and quality incidents are recognised, reported and analysed, and used to improve the care provided.[85]

Regulation of medicines and medical devices

Cosmetic surgery usually involves medicines and, in some cases, medical devices, which are regulated by the Therapeutic Goods Administration (TGA). The TGA is responsible for national regulation of the supply, import, export, manufacturing and advertising of therapeutic goods (medicines and medical devices) to ensure they are safe and fit for their intended purpose.

In its submission to the review, the TGA highlighted that the regulation of therapeutic goods is complex and involves:

- **Premarket approval required**: Therapeutic goods must be entered in the Australian Register of Therapeutic Goods (ARTG) before they can be lawfully imported, exported, supplied or advertised in Australia.
- **Risk-based regulation**: Therapeutic goods are regulated by examining evidence of their risks and comparing that to the evidence associated with their benefits. The identified level of risk determines: the amount and type of information needed for review, the degree of scrutiny necessary before the product can be made available in Australia and the level of safety monitoring once it is available. This risk-based approach to regulation allows greater effort to be directed to those therapeutic goods which pose greater risks to a patient's health.

[85] The Clinical Governance Standard requires organisations to meet four key criteria: governance, leadership and culture; patient safety and quality systems; clinical performance and effectiveness; and safe environment for the delivery of care. As per the standard, organisations' approach to delivering and supporting clinical care should include: developing policies, procedures and protocols; monitoring and reporting clinical performance; managing clinical risk; managing and reporting adverse events, including reporting on sentinel event; managing complaints and compliments; managing open disclosure; and engaging clinicians in planned, systematic audits of clinical services following agreed protocols and schedules.

- **Oversight of manufacturing**: *The Therapeutic Goods Act 1989* also requires [...] that manufacturers of therapeutic goods hold a licence (for medicines and biologicals) or a conformity assessment certificate (for medical devices). Manufacturers of therapeutic goods are regularly inspected by TGA or comparable overseas regulators to ensure ongoing compliance with manufacturing requirements.
- **Post-market monitoring**: Once therapeutic goods receive approval for supply, they are subject to ongoing monitoring to evaluate safety and efficacy. A key mechanism in this monitoring is adverse event reporting. All health professionals are encouraged to report adverse events, which include serious or unexpected reactions to medicines and serious medicine interactions, faults or problems with medical devices that have resulted, or could have resulted, in adverse events. An adverse event is not always caused by the therapeutic good itself. For example, an adverse event could be a result of incorrect [use] or other circumstances such as two properly functioning devices that do not operate as intended when used together.
- **Advertising**: Advertising of therapeutic goods is also regulated by the TGA. This is in addition to advertising restrictions under Ahpra requirements or other regulatory regimes, such as Australian Consumer Law, [overseen by the Australian Competition and Consumer Commission (ACCC) and the state and territory consumer protection agencies].
- **Compliance**: The TGA monitors, and enforces where necessary, compliance with the legislation, regulations, and rules for therapeutic goods; import, manufacture, advertising, supply, and export. The TGA promotes high levels of voluntary compliance by effectively engaging with and educating the regulated community, and works with other government bodies, including health and law enforcement agencies, to share information about therapeutic goods. A range of compliance actions are available to the TGA, ranging from educational activities to criminal prosecutions.[86]

Other laws

There are a range of other Commonwealth and state and territory laws which have implications for aspects of the cosmetic surgery sector and provide protections for consumers.

The Competition and Consumer Act 2010 (Cth) promotes competition and fair trading and consumer protection. In Schedule 2 it sets out the Australian Consumer Law, which prohibits conduct that is misleading or deceptive. The Australian Consumer Law[87] includes:

- core consumer protection provisions prohibiting misleading, deceptive or unconscionable conduct, and protecting consumers from unfair terms in standard form consumer contracts
- consumer guarantees that apply to services (for example, that they must be provided with acceptable care, skill and technical knowledge).

The Australian Consumer Law is administered by the Australian Competition and Consumer Commission (ACCC) and the state and territory consumer protection agencies and action can be taken in a range of Australian courts and tribunals.[88] The ACCC's website provides information on who to contact for consumer help.[89]

In addition, there are laws relating to negligence, civil liability and criminal law which apply to the cosmetic surgery sector.

All registered health practitioners and other health workers in Australia have a duty of care to avoid causing reasonably foreseeable harm. A breach of that duty may constitute negligence.

[86] Therapeutic Goods Administration, Response to the Independent review of the regulation of health practitioners in cosmetic surgery, May 2022.

[87] Australian Government, *Australian Consumer Law: A Framework Overview*, July 2013, accessed 23 February 2022.

[88] Australian Consumer Law, *The Australian Consumer Law*, accessed 27 July 2022.

[89] Australian Competition and Consumer Commission, *Where to go for consumer help*, accessed 26 July 2022.

States and territories have civil liability legislation under which claims for compensation for loss or harm arising from the negligence of a health professional or other health worker may be made and assessed. In most jurisdictions, the legislation provides that a medical practitioner will not have been negligent if he or she performed a procedure, or provided a treatment, in accordance with what is widely held by a significant number of respected practitioners in the relevant field to be competent practice.[90]

Criminal law may be used to hold health professionals accountable for criminal acts against their patients. They may also face criminal charges for negligent acts or omissions.

Stakeholder feedback – Submissions

Approximately 25 submissions commented on the issue of cooperation with other regulators. Around half of these believed that there are no barriers to effective information flow between Ahpra, the Medical Board and other regulators, while the remaining half stated that there are barriers to effective information flow (however, the majority of these submitters may have limited direct experience of these information flows).

Organisations likely to have had direct experience of working with Ahpra and the Medical Board generally stated that cooperation between regulators is cooperative, largely effective and for the most part information is shared appropriately and in a timely way. A few of these organisations pointed to some ad hoc issues that have been experienced in the sharing of information and stated that there may be opportunities to improve these processes.

Suggestions for improvement included the need to work together to clarify the respective roles and responsibilities of different regulators and develop joint models for investigating complaints and notifications.

The TGA said:

> *Issues around clinical practice may be identified through the TGA's post market and compliance activities, and this is conveyed to Ahpra on an ad hoc basis where issues are identified. Reciprocal advice of therapeutic goods issues identified in the context of Ahpra investigations is also helpful. Similarly exchange on advertising issues also takes place on an ad hoc basis.*

Observations and analysis

As has been discussed above, having a detailed working understanding of the roles and responsibilities of other regulators in this space is essential to ensure the most effective regulatory response to a notification.

For example, a notification received about a medical practitioner who performed an invasive procedure in their consulting rooms, is likely to breach the facility licensing legislation in several jurisdictions. Such conduct on the part of the practitioner would be of interest to that relevant state facility licensing regulator and the allegation that the practitioner is breaching the relevant state law is very pertinent to the Medical Board's handling of the notification.

In the high-volume notifications environment where staff are under the pressure of managing competing priorities, it is not efficient or feasible to have to research these jurisdictional matters each time a certain type of notification is received. It is also risky to rely on the individual expertise of staff (which may vary depending on their experience and previous exposure to such matters).

While the review found no strong evidence of deficits in this space, there were some indicators that suggested more could be done. Having regard to the lack of a standardised approach to assessing cosmetic surgery notifications, the review does not have confidence that all individual Ahpra staff involved in these matters understood the roles and responsibilities of the numerous regulatory agencies in this space and could therefore, either seek the correct information from those regulators, refer the matter to the correct place or fully understand the relevance of such matters to the assessment of the notification.

[90] See example *Civil Liability Act 2002* (NSW) s50. See also *Wrongs Act 1958* (Vic) s59(1).

Ahpra also currently does not have internal guidance material that clearly maps the various regulatory agencies, their roles, responsibilities and general powers in the cosmetic surgery sector. Given the complexity of the landscape, relying on individual expertise and not capturing that corporately is a recipe for missed opportunities. The complexity demands clear, documented guidance that is available to all staff who may be involved in managing notifications. This indicates that there are opportunities to improve the flow of information between regulators at national, state and territory levels.

Recommendations

8. Building on the work undertaken by the review:
    a) Ahpra identify and clearly map the roles, responsibilities and powers of each regulator in the cosmetic surgery sector (including on a state-by-state basis) and produce a corporate document available to relevant staff; and
    b) Once the mapping exercise is completed, Ahpra identify where any improvements are required to enhance the flow of information between these relevant regulators, including for example, identifying key contacts and/or where necessary entering into a memorandum of understanding or other agreement.

Chapter 3: Advertising Regulation

Introduction

A number of features unique to the cosmetic surgery sector suggest that advertising poses risks not present in the advertising of many other areas of medical practice. As has been discussed in Chapter 1, there is a lack of objective and unbiased information about the training and qualifications of practitioners in this sector, and cosmetic surgery lacks the protective measures found in other parts of the health system that inform consumers and direct them to qualified practitioners. The entirely elective nature of cosmetic surgery means that advertising plays a significant role in creating a desire or demand for these services which tends to distinguish it from other areas of health advertising. Finally, social media is extensively used as a tool to reach and influence consumer choice. All these factors combined raise concerns about the impact of cosmetic surgery advertising and the need to ensure that it is well regulated.

Recent media reporting has shone a spotlight on some very concerning alleged conduct of a small number of practitioners, raising concerns about the use of aggressive and inappropriate social media marketing techniques.

As will be discussed in this chapter, academic literature and previous reviews have identified the potential for cosmetic surgery advertising to mislead, noting that its primary intention is to sell, not educate. Submissions to this review have been highly critical of the advertising approach of some practitioners in this space and have called for Ahpra and the Medical Board to do more. Consumer research undertaken as part of this review highlights the potential reach and influence of advertising in this sector and on the ability of consumers to make informed choices.

Within the context of cosmetic surgery advertising, this chapter examines Ahpra and the Medical Board's powers, their use of relevant codes and guidelines, and their approach to compliance and enforcement (including Ahpra's *Advertising compliance and enforcement strategy for the National Scheme* (the Strategy)). The review makes recommendations in this area directed towards ensuring that the various risks posed by advertising conduct in the cosmetic surgery sector are appropriately categorised under the strategy so that stronger enforcement action is taken in high-risk matters.

The review further recommends that Ahpra:

- obtain legal advice specifically about the application of section 133(1)(e) of the National Law with respect to advertising that may encourage the 'indiscriminate or unnecessary' use of health services and the extent to which it may effectively prohibit forms of advertising of cosmetic surgery
- undertake a targeted audit of cosmetic surgery advertising to inform the design of future proactive auditing
- examine the use of technology to assist in advertising auditing/monitoring
- enhance the guidance to practitioners in this industry, including by providing specific examples of advertising that is considered inappropriate.

Ahpra and Medical Board's powers and responsibilities

Ahpra and the Medical Board's potential influence on cosmetic surgery advertising comes from the following interrelated key regulatory provisions and/or activities provided for in the National Law, namely:

- the existence of an advertising offence in the National Law (section 133)
- the power to issue guidance to practitioners (in the form of codes and guidelines) about advertising
- the power to take enforcement action about a breach, including prosecuting an advertiser for a breach of the advertising offence provision or taking disciplinary action against a practitioner for advertising conduct that falls short of the standards established in the codes and guidelines.

The advertising offence

Section 133(1) of the National Law states:

> *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that:*
>
> a) *is false, misleading or deceptive or is likely to be misleading or deceptive; or*
> b) *offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or*
> c) *uses testimonials or purported testimonials about the service or business; or*
> d) *creates an unreasonable expectation of beneficial treatment; or*
> e) *directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.*
>
> *'**regulated health service**' means a service provided by, or usually provided by, a health practitioner.*

Section 133 applies to any material advertising a regulated health service, including practice and practitioner websites or advertising through social media. A 'regulated health service' is defined as 'a service provided by, or usually provided by, a health practitioner'. Breaches of section 133 are prosecuted in the Local or Magistrates Court of the state/territory where they were allegedly committed and can incur financial penalties of $5,000 for each advertising offence for an individual and $10,000 for a body corporate.[91] The criminal standard of proof applies to prosecutions under this section, namely the case has to be proven beyond reasonable doubt.

Given the entirely elective nature of cosmetic surgery, the operation of section 133(1)(e) as it relates to advertising that encourages the 'indiscriminate or unnecessary' use of health services will be discussed in the 'analysis and observations' section of this chapter.

Codes and guidelines

The National Law empowers the Medical Board to develop and approve codes and guidelines that provide guidance to health practitioners registered in the profession.[92] Expectations and obligations established for practitioners who advertise a regulated health service are detailed in these documents.

Codes and guidelines are not enforceable rules that can provide a basis for prosecution or disciplinary action merely because a provision is breached. They are more general in their application and set out the standards of ethical and professional conduct the Medical Board expects of medical practitioners. They are used by the Medical Board and other regulators to evaluate a practitioner's conduct and to seek to determine whether a practitioner's conduct has met a required standard. Codes and guidelines are also admissible in proceedings under the National Law as evidence of what constitutes appropriate professional conduct or practice.[93]

Three publications have been issued that govern health service advertising and these are:

- Medical Board's *Good medical practice: a code of conduct for doctors in Australia*
- Medical Board's *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* (Cosmetic Guidelines)
- Ahpra and National Board's *Guidelines for advertising a regulated health service* (Advertising Guidelines).

The Medical Board's *Good medical practice: a code of conduct for doctors in Australia* provides that advertising must comply with relevant consumer protection legislation, therapeutic goods legislation, the advertising provisions in the National Law and the Advertising Guidelines issued by the Medical Board.[94] It further states that:

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[91] In 2019, Health Ministers announced their intention to increase the maximum penalty for breaching advertising restrictions from $5,000 for an individual and $10,000 for a body corporate to $60,000 for an individual and $120,000 for a body corporate. This is subject to approval and passage of an Amendment Bill.

[92] Section 35(1)(c) and section 39 of the National Law.

[93] Section 41 of the National Law.

[94] Medical Board of Australia, Good medical practice: a code of conduct for doctors in Australia, 2020, accessed 29 June 2022.

Good medical practice involves:

10.7.1 Making sure that any information you publish about your medical services is factual and verifiable

10.7.2 Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients

10.7.3 Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations

10.7.4 Not offering inducements or using testimonials

10.7.5 Not making unfair or inaccurate comparisons between your services and those of colleagues.

The Medical Board's Cosmetic Guidelines[95] contain specific provisions on advertising. In addition to reiterating the need to comply with relevant provisions of other codes and guidelines that pertain to advertising, they stipulate that:

10.2 Advertising content and patient information material should not glamorise procedures, minimise the complexity of a procedure, overstate results or imply patients can achieve outcomes that are not realistic

[…]

12.3 The medical practitioner should not provide or offer to provide financial inducements (for example, a commission) to agents for recruitment of patients.

Additionally, the Advertising Guidelines[96] were developed to help advertisers to understand their obligations when advertising a health service and issued in 2020. These guidelines explain the various elements of section 133 in the National Law, including through the use of examples.

The Advertising Guidelines cover many topics and provide expanded detail about issues that appear relevant to cosmetic surgery advertising. Table 6 provides some examples of this relevant content from the guidelines which may be relevant to cosmetic surgery advertising.

Table 6: Extracts from the Guidelines for advertising a regulated health service

Topic area	Extract from the Advertising Guidelines
4.1 False, misleading or deceptive advertising	• misleads, either directly or by implication through the use of emphasis, comparison, contract or omission • provides partial information and/or omits important details • makes statements about the effectiveness of the treatment that are not supported by acceptable evidence • minimises, underplays, or under-represents the risk or potential risk associated with a treatment or procedure • makes claims about providing a superior regulated health service.
4.4 Advertising that creates an unreasonable expectation of beneficial treatment	• creates an unreasonable expectation of outcomes or recovery time after providing a regulated health service • overstates the potential benefit of a treatment • minimises the complexity of risk associated with a treatment (i.e. using words or phrases such as 'safe', 'effective', 'risk-free', 'pain-free') without acknowledging possible adverse reactions or mixed/inconclusive evidence for the treatment • contains a claim, statement or implication that is likely to create an unreasonable expectation of beneficial treatment by: o either expressly, or by omission, indicating that the treatment is infallible, unfailing, magical, miraculous or a certainty, guaranteed or sure cure o stating that the practitioner has an exclusive or unique skill or remedy that will benefit the patient o uses photos or images of unrealistic outcomes.

[95] Medical Board of Australia, *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*, 2016, accessed on 29 June 2022.

[96] Ahpra and National Boards, *Guidelines for advertising a regulated health service*, 2020, accessed 8 August 2022.

4.4.1 Images and photographs	• Care should be taken when using graphic or visual representations in advertising of regulated health services to ensure they do not create an unreasonable expectation of benefit as the outcomes experienced by one person do not necessarily reflect the outcomes that other people may experience • Advertising may be in breach of this section of the National Law if [...] images are not genuine and/or have been edited or enhanced • Care should be taken when using 'before and after' images in advertising a regulated health service as they have the potential to be misleading or deceptive. These images may cause a member of the public to have unreasonable expectations of a successful outcome • Use of 'before and after' images are less likely to be misleading if: o the images are as similar as possible in content, camera angle, background, framing and exposure o the posture, clothing and make-up is consistent o the lighting and contrast is consistent o there is an explanation if images have been altered in any way o the referenced treatment or procedure is the only visible change to the person being photographed.
4.5 Encouraging the indiscriminate or unnecessary use of a regulated health service it states	• Encouraging the unnecessary and indiscriminate use of a regulated health service can lead the public to buy or use a regulated health service they do not need and is not clinically indicated or provides no therapeutic benefit. Any health intervention involves inherent risks, so encouraging the use of regulated health services which is not based on clinical need or therapeutic benefit is not in the public interest • Advertising may be unlawful when it [...] uses incentives such as prizes, discounts, bonuses, gifts that would encourage people to use services regardless of clinical need or therapeutic benefit. If the value of the prize greatly outweighs the cost and risk of the treatment to the person, it may encourage them to use a regulated health service regardless of clinical need or therapeutic benefit.

The guidelines also provide information about title use, title and endorsement protection and claims about competence and qualifications.[97]

Finally, the guidelines also deal with the prohibition against the use of testimonials (provided for in section 133(1)(c)) noting that 'patient stories and experiences, success stories, or fake testimonials' are all not permitted. There are currently proposed amendments before the Queensland Parliament which seek to remove the ban on testimonials. This issue will be discussed later in this chapter.

A significant amount of supporting material is published on the Ahpra website for practitioners, including examples of compliant and non-compliant advertising, a self-assessment tool, guides on understanding testimonial requirements and using titles, and FAQs.[98] However, no specific cosmetic surgery advertising examples are provided in this material.

Enforcement

Having set standards for practitioners about advertising and having explained the operation of section 133 of the National Law, the question arises as to how Ahpra and the Medical Board enforce compliance in this area?

Ahpra's enforcement strategy

Ahpra's approach is set out in their published Strategy[99] which outlines how Ahpra and the Medical Board monitor and seek to enforce compliance with the National Law's advertising requirements. The Strategy applies to anyone who advertises a regulated health service, which includes

[97] See 4.1.4

[98] See the Ahpra *Advertising Hub*

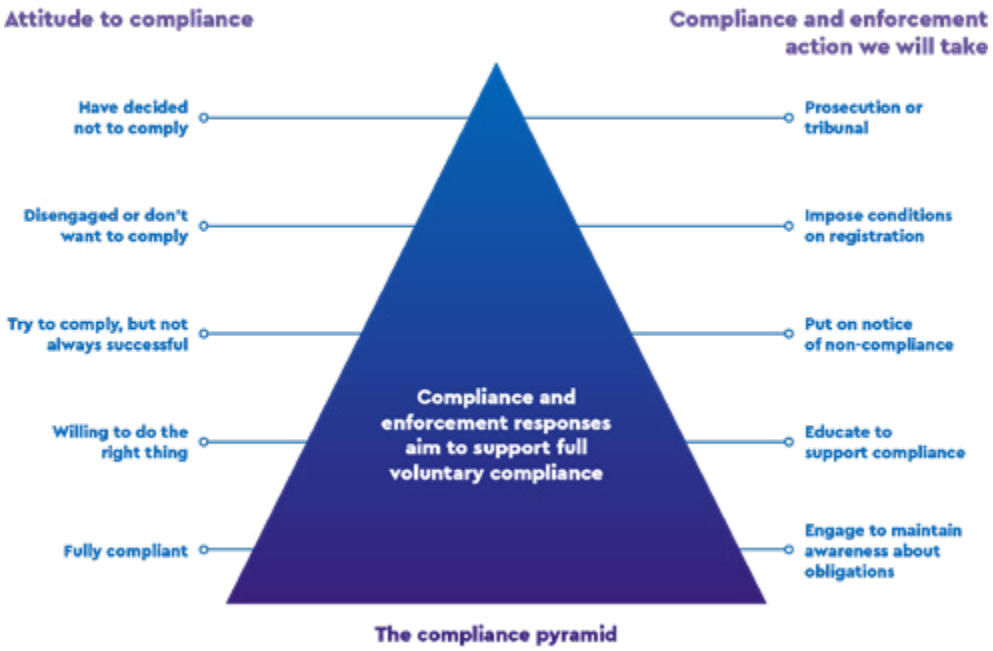
[99] Ahpra, *Advertising compliance and enforcement strategy for the National Scheme*, 2020, accessed 18 July 2022.

registered health practitioners; individuals who are not registered as health practitioners, and businesses, partnerships and corporate entities.

As is discussed below, most cases start with Ahpra writing to the advertiser to let them know their advertising breaches the National Law, providing them with educational resources, and requiring them to correct it within 30 days. Much of the focus is providing assistance and encouragement to the advertiser to seek to obtain voluntary compliance through education.

The Strategy is based around five key regulatory principles being: risk-based; targeted; proportionate; transparent; engaged. The Strategy utilises a regulatory pyramid approach (see Figure 7 below) that uses compliance attitude to inform compliance and enforcement action.

Figure 7 Regulatory pyramid – extract from the Advertising compliance and enforcement strategy



The approach is based on the assumption that 'most people are willing or trying to do the right thing'.[100]

On this point the Strategy further states:

> *We know that most health practitioners want to comply with their professional obligations, and most people (including advertisers who are not registered health practitioners) want to comply with the law. The focus of our strategy is to make compliance easier for those who are willing to do the right thing. We recognise some people need more help than others to comply, and we will target activities to help this group achieve compliance.*[101]

The Strategy also acknowledges that not all advertisers/practitioners fall into the above category, stating:

> *We also recognise that there are a small number of people, both practitioners and other advertisers, who will need more incentives to comply. This is where we target our enforcement action.*[102]

[100] Page 7

[101] Page 8

[102] Page 8

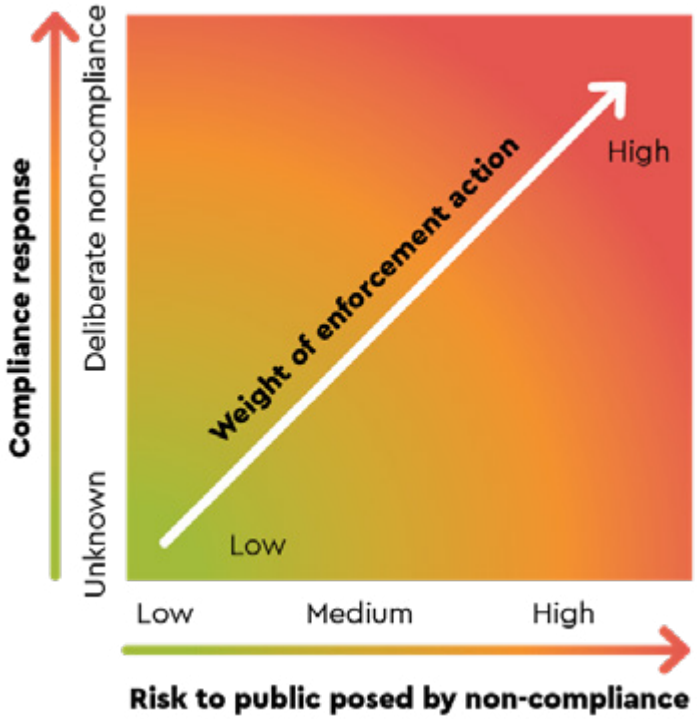
In addition to attitude to compliance, the Strategy also factors in the risk posed by the advertising conduct. High-risk matters that may warrant a more forceful response are those that may pose potential or actual harm. Relevant to cosmetic surgery advertising, the Strategy identifies the following types of matters that may be categorised as high risk:

- *raise concerns of actual harm to consumers*
- *target vulnerable groups [...]*
- *are widespread in a profession, and have potential to have significant adverse impacts on health care choices.* [103]

In essence the Strategy requires that regulatory action 'will escalate depending on the ongoing assessment of risk and the response of the advertiser' (as is detailed in Figure 8). As will be discussed later in this chapter, the Strategy also notes that:

> *Depending on patterns of advertising, there may be a need for an escalated approach on specific topics or in particular professions.*[104]

Figure 8: Ahpra's approach to enforcement action - extract from the Advertising compliance and enforcement strategy



The Strategy notes that the more forceful enforcement tools available under the National Law include the power to:

- investigate a practitioner's conduct
- impose conditions on the practitioner's registration such as restricting their ability to advertise their services
- take disciplinary action against a registered health practitioner in a panel or tribunal, and/or
- prosecute an advertiser of a regulated health service (which may be a registered health practitioner, another person or a business).

[103] Page 8
[104] Page 9

The table below outlines how the Strategy is intended to operate in practice, or more precisely, the action that is to be taken based on the risk and/or compliance response of the advertiser/ practitioner.

Table 7: Extracts from the Advertising compliance and enforcement strategy

Risk type/compliance response	Action
Low risk + no previous complaint	Write to advertiser to advise that their advertising is non-compliant and provide resources to help them comply with the National Law with a 30-day timeframe for amendment. Follow-up review undertaken. If issues still exist, secondary notice issued to registrant advising issues remaining and provision of a further 30 days to rectify and inform registrant their advertising will undergo a further, more comprehensive review. Case remains open until registrant becomes compliant, or conditions proposed/imposed due to non-compliance/non-engagement with requests.
Medium risk + no previous complaint	Write to advertiser to advise that their advertising is non-compliant and provide resources to help them comply with the National Law with a 30-day timeframe for amendment. Follow-up review undertaken.
Medium risk + advertising not corrected or History of non-compliant advertising (including low risk)	The practitioner will receive a show cause letter proposing to impose conditions on their registration restricting the practitioner's ability to advertise their services, and providing a further timeframe to amend their advertising. If the practitioner's advertising is not rectified, the conditions will be imposed and before they are removed, the practitioner will need to demonstrate their understanding of the advertising requirements. Continued non-compliance after the imposition of conditions may result in referral to a tribunal.
High risk	Certain high-risk matters will be identified as suitable for prosecution or disciplinary action from the outset.

Advertising complaints

Ahpra has the ability to receive complaints about alleged advertising breaches. According to Ahpra's *2020/21 Annual Report*, 386 complaints were received about advertising.

A specific PDF form titled *Criminal offences form – Complaints about practice and title protection and advertising* is available on Ahpra's website. Complainants are also advised that they may telephone Ahpra's 1300 number for further information.

The review was advised that all complaints received are assessed and triaged against the Advertising Guidelines in accordance with the principles and approach outlined in the Strategy. An initial assessment is conducted of the advertising to determine if it is low, medium or high risk with each case being assessed individually. When assessing advertising risk, consistent with the Strategy, key considerations are: number of breaches present, nature of the content, the types of claim made, complaints history, and compliance.

The review was advised by Ahpra that it has received very few complaints about cosmetic surgery advertising and had not received complaints about the matters subject to recent media reporting.

Audit/monitoring

Historically Ahpra has relied upon complaints to identify inappropriate or unlawful advertising. However, the review was advised that Ahpra is currently working through a proactive audit of a random sample of approximately 100 medical practitioners (not specific to cosmetic surgery) as part of an audit of all health professions over a two-year period, to determine each practitioner's compliance with the Advertising Guidelines. The audit covers all aspects of a registrant's advertising and may include:

- all websites
- all social media accounts, such as YouTube, Instagram, Facebook and TikTok
- LinkedIn
- practitioner review/source websites such as WhiteCoat and Google Reviews
- podcasts and TedX streaming.

Consistent with the approach detailed in the Strategy, registrants identified as having potentially non-compliant advertising are provided with examples of where their advertising is non-compliant and an explanation of why it is considered non-compliant with reference made to any relevant sections of the National Law.

The enforcement approach detailed above is then applied (including providing the registrant the opportunity to remedy the breach).

The review was advised that to date, a Board has not needed to impose conditions 'on a registrant's registration due to failure to correct advertising'. The review was also advised that of the cases closed in 2021/22 financial year there were 97 instances of practitioners correcting their advertising following a formal proposal to take regulatory action by imposing conditions. There were no instances where conditions were imposed.

Allied Health registrants renewing registration since October 2020, have been required to declare that any advertising is compliant with section 133 of the National Law and the Board's Advertising Guidelines. The renewal declaration for medical practitioners has been implemented for the 2022 renewal period.

Prosecutions and disciplinary proceedings about advertising breaches

While a breach of section 133 is a criminal offence for which a court may impose a monetary penalty, the Strategy provides:

> *[...] if a registered health practitioner breaches the advertising offence provisions of the National Law there are other enforcement approaches available. A breach of the advertising offence provisions by a registered practitioner is also a breach of the National Board's Advertising Guidelines and code of conduct, so the practitioner's conduct is grounds for disciplinary action in relation to their registration. This is a core aspect of our enforcement approach.*

Prosecutions appear to be used sparingly. The review was advised that to date there have only been five prosecutions by Ahpra under section 133 of the National Law. None related to cosmetic surgery matters.

The review was also advised that it is rare for disciplinary action against practitioners to be referred by National Boards to a state/territory tribunal for determination where advertising conduct is the only issue. Indeed, Ahpra's website includes a page titled Advertising cases heard by courts and tribunals which lists only five advertising disciplinary matters with the most recent being in 2013.

Reviews and research

Previous reviews of cosmetic surgery have raised concerns about aggressive and inappropriate advertising and marketing techniques. For example, a 1999 review[105] identified a number of practices that may be in breach of professional standards and fair-trading laws including: use models that imply the model has had the procedure or that the procedure can achieve that result; enhanced 'before and after' photos; statements that minimise the risk and discomfort of a medical procedure and claims that exaggerate the benefits of procedures.

A 2011 review[106] found:

> *[Cosmetic surgery] advertising and promotion, direct and indirect, is pervasive, transcends State borders and appears across the spectrum of print and electronic media. The internet has opened up further promotional opportunities and potentially another audience and market.*[107]

A 2013 UK review[108] noted that while advertising in this sector may have some legitimate functions '[...] they can also play a negative role particularly if they trivialise the risks of procedures, target vulnerable consumers, or mislead by portraying an outcome that may not be attainable for many'.

[105] Health Care Complaints Commission (HCCC), *The Cosmetic Surgery Report – Report to the NSW Minister for Health*, HCCC, 1999.

[106] Australian Health Ministers' Conference (AHMC), *Cosmetic Medical and Surgical Procedures – A National Framework*, AHMC, 2011.

[107] Australian Health Ministers' Conference (AHMC), *Cosmetic Medical and Surgical Procedures – A National Framework*, AHMC, 2011, p38.

[108] NHS Choices, The Keogh Mortality Review, for more information see https://www.england.nhs.uk/2013/12/sir-bruce-keogh-7ds/.

Academic literature on social media advertising of cosmetic surgery is not extensive, but it confirms the widespread use of social media to advertise, especially in competitive markets. It also noted that practitioners in this area are likely to be early adopters of technology.[109] The literature confirms that social media advertising tends to emphasise the benefits of cosmetic surgery and tends to minimise risks and that there is significant potential for healthcare advertising to mislead with the primary intention of advertising to sell, not educate the consumer.[110]

Social media and social networking are the most popular use of the internet among young people aged 16 to 24 years and adults aged 25 to 34 years. Research consistently demonstrates that the increasing incidence of body dysmorphia and body image concerns, eating disorders and mental health problems, particularly amongst young women, may be related to the increased use of social media.[111] At the same time, body image, self-esteem and the social environment are key factors driving the desire for cosmetic surgery. It is no surprise, then, that increased social media use appears to correlate with the increase in the number of young adults having cosmetic surgery.[112]

The use of social media to target advertisements to consumers through digital advertising technology services (also called 'ad tech') has been of growing concern, both nationally and internationally. While it is not within the power of Ahpra or the Medical Board to directly influence the conduct of ad tech providers, the targeting of advertising of particular groups is identified as an issue in the cosmetic surgery sector. Targeting of advertising through ad tech has also come to the attention of the ACCC, which in 2020 and 2021, undertook an inquiry into markets for the supply of ad tech services.[113]

Internationally, other jurisdictions also appear to face the challenges of effectively regulating cosmetic surgery advertising. Regulators in other countries have issued guidance similar to that produced by Ahpra and the Medical Board which covers such matters as misleading advertising including the use of before and after images, the trivialisation of treatment and targeting of advertisements for cosmetic procedures and how doctors should advertise their services.[114]

[109] CK Wheeler, H Said, R Prucz, RJ Rodrich, DW Mathes, 'Social Media in Plastic Surgery Practices: Emerging Trends in North America', *Aesthetic Surgery Journal*, 2011, 31(4):435–441, doi.org/10.1177/1090820X11407483, accessed 6 July 2022.

[110] A Holden, S Nanayakkara, J Skinner, H Spallek and W Sohn, 'What do Australian health consumers believe about commercial advertisements and testimonials? a survey on health service advertising', *BMC Public Health*, 2021, 21:74, https://doi.org/10.1186/s12889-020-10078-9.

[111] CE Walker, EG Krumhuber, S Dayan and A Furnham, 'Effects of social media use on desire for cosmetic surgery among young women', *Current Psychology*, 2021, 40:3355–3364; M Walker, L Thornton, M De Choudhury, J Teevan, CM Bulik, CA Levinson, S Zerwas, 'Facebook use and disordered eating in college-aged women', *Journal of Adolescent Health*, 2015, 57(2):157–163; B Jiotsa, B Naccache, M Duval, B Rocher, M Grall-Bronnec, 'Social Media Use and Body Image Disorders: Association between Frequency of Comparing One's Own Physical Appearance to That of People Being Followed on Social Media and Body Dissatisfaction and Drive for Thinness', *International Journal Environmental Research Public Health*, 2021, Mar 11;18(6):2880; G Mannino, L Salerno, RC Bonfanti, G Albano, G Lo Coco, 'The impact of Facebook use on self-reported eating disorders during the COVID-19 lockdown', *BMC Psychiatry*, 2021, Dec 7;21(1):611; AG Mabe, KJ Forney, PK Keel, 'Do you "like" my photo? Facebook use maintains eating disorder risk', *International Journal of Eating Disorders*, 2014, 47(5):516–523; S Stronge, LM Greaves, P Milojev, T West-Newman, FK Barlow, CG Sibley, 'Facebook is linked to body dissatisfaction: comparing users and non-users', Sex Roles, 2015, 73(5–6):200–213; EP Meier, J Gray, 'Facebook photo activity associated with body image disturbance in adolescent girls', *Cyberpsychology, Behavior, and Social Networking*, 2014, 17(4):199–206.

[112] CE Walker, EG Krumhuber, S Dayan and A Furnham, 'Effects of social media use on desire for cosmetic surgery among young women'.

[113] The inquiry found that ad tech services are an important part of the digital economy, but the ad tech market is dominated by monopoly providers who have sometimes not acted in the best interest of consumers. As a result of the inquiry, the ACCC is seeking legislative amendments to consumer and privacy laws to provide greater protections for consumers – for example, through stronger requirements for data harvesters to seek permission from consumers before they collect data. The Office of the Australian Information Commissioner is also undertaking related work to strengthen privacy requirements on digital platforms and strengthen protections for vulnerable groups. ACCC, Digital advertising services inquiry: *Final report*, 2021, accessed 13 July 2022.

[114] The Advertising Standards Authority, *Guidance on the marketing of surgical and non-surgical cosmetic procedures*, 2016, accessed 15 June 2022; Medical Council of New Zealand, *Communication & consent*, accessed 15 June 2022.

In November 2021, the two UK standards advertising authorities, the Committee of Advertising Practice (CAP) and Broadcast Committee of Advertising Practice (BCAP) announced new restrictions prohibiting the advertising of cosmetic interventions from being directed at young people aged under-18.[115] These restrictions were introduced in response to growing public health and political concerns about the potential harms of such advertising on children and young people. This is a useful example of action being taken outside of the health regulatory environment to tackle issues in the cosmetic surgery space.

While the approach to cosmetic surgery advertising taken in other countries is similar to that in Australia, in France, all forms and methods of publicity and advertising cosmetic surgery, whether direct or indirect, and in whatever form, including on the internet, are banned. This applies to all French doctors.[116]

Stakeholder feedback

Submissions

The topic of cosmetic surgery advertising elicited many strong responses from submitters to the review. Issues concerning the commercial nature of cosmetic surgery, the use of advertising to glamorise cosmetic surgery, the use of social media as a marketing tool and the targeting of vulnerable people through digital advertising approaches were strong themes in the feedback received from participants in the review. Submitters were asked if the current approach to regulating advertising of cosmetic surgery is sufficient. Around one third of respondents said they believed current regulations are adequate, although a number of these also still raised concerns about such matters as the use of social media for advertising purposes or the current regulatory approach by Ahpra.

A small number of submitters supported greater freedom in advertising, as illustrated by this statement from a medical practitioner:

> *The regulation of advertising is antiquated – as long as providers are not breaching consumer law in their advertising, it is time for Ahpra et al to move on and allow all practitioners to promote their services with the freedom that all other industries are afforded.*

However, the majority of submitters (around two thirds) stated that the current regulatory approach is not adequate and raised concerns about such matters as:

- the use of sexualised and other images which glamorise cosmetic procedures
- the use of social media influencers to market procedures
- the use of social media to promote cosmetic surgery including the difficulty in monitoring social media content that is only temporarily displayed (disappearing content)
- the use of social media by doctors to create 'celebrity' or 'star' status for themselves
- the use of before and after images to enhance the image and the outcome of the procedure, and minimise the complexity and risks associated with it
- the difficulties associated with enforcement of the regulations, particularly in social media, and
- consent procedures for the use of patient images, including the use of 'dual consent' processes where patients are required to consent to the surgery as well as the use of the images and are not given the option to consent only for surgery.

Examples of statements from submitters raising such issues include this statement by ASPS expressing concern:

> *The current approach to regulating advertising in cosmetic surgery is not sufficient and has not been for some time. Advertising by 'cosmetic surgeons' has often been associated with 'soft' pornography, with the use of sexualised images and targeting vulnerable patients with the promise of changing their lives.*

[115] The Advertising Standards Authority, *New targeting rules for cosmetic interventions advertising come into force today*, 2021, accessed 28 June 2022

[116] A Fogli, 'France sets standards for practice of aesthetic surgery', *Clinical risk*, 2009, 15(6): 224-226.

A medical practitioner said:

> *It is difficult to police advertising, as a large proportion occurs via social media and is transient.*

The research and advocacy group, Operation Redress, shared this concern:

> *Too many providers are using hashtags and captions such as #bodygoals, #curveinspo, #bikinibody, #bodyinspo and #summerbody to promote cosmetic surgery. The idea that some human bodies are not Summer-ready for aesthetic reasons is surely not supported by acceptable evidence. Doctors, who are esteemed people in society should not, in our view, be perpetuating the myth that you must look a certain way or be a certain size in order to wear a bikini, or be allowed to enjoy the Summer.*

A medical practitioner shared this concern:

> *There is indirect advertising taking place constantly on [social media] platforms that traditional guidelines do not adequately cover. This especially poses a risk to the adolescent population group as I found in my personal practice that there were many 18-year-olds seeking [non-surgical] procedures as soon as they could legally do so.*

A medical practitioner said:

> *There needs to be greater scrutiny of social media and YouTube advertising, [which] often flies under the radar.*

A consumer shared their experience:

> *Many women like me believe what we see on social media and place our trust in doctors who don't necessarily have our best interests at heart. I feel stupid and ashamed that I fell for the sales and marketing tactics but was thorough in my research.*

Concerns were also voiced about the use of marketing algorithms by the big technology companies to target vulnerable people with advertising based on their search history encouraging them to have cosmetic surgery. As will be discussed below, this was a matter of particular concern to some participants in the focus groups.

Submitters made a number of suggestions for improvement, including:

- having more specific advertising guidelines for cosmetic surgery, which require advertisements to include the practitioner's qualifications
- using specific examples in the guidelines to illustrate what is and what is not acceptable advertising in cosmetic surgery
- banning the use of filters and other photo or video editing of patient images
- requiring warnings to be placed on advertisements about the risks of procedures.

Concern was also raised about the use and storage of before and after photos used in advertising that would often be of an intimate nature. Clear consenting documentation should be obtained from patients outlining exactly how the images will be used and where they will be stored. Storage of the images on a practitioner's mobile telephone was rightly seen as unacceptable.

A small number of submissions went so far as to suggest banning all advertising on social media platform. One medical practitioner submitter suggested:

> *Social media and celebrity TV networks and shows should be banned as a means of advertising for all medical practitioners to advertise their medical practice. This type of advertising demeans medicine in general and appears to diminish the risks associated in cosmetic surgery.*

One health practitioner submitter suggested:

> *More specific guidelines could be given in relation to new technologies available through Instagram and Tiktok where cosmetic surgeries are now being advertised. For example, the use of filters, emojis and other forms of photo or video editing should be restricted on posts relating to cosmetic surgery, as this trivialises the procedures, minimises the risks, and exaggerates the benefits[...]The use of before and after photos should be banned or heavily regulated as these often exaggerate the benefits or are subject to other external factors which may contribute to the difference in the photos, beyond the surgery or treatment being advertised. The posts should be age restricted to prevent young people being exposed to this content.*

A number of submissions suggested that Ahpra needs to adopt a more proactive approach to investigating potential breaches of the Advertising Guidelines. There is consistent perception that the current approach is based on self-regulation and driven by complaints. Respondents suggested that Ahpra should be more proactive in auditing compliance with the Advertising Guidelines, rather than waiting until a complaint has been lodged. While it was acknowledged that the monitoring and auditing of advertising would require substantial resources, it was suggested that the regulation of advertising needs to be flexible and responsive and must keep up with the rapid changes in online and social media advertising. These views are illustrated by the following extracts from submissions.

The Australasian Foundation for Plastic Surgery said:

> *Current regulation and guidance is widely perceived as having no 'teeth' and isn't a massive deterrent to unhelpful advertising.*

Maurice Blackburn Lawyers said:

> *[Ahpra's current] strategy very much relies on members of the public having an awareness of, for example, misleading claims and, once recognised, taking the next step of reporting them. This is one area where we would like to see Ahpra taking more proactive steps to inform themselves of problematic advertising practices – particularly on easily accessible social media platforms.*

Consumer survey

The influence of advertising on consumers' choice of a doctor is further illustrated by the responses to the consumer survey.

When asked 'How did you/would you find a doctor?', searching online was the third highest response category behind recommendations from a GP or other doctor and recommendations from family and friends. A total of 37%[117] of all respondents said they had used an internet search to find a medical practitioner to perform cosmetic surgery. A further 17% said they had found a doctor via social media (looking at the doctor's social media accounts) and 17% looking at the doctor's website.

The influence of online sources was even higher for survey respondents who had had cosmetic surgery and indicated they were not happy with the surgery. These patients had been most likely to find a doctor:

- through an online search (42%)
- from the doctor's social media account/s (for example, Instagram, TikTok or Facebook) (30%)
- based on recommendations from family and friends (20%), and/or from the doctor's or clinic's online or print advertisements (19%).

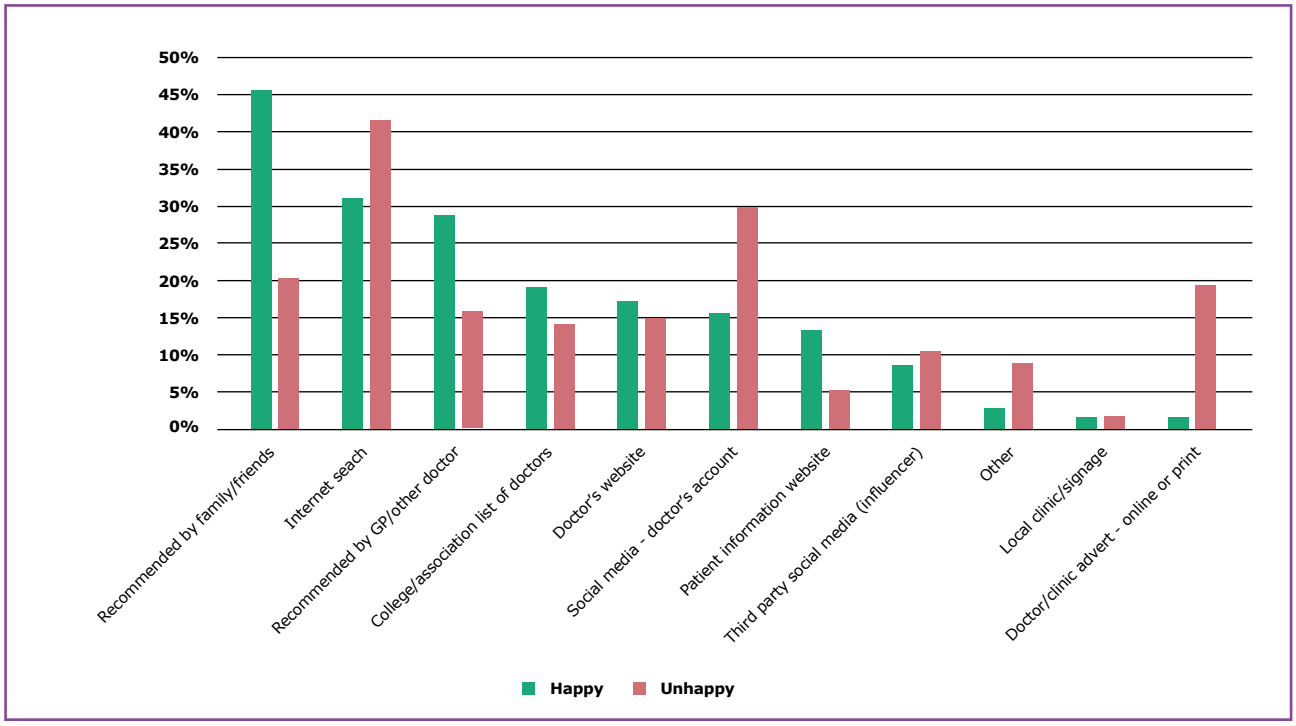
This is in contrast to respondents who were happy with the surgery, who were most likely to find a doctor:

- based on recommendations from family and friends (46%)
- through an online search (31%), and/or
- based on recommendations from a GP or other doctor (29%).

These results are shown in Figure 9.

[117] Consumers could select multiple responses when answering survey questions – totals add to more than 100%

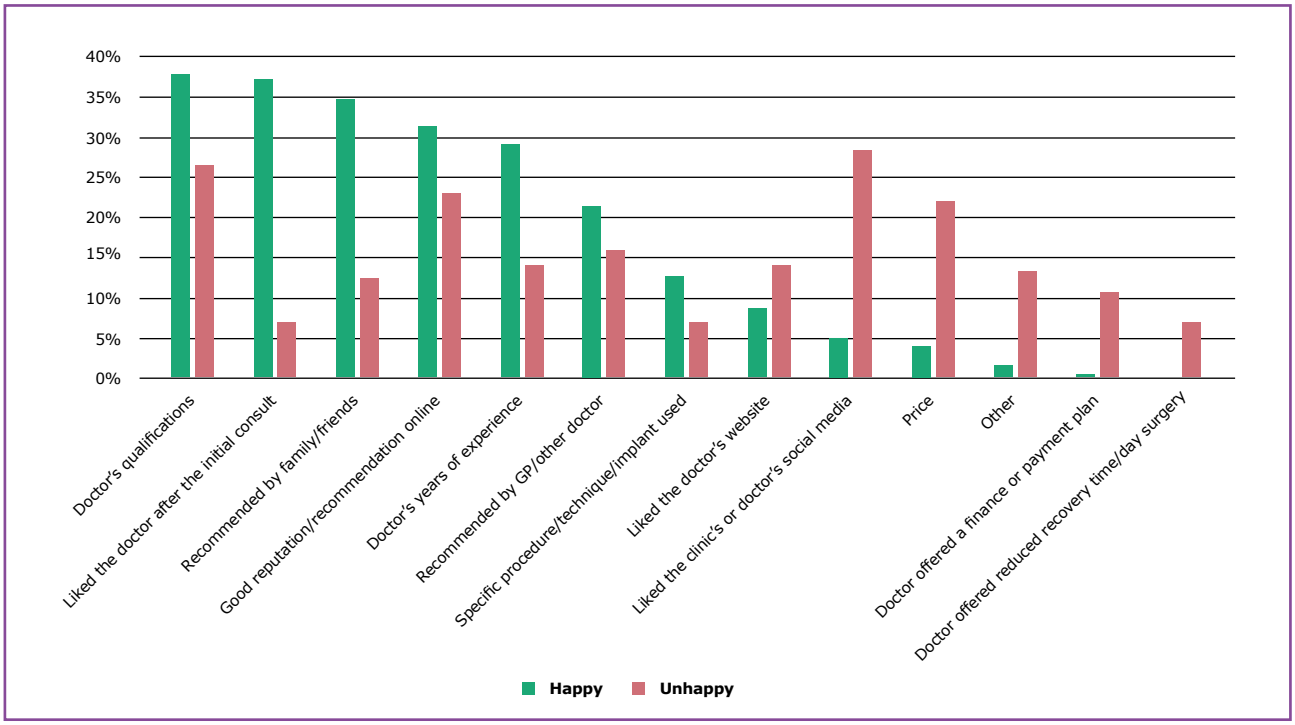
Figure 9: How did you find a doctor? Happy patients compared with unhappy patients



The use of 'doctor advertising – online or print' as a source of information demonstrates the most significant difference between the two cohorts, with the unhappy group reporting 19% use as opposed to the happy group which reported only 2%.

Similar results were seen in response to the question, 'What was your main reason(s) for going ahead with that doctor?' Again, patients who were unhappy with the results of their surgery were more likely to have chosen their doctor because they liked the doctor's (or clinic's) social media (28% of unhappy patients compared to 5% of patients who were happy). This data is presented in Figure 10.

Figure 10: 'What was your main reason(s) for going ahead with that doctor?' Happy patients compared with unhappy patients



The influence of advertising and social media is further illustrated by these statements from survey respondents:

> *[The doctor] followed me on Instagram. I would not have followed any plastic surgery accounts if not for Instagram [...]*
>
> *Don't fall for the surgeon with the most prominent marketing. Just because they have a big social media presence and following, doesn't mean they're the best.*

Consumer focus groups

In the consumer focus groups, discussion about advertising was passionate and many participants felt angry about the advertising they had seen. A number of participants described being 'bombarded' with online advertisements for cosmetic surgery after clicking links on Facebook or another social media site. They expressed concern about targeting cosmetic surgery advertisements at people from their search history. One participant rather vividly described the flood of advertisements as 'like having a leech on your back and you have to grab it and throw it off.'

Participants said advertising appeared to be targeting three groups – young women, women in their 30s and 40s with a higher disposable income, and anyone already considering cosmetic surgery. Statements from the focus group included:

> *They all have links to their Instagram, on their websites and yet it's, you know, look at this transformation: the mummy makeover, which, I hate that term; showing before and afters, even in-surgery shots, and it's just disgusting and they're surgeons living this sort of like lavish sort of lifestyle [...]*
>
> *I don't really watch commercial TV, anything like that, but I've seen so much on social media. So TikTok, Instagram, especially in Facebook and it's a lot of 'before and afters' and there's so many videos of in-surgery action shots that I've seen and it's [...] the way they talk about it, as kind of like the transformation, like, 'look what this person was and look what they're like [now]. I've transformed them'.*
>
> *They gloss over how important it is to have either a plastic surgeon or a cosmetic surgeon. It's more about they show plenty of before and afters, but it's always the success stories [...].*

Observations and analysis

While this review did not undertake any systematic audit of advertising, it does not take much searching on the internet, particularly of social media, to start to find examples of some practitioners advertising in a manner that is consistent with the issues raised by submitters or highlighted in previous reviews. While much of the content may not amount to an offence under the National Law, the review considers that it would fall short of the standard expected by the professional peers and the public. There appears to be a basis for extending the scope of Advertising Guidelines beyond just the operation of the offence provision and to also reflect broader professional expectations.

As is discussed above, research suggests a connection between social media use and the increasing incidence of body dysmorphia and other body image concerns (particularly amongst young women). In these circumstances, the review is particularly concerned with tactics employed by some practitioners on social media, including using images of models who are unlikely to have had cosmetic surgery to promote a particular surgical procedure, content that actively encourages people to pursue what is promoted as a socially accepted or perfect body type and the use of influencers to promote procedures.

Advertising that 'encourages' the 'indiscriminate or unnecessary use of a regulated health service'

As has been mentioned above, section 133(1)(e) provides that a person must not advertise in a way that 'directly or indirectly encourages the[...] indiscriminate or unnecessary use of regulated health services'. Purely aesthetic cosmetic surgery, by its very nature, is an elective procedure for which no clinical or functional need exists. In these circumstances there may be an argument that some forms of advertising of cosmetic surgery may in effect be prohibited by section 133.

The terms 'directly or indirectly encourages' potentially capture a broad range of activity. The dictionary definition[118] of the word 'necessary' includes 'needed to be done' or 'essential' and therefore, 'unnecessary' would mean not needed to be done or unessential. It is difficult to argue that aesthetic cosmetic surgery is something that is 'needed to be done' or 'essential'. Just because it has potential personal benefits for a consumer does not make it 'essential', it only makes it potentially beneficial. While proponents of cosmetic surgery argue that it may also provide psychological benefits (such as improved self-esteem), as is discussed in 'Chapter 4 – Influencing Practice', evidence of this is not so clear.

On the other hand, it can also be argued that there are physical changes that can be demonstrated from some forms of cosmetic surgery. Procedures such as breast implants and facelifts lead to an observable physical change. In this way, they are a 'necessary' procedure to produce that physical result and therefore might not be interpreted to be unnecessary.

The question of the interpretation of section 133(1)(e) as it relates to advertising that encourages indiscriminate or unnecessary use of a health service, to the knowledge of the review team, has not been tested in court.

Given the complexity of this issue and its importance to Ahpra's approach to regulation of advertising cosmetic surgery, the review considers that Ahpra and the Medical Board should obtain legal advice specifically about the application of section 133(1)(e) to cosmetic surgery. While the review would not expect that legal advice to be publicly released, it could play an important role in informing revisions to guidelines and Ahpra's approach to potential prosecutions.

Recommendations

9. Ahpra obtain legal advice specifically about the application of section 133(1)(e) to cosmetic surgery and the extent to which it may effectively prohibit forms of advertising of cosmetic surgery.

[118] Oxford Languages, https://languages.oup.com/google-dictionary-en/, accessed 29 July 2022.

Enforcement

The issue of cosmetic surgery advertising elicited strong and consistent responses in this review. There is a clear perception that Ahpra and the Medical Board need to do more to address these problems, both being more proactive in detecting unacceptable and inappropriate advertising content and responding in a more forceful fashion to the rule breakers. Does this perception match the reality?

The review considers the risk-based approach outlined in the Strategy to advertising compliance and enforcement is well considered, logical and based on sound research. It seeks to deploy the use of its finite resources in a manner that is generally focused on education and engagement but notes that stronger action in some cases may be necessary.

The difficulty in the cosmetic surgery space is that much of the Strategy is focused on encouraging and supporting compliance 'among the majority of advertisers who want to advertise responsibly', noting that 'most people are willing or trying to do the right thing'.[119] For medical practitioners in this category, the Strategy's approach is reasonable and appropriate. One would expect that there is likely to be a cohort of practitioners who, although they may be advertising cosmetic surgery services in a way that is in breach of the standards, will respond in a positive manner and amend their approach.

However, what of the cohort who are knowingly and intentionally flaunting the requirements and who may have little interest in voluntarily complying? The Strategy does make provision for this group. It states:

> *We also recognise that there are a small number of people, both practitioners and other advertisers, who will need more incentives to comply. This is where we target our enforcement action.*
>
> *Compliance and enforcement action will escalate depending on the ongoing assessment of risk and the response of the advertiser. Depending on patterns of advertising, there may be a need for an escalated approach on specific topics or in particular professions.*[120]

In these cases, the Strategy correctly notes that enforcement tools under the National Law are available that include either prosecuting an advertiser for an offence under section 133 or disciplining a practitioner. These are available sanctions with 'teeth'. If the monetary fine provided for under section 133 is seen as inconsequential, action can be taken about the practitioner's registration; at its highest it can be suspended or cancelled.

The review found that these stronger enforcement tools have not been deployed for cosmetic surgery advertising. To date, no cosmetic surgery advertising matter has been the subject of charges or a prosecution under section 133. The review is not aware of any disciplinary finding and sanctions being imposed on a practitioner undertaking cosmetic surgery advertising specifically for breaching the Advertising Guidelines.

In practice Ahpra's first response appears typically to be to write to the practitioner, then if the practitioner does not respond to gradually escalate action. However, the review believes that Ahpra needs to consider applying a stronger response at an earlier stage for some high-risk matters.

There appears to be a case for Ahpra and the Medical Board to take more forceful action about the class of practitioners engaging in the more egregious advertising conduct, while at the same time promoting compliance for lower risk offenders through education and engagement. There appears to be a need to ensure that the risks posed by advertising in this sector are appropriately categorised within the risk framework set out in the Strategy. This would include placing some of the more serious conduct into the high-risk category which should in turn trigger a stronger initial enforcement response for those very serious matters.

Some of the advertising conduct that has been identified and reported on more recently is likely to satisfy the same criteria given in some of the high-risk examples under the Strategy, as they likely:

[119] Ahpra and National Boards, *Advertising compliance and enforcement strategy for the National Scheme*, p8.

[120] Ahpra and National Boards, *Advertising compliance and enforcement strategy for the National Scheme*, p9.

- *raise concerns of actual harm to consumers*
- *target vulnerable groups[...]*
- *are widespread in a profession and have potential to have significant adverse impacts on healthcare choices.*

As has been mentioned above, Ahpra audits the advertising of a representative number of all medical practitioners, not just those undertaking cosmetic surgery. It is likely that more auditing and monitoring of cosmetic surgery advertising will be necessary to start to address the conduct issues. How much Ahpra can manage depends on their available resources.

The review considers that a good start would be to, as is provided for in the Strategy, take 'an escalated approach on specific topics or in particular professions'. This could involve undertaking a targeted audit project directed at cosmetic surgery advertising. This would allow for various enforcement approaches to be taken about the practitioners identified in the audited sample as breaching the law and guidelines (depending on the risk categorisation of the offending conduct). It would also inform Ahpra about relevant issues in this sector and assist in ensuring that future auditing more robustly applies the Strategy to the risks in this sector. Observations from the audit could also be published. This approach may also have some deterrent effect on cosmetic surgery advertising more generally and promote advertising compliance across the industry.

It must be acknowledged that there are limits to what Ahpra and the Medical Board will be able to realistically achieve. They are constrained by both the limits of their powers and finite nature of their resources. Prosecuting practitioners for breaching section 133 requires each element to be proven to the criminal standard of proof (that is, being beyond reasonable doubt). Successful prosecutions often turn on the facts in the particular case, so even where a conviction may be obtained it may not necessarily establish a clear precedent for how the law applies to other examples of advertising. Disciplinary actions before a tribunal for advertising conduct also pose challenges. They are time consuming and expensive. Some of the advertising conduct that has been identified by stakeholders, while concerning, may not be easily actionable in the current regulatory environment.

It will be challenging to meet community and stakeholder expectation about proactive monitoring. Cosmetic surgery is only one area of practice and the review notes that Ahpra manages the registration and regulation of over 850,000 registered practitioners nationally. The ever-increasing number of social media platforms and advertising opportunities pose significant challenges for the regulator in trying to keep pace with the developments. While technological solutions are available to increase the reach of monitoring and make it more effective, follow-up action requires resourcing and that resourcing is finite.

The review raises these matters not as an excuse for Ahpra and the Medical Board to do nothing. As has been detailed in this chapter, the review considers more can be done and outlines practical steps that can be taken including taking action about the most egregious cases of illegal or inappropriate advertising.

Recommendations

10. Ahpra and the Medical Board review their regulatory approach to advertising in the cosmetic surgery sector including by:
    a) ensuring that the risks posed by advertising in this sector are appropriately categorised within the risk framework set out in the Advertising compliance and enforcement strategy for the National Scheme so that stronger enforcement action is taken about high-risk matters (including, where appropriate, taking prosecutorial action in some matters)
    a) undertaking an industry-specific audit which should, among other things, inform the future proactive monitoring/auditing of activities in this space.

Guidelines

In addition to concerns about the compliance and enforcement strategy, the review has heard from stakeholders that the current Advertising Guidelines do not adequately address issues about the potential harms of advertising including concerns about targeting young people and misleading consumers by glamorising results and minimising risks.

As has been detailed earlier in this chapter, much of the extensive advertising guidance material published by Ahpra and the National Boards has direct application to cosmetic surgery advertising. However, the Advertising Guidelines tend to be limited to explaining the operation of the advertising offence provision. As with other codes and guidelines issued by National Boards, they are intended to set out the standards of ethical and professional conduct expected by the Medical Board. In this sense they can also reflect the standards expected of professional peers and have regard to general community expectations. This is particularly the case with the disciplinary provisions in the National Law that seek to measure the conduct of a practitioner against the standard 'which might reasonably be expected of a health practitioner by the public or the practitioner's professional peers'.[121] The review sees no need to limit the advertising guidance material directed at registered practitioners to only what may amount to an advertising offence.

There would be benefit in refreshing and updating the Advertising Guidelines and/or producing additional material specifically about cosmetic surgery to clarify standards expected of practitioners, particularly in such areas as:

a) avoiding the glamorisation and trivialisation of procedures including the downplaying of risk
b) avoiding the use of images of models who have not undergone a cosmetic procedure(s) to promote a cosmetic procedure
c) avoiding the promotion of procedures through the use of social media influencers
d) avoiding the use of content that implies cosmetic surgery should be utilised to obtain an acceptable/ideal body type (for example, 'being beach ready')
e) promoting the use of disclaimers
f) limiting benefit statements to those that are objectively demonstrable/provable (that is, the physical changes not the claimed psychological or social benefit)
g) limiting the filming and use of content that shows surgical procedures to educational purposes only and not for entertainment
h) strengthening procedures for informed consent about the use of and storage of patients' before and after photos
i) preventing the targeting of young or otherwise vulnerable groups with advertising (including through algorithms and other marketing technology).

There would also be benefit in providing examples of what would be considered to be unacceptable cosmetic surgery advertising. Greater clarity would not only benefit practitioners who advertise, or are contemplating advertising, but also Ahpra and the Medical Board when assessing advertising complaints or auditing advertising. Having more detailed and specific examples should assist in categorising the advertising against the Strategy risk categories.

In updating the Advertising Guidelines, the review considers that it would also be necessary to review the advertising provisions in the Cosmetic Guidelines to ensure consistency.

[121] See definition of unprofessional conduct in the National Law (section 5).

Recommendations

11. Ahpra and the Medical Board revise the Advertising Guidelines, the Cosmetic Guidelines and/or produce additional material specifically about cosmetic surgery to clarify the standards expected of practitioners (including specific examples of inappropriate content or approaches) by addressing such areas as:
    a) avoiding the glamorisation and trivialisation of procedures, including the downplaying of risk
    b) avoiding the use of images of models who have not undergone a cosmetic procedure(s) to promote a cosmetic procedure
    c) avoiding the promotion of procedures through the use of social media influencers
    d) avoiding the use of content that implies cosmetic surgery should be utilised to obtain an acceptable/ideal body type
    e) promoting the use of disclaimers
    f) limiting benefit statements to those that are objectively demonstrable/provable (that is, the physical changes – not claimed psychological or social benefit)
    g) limiting the filming and use of content that shows surgical procedures to educational purposes only and not for entertainment
    h) strengthening procedures for informed consent on the use of and storage of patients' before and after photos
    i) preventing the targeting of young or otherwise vulnerable groups with advertising (including through algorithms and other marketing technology).

Other matters

Use of technology

The review notes that Ahpra's approaches to auditing are largely manual. Further, the use of social media by practitioners poses additional challenges (including the use of disappearing content on some of these platforms). Technology is available to monitor and capture some advertising content in real time. This may potentially reduce the administrative burden of auditing and also increase the information available to Ahpra about practitioners of concern. While the review is not suggesting the deployment of this technology to monitor all practitioners in this sector, it may be beneficial to use it in targeted exercises.

Recommendations

12. Ahpra and the Medical Board consider the use of technology to assist in the monitoring/auditing of advertising in the sector.

Relationship with other regulators

Finally, other regulators also operate within this environment and the responsibility to regulate cosmetic surgery advertising does not fall solely on Ahpra and the Medical Board. The ACCC and the various state/territory consumer protection/fair trading departments can receive complaints about advertising and promotion that may breach the Australian Consumer Law. Australian Consumer Law prohibits businesses from making false or misleading statements or representations. The law also imposes fines for businesses that mislead consumers with maximum penalties that are much higher than those under the National Law.[122]

[122] See Australian Competition and Consumer Commission, *Advertising & Promotions*, accessed 13 July 2022.

In its submission to the review, the TGA advised that it has recently undertaken significant advertising reforms, including a new Therapeutic Goods Advertising Code (the Code) which came into effect from 1 January 2022, with a transitional period to 30 June 2022. The Code sets out minimum requirements for advertising therapeutic goods to the public, and makes provision for criminal offences and civil penalties for advertising that does not comply with the Code.[123] The TGA also has a social media advertising guide, which is currently being updated to reflect the new Code.

While not a specific recommendation of this review, there may be benefit in Ahpra attempting to network with some of these other key regulators to assist in identifying regulatory gaps, facilitate the sharing of information and learnings and to inform future strategy. The review acknowledges that consumer protection regulators have a very broad role, not specific to health services, so have to make strategic decisions about which matters to prosecute. However, the review notes, for example that the ACCC has been willing to take action against egregious practices in the health sector in the past. Ahpra could work with the ACCC to ensure that there is a clear process for referring matters that may be serious enough for the ACCC to consider enforcement action under general consumer law.

Testimonials

As mentioned earlier in this chapter, there are currently proposed amendments before the Queensland Parliament which seek to remove the ban on testimonials in the Health Practitioner Regulation National Law. Queensland is the host jurisdiction for the National Law, which means that amendments must be introduced into the Queensland Parliament for review, debate and passage.[124] On 11 May 2022, the Queensland Minister for Health and Ambulance Services, introduced the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 into the Queensland Parliament.[125]

The Bill was referred to the Queensland Parliament's Health and Environment Committee (the committee) for detailed consideration. The committee tabled its report on 1 July 2022 and recommended that the Bill be passed and that the Queensland Minister for Health and Ambulance Services provide an undertaking, during the second reading debate, to not commence the provisions repealing the prohibition on testimonials in health service advertising until:

- the completion of the Independent review of the regulation of health practitioners in cosmetic surgery, and
- the accompanying guidelines and educational material have been published.

In its report, the committee acknowledged that several stakeholders raised concerns about the potential impact of removing the prohibition on testimonials in advertising health services, especially for cosmetic surgery. The committee noted that the removal of the prohibition would not mean that the use of testimonials in health service advertising is unregulated. Testimonials that are false, misleading or deceptive in a way that creates an unreasonable expectation of beneficial treatment or in a way that encourages the indiscriminate or unnecessary use of health services will still be prohibited.

The committee's report noted that several submitters recommended that the removal of the prohibition on testimonials be delayed until the completion of this review, and Ahpra had developed guidance on ensuring testimonials meet advertising requirements and undertaken an awareness campaign. The committee agreed with submitters that it would be prudent to await the completion of this review, to ensure that Ahpra was able to publish accompanying guidelines and educational material before removing the prohibition.

The review shares a number of the concerns raised both by stakeholders during the Queensland Parliamentary committee process and in submissions to this review. The review's observations about testimonials is limited to its application to the cosmetic surgery sector.

[123] Therapeutic Goods Administration, *Therapeutic Goods Advertising Code*, 2022, accessed 13 July 2022.

[124] If passed, changes are applied automatically in each state and territory – except in New South Wales and South Australia where a regulation is made to confirm the changes and in Western Australia where a corresponding amendment Bill would go through the WA parliamentary process.

[125] The Bill was subject to extensive community consultation, including a 2018 consultation paper, Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose. In addition to the consultation paper, eight consultation forums were held across all Australian states and territories.

As has been outlined in this, and other chapters of this report, the current lack of reliable information for consumers (particularly about the training and qualifications of the practitioner) is a fundamental problem and significant risk. What consumers need is objective and unbiased information. Testimonials, when selectively used by practitioners, are more likely to be the opposite; subjective and biased (even when they may not be false, misleading or deceptive). In these circumstances, the review is concerned that testimonials have the potential to further contribute to misunderstanding and confusion among consumers.

Further, as has been observed in this chapter, Ahpra faces significant challenges under the current legislative regime in regulating cosmetic surgery advertising, both in monitoring and enforcing compliance. Regulating and responding to the use of testimonials is likely to add to the regulatory burden, as resources will need to be applied to ascertaining whether a testimonial is false, misleading or deceptive, as part of the monitoring/auditing process or in responding to complaints.

If the testimonial ban amendment is to proceed, educational and guidance material for practitioners about the use of testimonials will be essential, as will be internal policy and procedural material for Ahpra staff about compliance and enforcement. The review considers that it would be useful for the material to provide various examples of what would be considered as inappropriate and/or unlawful use of testimonials (including for example testimonials in exchange for discounts, procedures or payment or testimonials that make misleading representations about training, qualifications and experience).

Finally, having regard to this proposed amendment, the review considers the implementation of the recommendations about advertising, and other related matters, contained in this report will be all the more important. Ideally, Ahpra should attempt to discourage the use of testimonials by practitioners in the cosmetic surgery sector until the recommendations in this report have been progressed (although it is noted there may be significant challenges in enforcing this and it may only likely be achieved voluntarily).

Chapter 4: Influencing Practice

Introduction

Publishing codes and guidelines is a way in which a National Board, like the Medical Board, can seek to influence practice by making its expectations clear to the practitioners it registers. Not only is guidance on good practice helpful for practitioners, it also communicates to the community the standard expected of doctors.

The Medical Board's central governing publication is its code of conduct, *Good medical practice: a code of conduct for doctors in Australia*, which covers a range of aspects of practice including communication, informed consent, cultural safety, working with healthcare professionals, professional behaviour, doctors' health, teaching and research.

The Medical Board can also issue additional guidance to support good practice. Following a report from Health Ministers which identified cosmetic surgery as a unique area of practice where further guidance is needed,[126] the Medical Board consulted on and subsequently approved *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* (referred to earlier in this report as the Cosmetic Guidelines). They apply to registered medical practitioners who perform cosmetic medical and surgical procedures regardless of the practitioner's registration type. These guidelines have been in place since 2016 and are due for review.

This chapter examines whether the Medical Board's current Cosmetic Guidelines adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience. This chapter outlines the review's analysis of the adequacy of the Cosmetic Guidelines, identifies areas where more clarity and detail is required and recommends that Ahpra and the Medical Board consult on and update the Cosmetic Guidelines to address these identified issues.

Finally, the review acknowledges that there are many aspects related to the practice of doctors in this area that fall well outside the control and responsibility of Ahpra and the Medical Board and sit with various regulators across the country. In acknowledging Ahpra and the Medical Board's broad visibility of potential patient safety issues across various jurisdictions, the review recommends that they take some role in seeking to facilitate national reform.

Ahpra and the Medical Board's responsibilities and powers

The Medical Board may develop and approve codes and guidelines to provide guidance to registered medical practitioners.[127] When developing or revising a code or guideline, the Board must ensure there is wide-ranging consultation about its content.[128] Codes and guidelines apply in all states and territories.

Codes and guidelines are not enforceable rules that can ground action merely because a provision is breached. They are more general in their application and set out the standards of ethical and professional conduct the Medical Board expects of medical practitioners. They are used by the Medical Board and other regulators to evaluate practitioners' conduct and to seek to determine whether a practitioner's conduct has met a required standard. Codes and guidelines are admissible in proceedings under the National Law or law of a co-regulatory jurisdiction as evidence of what constitutes appropriate professional conduct or practice of a registered practitioner.[129]

Guidelines enable the Medical Board to provide guidance to practitioners and make the Medical Board's expectations of good medical practice clear. However, Ahpra and the National Boards, as the regulators, are not in the practice of issuing specific clinical standards for practitioners. This is left to other bodies such as specialist medical colleges, the National Health and Medical Research Council and the Australian Commission on Safety and Quality in Health Care.

[126] Australian Health Ministers' Conference (AHMC), *Cosmetic Medical and Surgical Procedures – A National Framework*, AHMC, 2011.

[127] Section 39 of the National Law.

[128] Section 40 of the National Law.

[129] Section 41 of the National Law.

The Cosmetic Guidelines issued by the Medical Board cover these aspects of practice:

1. Recognising potential conflicts of interest
2. Patient assessment
3. Additional responsibilities when providing cosmetic medical and surgical procedures for patients under the age of 18
4. Consent
5. Patient management
6. Provision of patient care by other health practitioners
7. Prescribing and administering schedule 4 (prescription only) cosmetic injectables
8. Training and experience
9. Qualifications and titles
10. Advertising and marketing
11. Facilities
12. Financial arrangements.

As the Medical Board only regulates medical practitioners, the Cosmetic Guidelines do not apply to other registered health practitioners or to unregistered providers of cosmetic procedures.

Supporting material has also been published by the Medical Board, including FAQs about the Cosmetic Guidelines and an information sheet *Cosmetic medical and surgical procedures – guidance on financing schemes*.

Other jurisdictions

The review looked at how other comparable jurisdictions set standards and provide guidance for medical practitioners who provide cosmetic surgery.

In New Zealand, the Medical Council of New Zealand (MCNZ) has a *Statement on cosmetic procedures* which outlines the standards expected of doctors who perform cosmetic procedures, which may be used in disciplinary matters.[130] In the United Kingdom, the General Medical Council (GMC) has *Guidance for doctors who offer cosmetic interventions* which sets out the expected standard for all doctors who offer cosmetic interventions.[131] Other jurisdictions also have guidance including the European Standards for Aesthetic Surgery Services and the Singapore Medical Council's Guidelines on aesthetic practices for doctors.

Similar to Australia, other jurisdictions provide guidance on the key areas of cosmetic practice such as patient assessment, patients under the age of 18, consent, patient management, working with other health practitioners, training, advertising, facilities and financial arrangements. Much of the content is very similar, for example, requiring a seven-day cooling-off period, provision of information in writing and ensuring advertising is not misleading.

With required training, there are some differences, and these are generally attributable to different legislative powers in other jurisdictions. New Zealand has medical registration in a vocational scope and the MCNZ's statement lists categories of cosmetic procedures and which doctors with which specialist training may perform them. Similarly, the Singapore Medical Council's guidelines list surgical procedures and specify which specialists can perform each procedure. The GMC's guidance is more similar to Australia's and merely requires doctors to 'recognise and work within the limits of (their) competence' and 'undergo training'.[132]

Stakeholder feedback

Submissions

A large number of stakeholders provided feedback in their submissions about the Medical Board's codes and guidelines. This included organisations, registered medical practitioners and individuals.

[130] Medical Council of New Zealand (MCNZ), *Statement on cosmetic procedures*, MCNZ, 2017.

[131] General Medical Council (GMC), *Guidance for doctors who offer cosmetic interventions*, GMC, 2016.

[132] GMC, *Guidance for doctors who offer cosmetic interventions*.

Almost all the organisations who made a submission in this area predominantly provided feedback about the Cosmetic Guidelines. More than 100 medical practitioners also provided feedback on these guidelines. This feedback was from medical practitioners who provide cosmetic surgery and from those who do not. Submitters included specialist plastic surgeons, other specialist surgeons, other specialists including specialist general practitioners and practitioners who do not have specialist registration.

Some stakeholders noted that the Cosmetic Guidelines were published in 2016 and are due, or overdue, for review. Some stakeholders, such as the ACCSM and the Victorian Perioperative Consultative Council (VPCC), acknowledged that the guidelines are reasonable but could be improved. However, in response to the consultation question as to whether the current guidelines 'adequately address issues relevant to the current and expected future practice of cosmetic surgery', the overwhelming feedback was that the Cosmetic Guidelines are not adequate and should be strengthened.

General feedback included that more clarity or detail was needed to make the Medical Board's expectations clearer. The ASPS was one of the stakeholders who suggested that the Medical Board could be more explicit about its expectations, suggesting that the Cosmetic Guidelines could be strengthened by changing the use of 'should' to 'must'.

In addition to feedback on existing content in the Cosmetic Guidelines, stakeholders raised medical practitioner compliance as an area of concern and noted examples of practitioners' poor compliance with the Cosmetic Guidelines including recent cases publicised in the media. The ASPS and the Royal Australian College of General Practitioners (RACGP) were two of the organisations that suggested that Ahpra and the Medical Board should consider monitoring and/or auditing practitioners' compliance with the Cosmetic Guidelines with the ASPS noting that it is warranted in cosmetic surgery because of its commercialised nature. Some medical practitioners commented that guidelines are of limited use unless they are 'enforced'.

Submission feedback about specific areas of the Cosmetic Guidelines will be discussed in more detail below.

Consumer survey and focus groups

The consumer survey and the focus group process did not ask specific questions about Medical Board codes and guidelines as the guidelines are for medical practitioners.

However, both the responses from the survey and the focus groups provided valuable insights from a consumer's perspective about such issues as consent, the processes for gaining informed consent and the information provided (or not provided) to consumers.

Technical Advisory Group and Consumer Reference and Advisory Group input

As has been discussed in the Introduction Chapter of this report, a Technical Advisory Group (TAG) was established to inform the review about technical and clinical aspects related to cosmetic surgery. One of the roles of this group was to produce technical guides for some of the most common cosmetic surgical procedures. In the development of this guidance material, the group provided helpful advice and feedback about areas that are also in the Cosmetic Guidelines and which should be of assistance to Ahpra and the Medical Board when refreshing these guidelines. Feedback was provided about such matters as patient assessment including psychological screening and cooling-off periods, consent, and postoperative care.

The Consumer Reference and Advisory Group (CRAG) also discussed issues and provided advice about patient assessment and psychological screening, consent including informed financial consent, practitioners' training and titles, and advertising.

Cosmetic Guidelines – Feedback and analysis

The review received feedback from stakeholders about almost every section of the Medical Board's Cosmetic Guidelines. However, several key issues relevant to the Cosmetic Guidelines were consistently raised by consumers, in submissions, in the review's meetings with stakeholders and by the TAG and the CRAG. These were:

- patient assessment, including psychological screening
- informed consent
- patient management, including anaesthesia and postoperative care
- facilities
- training and experience
- qualifications and titles
- advertising and marketing.

The review examined each of these areas in detail and each is discussed below (along with relevant stakeholder feedback and the review's analysis and findings).

The review is generally not suggesting specific text or edits to the Medical Board's Cosmetic Guidelines but has identified the areas that the Medical Board needs to address and update. The TAG's procedure guides will provide a useful additional resource for the Medical Board when it reviews the Cosmetic Guidelines.

The Medical Board is required to undertake wide-ranging consultation on any changes to guidelines and this will provide all stakeholders including organisations, practitioners and consumers an opportunity to provide further input on any proposed changes to the guidelines.

Definition

Current Cosmetic Guidelines

Cosmetic medical and surgical procedures are operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.

Stakeholder feedback

Submitters did not raise significant issues with the definition in the Cosmetic Guidelines. However, the CRAG noted that if cosmetic surgery does not necessarily increase a patient's self-esteem, the reference to 'boosting the patient's self-esteem' in the definition should be reviewed.

Research

Research suggests that generally cosmetic surgery does result in patients having increased satisfaction with their appearance.[133] However, the research is mixed about whether cosmetic surgery improves self-esteem. Some studies suggest a small increase in self-esteem, while other studies find no significant changes in self-esteem,[134] and note conflicting results in other studies.[135] As has been noted elsewhere in this report, consumers with body dysmorphic disorder (BDD) are very unlikely to experience improved self-esteem from these procedures.

Observations and analysis

Dissatisfaction with body image is cited as the main factor motivating people to undergo cosmetic procedures.[136] However, a desire to improve self-esteem is also frequently cited as a motivation for cosmetic surgery.[137]

[133] T von Soest, IL Kvalem, KC Skolleborg, and HE Roald, 'Psychosocial changes after cosmetic surgery: a 5-year follow-up study', 2011, *Plastic and Reconstructive Surgery*, 2011, 128(3), 765–772, https://doi.org/10.1097/prs.0b013e31822213f0; DB Sarwer, 'Body image, cosmetic surgery, and minimally invasive treatments', *Body Image*, 2019, 31, 302–308, https://doi.org/10.1016/j.bodyim.2019.01.009.

[134] von Soest et al., 'Psychosocial changes after cosmetic surgery: a 5-year follow-up study'.

[135] Sarwer, 'Body image, cosmetic surgery, and minimally invasive treatments'.

[136] VE Di Mattei, EP Bagliacca, A Ambrosi, L Lanfranchi, FB Preis, and L Sarno. 'The impact of cosmetic plastic surgery on body image and psychological well-being: a preliminary study' *International Journal of Psychology & Behavior Analysis*, 2015, 1(103): 1–6, http://dx.doi.org/10.15344/2455-3867/2015/103.

[137] G Sharp, P Maynard, AR Hudaib, CA Hamori, J Oates, J Kulkarni, and DB Sarwer, 'Do genital cosmetic procedures improve women's self-esteem? A systematic review and meta-analysis' *Aesthetic Surgery Journal*, 2020, 40(10), 1143–1151, https://doi.org/10.1093/asj/sjaa038.

The review considers that no definitive and objective position can be reached about whether cosmetic surgery boosts self-esteem. The review is concerned with the specific reference to this factor in the Cosmetic Guidelines definition, and more particularly, the potential that the definition itself perpetuates a position (namely that cosmetic surgery boosts self-esteem) that may not be supported in the literature.

The review considers that this aspect of the definition should be amended with reference to 'boosting the patient's self-esteem' being removed.

Patient assessment

Issues relating to preoperative screening, cooling-off periods and the use of video consultations were raised by stakeholders and was a focus of the review under the Patient Assessment section of the Cosmetic Guidelines. Each topic will be dealt with separately below.

Preoperative screening

Current Cosmetic Guidelines

2. Patient assessment

2.3 The medical practitioner who will perform the procedure should discuss and assess the patient's reasons and motivation for requesting the procedure including external reasons (e.g. a perceived need to please others) and internal reasons (e.g. strong feelings about appearance). The patient's expectations of the procedure should be discussed to ensure they are realistic

2.4 The patient should be referred for evaluation to a psychologist, psychiatrist or general practitioner, who works independently of the medical practitioner who will perform the procedure, if there are indications that the patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure.

Stakeholder feedback

The feedback in submissions reiterated the importance of patient selection and comprehensively assessing patients. A retired reconstructive plastic surgeon commented that 'the psychology and appropriateness of each patient for the operation requested requires careful analysis, in each case [...]'.

A medical indemnity insurer suggested that greater clarity is needed on when referral for psychological evaluation is required.

A clinical psychologist who specialises in the treatment of people with body image concerns, who was also a member of the CRAG,[138] submitted that the current guidelines:

> *[...] do not provide sufficient guidance to safeguard the psychological wellbeing of clients seeking cosmetic procedures. For example, psychological factors such as body dysmorphic disorder (BDD), anxiety, depression, obsessive-compulsive disorder and personality disorders are known to increase the risk of poor cosmetic treatment outcomes and may potentially worsen psychological functioning for these patients. While the current guidelines recommend referral to a mental health professional if these issues are identified, many practitioners who provide cosmetic procedures may not have had sufficient training to assess for these issues.*

This submission suggested that the use of validated screening tools for mental health concerns (such as BDD, anxiety and depression) should be recommended in the Cosmetic Guidelines, as screening tools are often more sensitive and accurate than relying on clinical intuition alone.

[138] Dr Toni Pikoos is a clinical psychologist, postdoctoral researcher and educator who specialises in Body Dysmorphic Disorder, eating disorders and body image concerns. Dr Pikoos' PhD examined the relationship between Body Dysmorphic Disorder and non-surgical cosmetic procedures.

The Australasian Foundation for Plastic Surgery noted that, 'The current guidelines do not address the medical practitioner's level of training/or lack thereof in relation to the psychological assessment of the patient'. They recommended introducing requirements for appropriate CPD training for practitioners about patient selection and the psychological vulnerability of patients. Some TAG members also supported the need for screening all patients for BDD, although they noted that there isn't one tool that is universally agreed upon.

Research

There is a great deal of literature about the impact of cosmetic surgery on patients with BDD, and the importance of psychological screening for all patients prior to undergoing cosmetic surgery. BDD is a psychiatric disorder characterised by emotional distress and a preoccupation with a perceived defect in one's appearance.[139] It is associated with substantial psychiatric comorbidity, poor quality of life and high rates of suicidality.[140]

The prevalence of BDD is estimated to be approximately 2.4% in the general population, but significantly higher in cosmetic surgery patients, with estimates ranging from 5% to 20%.[141] Studies show that patients with BDD often have unrealistic expectations about cosmetic surgery and are more likely to end up dissatisfied with the results, regardless of the actual outcome.[142] Patients with BDD are more likely to have complications following cosmetic surgery, and have higher rates of re-operation.[143]

Studies suggest poor outcomes of cosmetic surgery in individuals with BDD[144] and for some, BDD symptoms may worsen following cosmetic procedures, with some studies finding patients become more preoccupied with appearance, or they shift their concern to a different physical feature.[145] BDD has been considered a contraindication for cosmetic surgery, although there is now some evidence that some patients with mild BDD may experience some improvement in symptoms following some cosmetic procedures, noting also that more research is needed.[146]

A number of studies have shown that psychological screening tools are effective for assessing cosmetic surgery patients for BDD and can identify patients who are more likely to benefit psychologically from the proposed surgery, as well as those who are poor candidates for cosmetic surgery, psychologically speaking.[147] Studies have also shown that these validated screening tools have a much greater sensitivity than surgeon intuition alone. In fact, some studies have shown

[139] BDD has been defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition, 2013; L Bowyer, G Krebs, D Mataix-Cols, D Veale, and B Monzani, 'A critical review of cosmetic treatment outcomes in body dysmorphic disorder', *Body Image*, 2016, 19, 1–8, doi.org/10.1016/j.bodyim.2016.07.001; S Higgins and A Wysong, 'Cosmetic surgery and body dysmorphic disorder – an update', *International Journal of Women's Dermatology*, 2018, 4(1), 43–48, doi.org/10.1016/j.ijwd.2017.09.007.

[140] L Bowyer, 'A critical review of cosmetic treatment outcomes in body dysmorphic disorder'; CE Crerand, KA, Phillips, W Menard and C Fay, 'Nonpsychiatric medical treatment of body dysmorphic disorder', *Psychosomatics*, 2005, 46(6), 549–555, https://doi.org/10.1176/appi.psy.46.6.549.

[141] AW Joseph, L Ishii, SS Joseph, JI Smith, P Su, K Bater, P Byrne, K Boahene, I Papel, T Kontis, R Douglas, C Nelson, and M Ishii, 'Prevalence of body dysmorphic disorder and surgeon diagnostic accuracy in facial plastic and oculoplastic surgery clinics', *JAMA Facial plastic surgery*, 2017, 19(4), 269–274, https://doi.org/10.1001/jamafacial.2016.1535; Crerand, 'Nonpsychiatric medical treatment of body dysmorphic disorder'; Higgins, 'Cosmetic surgery and body dysmorphic disorder–an update'; Bowyer, 'A critical review of cosmetic treatment outcomes in body dysmorphic disorder'; AJ Woolley and JD Perry, 'Body dysmorphic disorder: Prevalence and outcomes in an oculofacial plastic surgery practice', *American Journal of Ophthalmology*, 2015, 159(6), https://doi.org/10.1016/j.ajo.2015.02.014.

[142] Higgins, 'Cosmetic surgery and body dysmorphic disorder – an update'; Joseph, 'Prevalence of body dysmorphic disorder and surgeon diagnostic accuracy in facial plastic and oculoplastic surgery clinics'; IE Sweis, J Spitz, DR Barry, M Cohen, 'A review of body dysmorphic disorder in aesthetic surgery patients and the legal implications', *Aesthetic Plastic Surgery*, 2017, 41, 949–954, doi.org/10.1007/s00266-017-0819-x.

[143] Woolley, 'Body dysmorphic disorder: Prevalence and outcomes in an oculofacial plastic surgery practice'.

[144] Bowyer, 'A critical review of cosmetic treatment outcomes in body dysmorphic disorder'; Sweis, 'A review of body dysmorphic disorder in aesthetic surgery patients and the legal implications'.

[145] TD Pikoos, SL Rossell, N Tzimas, and S Buzwell, 'Is the needle as risky as the knife? The prevalence and risks of body dysmorphic disorder in women undertaking minor cosmetic procedures', *Australian & New Zealand Journal of Psychiatry*, 2021, 55(12), 1191–1201, doi.org/10.1177/0004867421998753.

[146] Higgins, 'Cosmetic surgery and body dysmorphic disorder–an update'; Di Mattei, 'The impact of cosmetic plastic surgery on body image and psychological well-being: a preliminary study'; Bowyer, 'A critical review of cosmetic treatment outcomes in body dysmorphic disorder'.

[147] Higgins, 'Cosmetic surgery and body dysmorphic disorder – an update'; Di Mattei, 'The impact of cosmetic plastic surgery on body image and psychological well-being: a preliminary study'.

that surgeons are relatively poor at screening for patients with BDD when compared with validated screening instruments, with one study estimating surgeon sensitivity at around 5% compared to a sensitivity of up to 100% for validated screening instruments.[148]

Observations and analysis

Generally, it is considered that the statements in the Cosmetic Guidelines about patient assessment are largely useful, noting they include references to practitioners assessing a patient's reasons for wanting the surgery and that the patient should be referred for psychological evaluation when indicated.

It is considered that screening for psychological issues is critical for cosmetic surgery patients to identify consumers who are unsuitable candidates for cosmetic surgery. BDD is more prevalent in cosmetic surgery patients than the general population and identifying patients with BDD can be difficult. There is no one specific screening tool that should be recommended, but the literature supports a number of valid screening tools with high levels of sensitivity and specificity, and more than one of these could be suitable for use in a cosmetic surgery setting.

The review considers that the current Cosmetic Guidelines about preoperative screening should be strengthened and include reference to the use of a validated psychological screening tool to assess for underlying psychological conditions and documentation of the process and outcome.

The review also notes the importance of practitioners being trained in this area which should be considered by the Medical Board when dealing with the issue of minimum training and qualifications (covered elsewhere in this report).

Cooling-off period

Current Cosmetic Guidelines

2. Patient assessment

2.5 Other than for minor procedures that do not involve cutting beneath the skin, there should be a cooling off period of at least seven days between the patient giving informed consent and the procedure. The duration of the cooling off period should take into consideration the nature of the procedure and the associated risks.

4. Consent

4.3 Other than for minor procedures, informed consent should be obtained in a pre-procedure consultation at least seven days before the day of the procedure and reconfirmed on the day of the procedure and documented appropriately.

Stakeholder feedback

The CRAG discussed cooling-off periods and observed that while cooling-off periods ensure there is a minimum period of time before a patient can have the surgery, they have limitations as they occur after a consumer has psychologically committed to a procedure. The TAG had general discussions about the cooling-off period and seven days was generally supported with some discussion about practitioners opting for a slightly longer period for complex procedures.

Through engagement with stakeholders, the review became aware of a potential perverse incentive about the current cooling-off period. In practice, to comply with this requirement a practitioner could see a patient at the first consultation, present them with the consenting documentation to sign and then book the procedure for seven or more days later. This has the potential to encourage a practitioner to present the consent forms for signing to a patient at the first consultation, placing undue pressure on the consumer to make a decision to proceed with the surgery at the first consultation.

[148] Higgins, 'Cosmetic surgery and body dysmorphic disorder–an update'; Joseph, 'Prevalence of body dysmorphic disorder and surgeon diagnostic accuracy in facial plastic and oculoplastic surgery clinics'.

A CRAG member with academic expertise in marketing and human behaviour[149] noted that:

> *The problem with the current cooling-off periods is that they operate after a customer has taken ownership of something or signed an agreement. Our research finds cooling-off periods simply don't overcome many of the inherent biases of human behaviour.*[150]

Observations and analysis

The review is concerned that, if at the first consultation, the consumer has signed the consent form and possibly agreed upon a date for the procedure, they have potentially (in their mind) locked themselves in, making it difficult to change their mind. Noting the invasive and permanent nature of what is a purely elective procedure, the review considers that the current Cosmetic Guidelines may (inadvertently) be encouraging this practice.

The review considers that this aspect of the Cosmetic Guidelines should be amended. Such amendment could leave the seven-day cooling-off period intact but provide that consumers should not be requested to sign consent forms at their first consultation.

Video consultations

Current Cosmetic Guidelines

2. Patient assessment

2.1 The patient's first consultation should be with the medical practitioner who will perform the procedure or another registered health practitioner who works with the medical practitioner who will perform the procedure. It is not appropriate for the first consultation to be with someone who is not a registered health practitioner – for example, a patient advisor or an agent.

Stakeholder feedback

In other feedback about patient consultations, some stakeholders noted that it would be helpful to provide guidance on the use of video consultations for cosmetic surgery consultations, noting their widespread use in medicine more generally during the COVID-19 pandemic. Currently the Cosmetic Guidelines specify that the consultation must be with the medical practitioner providing the surgery but do not provide any guidance on the type of consultation – in-person or by video. Stakeholders suggested that guidance would be helpful. Most suggestions were that video consultations could be used as additional consultations, confirming that an in-person pre-surgery consultation is critical.

Observations and analysis

In 2016, when the Cosmetic Guidelines were issued, patient consultations by video were not common in any area of medicine, except for some use in rural and remote areas to enable access to specialist services. The Medical Board has guidelines for *Technology-based patient consultations* which were issued in 2012. They apply to all medical practitioners and provide guidance for practitioners who use technology-based consultations with patients.

During the COVID-19 pandemic, video consultations between doctors and patients have become much more common. Whether video consultations for elective cosmetic surgery are needed and/or appropriate should be further considered.

The review does not express an opinion about exactly how this issue should be resolved, noting the feedback from stakeholders and the exponential growth in the use of telehealth generally. However, the Medical Board should review the issue of face-to-face and technology-based consultations for cosmetic surgery in its Cosmetic Guidelines and/or in the Medical Board's Guidel*ines for technology-based consultations*, which the review understands are currently being revised.

[149] Dr Paul Harrison, Senior Lecturer and the Unit Chair of Consumer Behaviour in the Department of Marketing in Deakin Business School.

[150] P Harrison, 'Cooling-off periods for consumers don't work: study', *The Conversation*, 28 November 2016, accessed 27 July 2022.

Consent and financial consent

Current Cosmetic Guidelines

4. Consent

4.1 The medical practitioner who will perform the procedure must provide the patient with enough information for them to make an informed decision about whether to have the procedure. The practitioner should also provide written information in plain language. The information must include:

- what the procedure involves
- whether the procedure is new or experimental
- the range of possible outcomes of the procedure
- the risks and possible complications associated with the procedure
- the possibility of the need for revision surgery or further treatment in the short term (e.g. rejection of implants) or the long term (e.g. replacement of implants after expiry date)
- recovery times and specific requirements during the recovery period
- the medical practitioner's qualifications and experience
- total cost including details of deposits required and payment dates, refund of deposits, payments for follow-up care and possible further costs for revision surgery or additional treatment, and
- the complaints process and how to access it

4.2 Informed consent must be obtained by the medical practitioner who will perform the procedure

4.3 Other than for minor procedures, informed consent should be obtained in a pre-procedure consultation at least seven days before the day of the procedure and reconfirmed on the day of the procedure and documented appropriately.

12. Financial arrangements

12.1 The patient must be provided with information in writing about the cost of the procedure, which should include:

- total cost
- details of deposits required and payment dates
- refund of deposits
- payments for follow-up care
- possible further costs for revision surgery or additional treatment, and
- advising the patient that most cosmetic procedures are not covered by Medicare.

Stakeholder feedback

Many stakeholders provided feedback relevant to Section 4 and Section 12.1 of the Cosmetic Guidelines, with the majority stating that the guidelines should include more detail about what information should be given to patients to enable them to give fully informed consent (including fully informed financial consent).

Approximately two-thirds of submitters who commented on this issue believed that the current guidelines are not adequate when it comes to information for consumers. Submitters believed that practitioners should be required to provide more information on:

- their training and qualifications, including whether or not the practitioner meets any minimum standards or endorsements that may be required for cosmetic surgery
- the details of the proposed procedure(s), including what is involved, potential risks, and the range of potential outcomes, both short and long term

- the costs involved in the procedure, including any before and after care, the cost of any other practitioners involved (such as the anaesthetist), and the cost of the hospital or day procedure facility
- the avenues available to make a complaint if the consumer is dissatisfied
- adverse events in cosmetic surgery to help patients become more informed about potential risks.

Some submitters suggested the need to make information for consumers simpler, by using plain language and providing information in the patient's preferred language, including enabling patients to give consent in their preferred language.

The TGA also suggested that medical practitioners should give consumers the TGA patient implant cards (PICs) and patient information leaflets (PILs), where surgery includes implants, to support informed consent.

Some also suggested that there should be more auditing of medical practitioners to ensure that they comply with the codes and guidelines for informed consent. Several submitters stated that the requirements in the codes and guidelines are adequate, but not always followed by medical practitioners, and not always understood by patients. For example, two organisations said:

> *Informed consent is often under emphasised. Many people when asked what they have consented to cannot give you a clear description of what is being undertaken, what implant they are having and what the possible complications are. A good test of adequate informed consent would be to have the consumer patient relay this in verbal or audio and confirm that they understand. [Australian Federation of Medical Women]*

> *From our experience of hearing from dissatisfied consumers or those who have suffered adverse outcomes, there are clearly deficiencies in the consent process. The consent process needs to be a meaningful one and not a tick the box exercise. The provision of written information alone is insufficient. The process should require a dedicated and full discussion with patient understanding being checked. [Maurice Blackburn]*

Consumers in focus groups also raised concerns about the information they received from practitioners and the processes around providing informed consent. These consumers reported a stark difference between the information and preparation prior to cosmetic surgeries, compared to other surgical procedures. For cosmetic surgery they described being given 'fancy-looking packets with all the information in it' and being told to 'go away and read it yourself'. They also described surgeons 'glossing over a lot of things' and the consent process being 'not a process of information sharing, rather a financial transaction and signatures on a page'.

In response to the question 'what did you want to know before consenting to the procedure?', participants in consumer focus groups responses included:

- *I would like the qualifications of the doctor*
- *What are the risks of something going wrong?*
- *What the process is for complications, just like full clarity*
- *What happens in the next couple of years, following the procedure? Because it doesn't just end after you leave*
- *I would like to see what research is available: I think clinicians can communicate research in a way that's accessible to consumers saying, you know, these are the adverse effects, these are the side effects we've seen, this is the percentage of people that things happen to. Yeah, I'd really like to see that [at the] first consult, you know, I want to all knowledge of the risks and the current research*
- *Do I have to be in a hospital [for after care]? If so, how much is that going to cost?*
- *What are the costs?*

Research and other guidance material

Studies show that when the information provided to patients is simple, clear and free from jargon, it results in improved patient knowledge, better patient recall, better understanding and better adherence to instructions from medical practitioners.[151] Equally important, according to

[151] A King and RB Hoppe, '"Best practice" for patient-centered communication: a narrative review', *Journal of Graduate Medical Education*, 2013, Sep;5(3):385–93, https://doi.org/10.4300/jgme-d-13-00072.1.

these studies, is the medical practitioner checking that the patient understands the information provided. These studies also show that patient satisfaction is strongly associated with the medical practitioner's communication and interactions with the patient. Providing information to consumers, and obtaining informed consent, are not just important requirements for medical practitioners, but are also associated with better patient outcomes.

Some international studies suggest that, in practice, medical practitioners in multiple fields frequently fall short of best practice in obtaining informed consent from patients.[152]

The Australian Charter of Healthcare Rights (the Charter) describes the rights that consumers can expect when receiving health care.[153] It includes a consumer's rights to information about their treatment, including possible benefits and risks, waiting times and costs, and a right to be told if something goes wrong. It also includes consumers' rights to provide feedback or make a complaint and have their concerns addressed in a transparent and timely way and in a way that doesn't impact on the care they receive.

Informed consent is central to the right to information in the Charter, and there is accompanying guidance for practitioners on how to obtain informed consent.[154] It provides guidance on obtaining valid informed consent, principles for assessing legal capacity, information on legal obligations, and links to further information and resources.

The National Safety and Quality Health Service Standards also require all hospitals and day procedure services to have informed consent processes that comply with legislation, lawful requirements and best practice.

There are a number of patient information resources available on cosmetic surgery. The ASPS, ASAPS and ACCSM all produce resources for patients, and these are readily accessible online.[155] These publications include information on what is involved in different cosmetic procedures, risks and potential complications, how to choose a suitable surgeon, and what questions to ask the surgeon. Some also include information on how to make a complaint. It is not clear whether or not the consumers who engaged in the review had access to these resources (or others) before their surgery or how widespread the use of these resources is.

Observations and analysis

Ensuring consumers have access to accurate and sufficient information and are able to give fully informed consent before having a procedure is critical to ensuring public safety. Informed consent can only be made if a patient fully understands the benefits and risks involved. Medical practitioners have a legal, ethical and professional responsibility to provide consumers with information and to ensure that they understand that information so that their consent is truly fully informed.

In this area, there were two key questions for the review to consider:

i. Do the current Cosmetic Guidelines give sufficient guidance to practitioners about the information they should provide to consumers?

ii. Are medical practitioners complying with these requirements?

[152] See for example, VJ Zonjee, JPL Slenders, F de Beer, M Visser, B ter Meulen, R Van den Berg-vos and S van Schaik, 'Practice variation in the informed consent procedure for thrombolysis in acute ischemic stroke: a survey among neurologists and neurology residents', *BMC Medical Ethics*, 2021, 22, 114. doi.org/10.1186/s12910-021-00684-6; M Hanson and D Pitt, 'Informed consent for surgery: risk discussion and documentation', *Canadian Journal of Surgery*, Feb 2017, 60 (1) 69–70, https://doi.org/10.1503/cjs.004816; J Ochieng, C Ibingira, W Buwembo, I Munabi, H Kiryowa, D Kitara, P Bukuluki, G Nzarubara and E Mwaka, 'Informed consent practices for surgical care at university teaching hospitals: a case in a low resource setting', *BMC Medical Ethics*, 2014, 15, 40, doi.org/10.1186/1472-6939-15-40; WK Leclercq, BJ Keulers, S Houterman, M Veerman, J Legemaate and M Scheltinga. 'A survey of the current practice of the informed consent process in general surgery in the Netherlands', *Patient Safety in Surgery*, 2013, 7, 4, doi.org/10.1186/1754-9493-7-4.

[153] Australian Commission on Safety and Quality in Health Care, Australian Charter of Healthcare Rights, 2019, accessed 29 June 2022.

[154] Australian Commission on Safety and Quality in Health Care, Informed consent in health care Fact sheet, 2020, accessed 29 June 2022.

[155] The ASPS website contains general information about plastic surgery, as well as information about specific procedures. The ASAPS website provides information about cosmetic surgery as well as patient information guides. The ACCSM website has a Patient Information Brochure and information about specific procedures.

Are the guidelines sufficient?

Section 4 of the current Cosmetic Guidelines requires the practitioner to provide written information to the patient about the procedure in plain language so they can make an informed decision. It lists the topics that practitioners must provide information on, including information about the procedure, the risks, possible outcomes, costs and the doctor's qualifications. The information must also include the complaints process and how to access it. Section 12 of the Cosmetic Guidelines includes information on financial arrangements and the cost information that must be provided to patients so they can provide informed financial consent.

In the circumstances, the review considers that the current Cosmetic Guidelines are generally comprehensive and, with some relatively minor additions and amendments, could easily address those topics raised by submitters and consumers that require more attention. Table 8 shows the topics that submitters and consumers indicated are critical to the issue of informed consent and the degree to which these are already addressed by the current Cosmetic Guidelines.

Table 8: The extent to which information for consumers is addressed by the current Cosmetic Guidelines

Topic	Included in current Cosmetic Guidelines?	Reference to Cosmetic Guidelines/comment
The practitioner should use plain language and provide information in the patient's preferred language	Partially	See 4.1 'The practitioner should also provide written information in plain language'. The Cosmetic Guidelines do not currently address the issue of consumers from non-English speaking backgrounds. The Cosmetic Guidelines should be amended to include reference to ensuring that information is provided in a language understood by the consumer.
The practitioner's training, qualifications and experience relevant to the procedure(s) being proposed	Yes	See 4.1 'The information must include [...] the medical practitioner's qualifications and experience'. Some recommendations are made in this report about establishing minimum training and qualifications standards about cosmetic surgery (both by providing more information in the Cosmetic Guidelines (see below) and establishing an area of practice endorsement (see 'Chapter 1 – Education, Training and Qualifications'). If, and when, these recommendations are implemented, this section of the Cosmetic Guidelines should also be amended to reflect those other changes. Consideration should be given, for example, to requiring medical practitioners to disclose to consumers if they do not meet minimum training requirements detailed in the Cosmetic Guidelines or do not hold an area of practice endorsement.
What the procedure involves, the risks, potential complications and the range of potential outcomes, both short- and long-term	Partially	See 4.1 'The information must include [...] what the procedure involves', 'the range of possible outcomes of the procedure', 'the risks and possible complications associated with the procedure'. The Cosmetic Guidelines do not currently require the potential outcomes/complications to be explained with reference to the short- and long-term nor do they require discussion about any comorbidities the consumer may have. The Cosmetic Guidelines should be amended to include these.
Whether the procedure is new or experimental	Yes	See 4.1 'The information must include [...] whether the procedure is new or experimental'.
Alternatives to the procedure(s) proposed, including non-surgical options if available and suitable for the patient	Yes	See 2.6 'The medical practitioner who will perform the procedure should discuss other options with the patient, including medical procedures or treatment offered by other health practitioners and the option of not having the procedure'.
Recovery times	Yes	See 4.1 'The information must include [...] recovery times and specific requirements during the recovery period'.
The possibility of the need for revision surgery both in the short- or long-term	Yes	See 4.1 'The information must include [...] the possibility of the need for revision surgery or further treatment in the short term (for example, rejection of implants) or the long term (for example, replacement of implants after expiry date)'.
Ensure patients understand the information provided including checking the consumer's understanding	No	The Cosmetic Guidelines are focused on providing the patient with information and do not address the issue of ascertaining that the patient understands the information. The Cosmetic Guidelines should be amended to emphasise the need to confirm patient understanding.

Topic	Included in current Cosmetic Guidelines?	Reference to Cosmetic Guidelines/comment
Transparent details about the full costs of the procedure, to ensure informed financial consent including: o the cost of any additional medical practitioners who will be involved in the procedure (for example, the anaesthetist) o the cost of the hospital or day procedure centre o the cost of any implants or other devices to be used o the cost of any after care, including any garments or devices required to support recovery during the post-operative period o the likely cost of any revision surgery or additional treatment that may be required o the cost of any postoperative appointments with the surgeon.	Partially	See 4.1 'The information must include [...] total cost including details of deposits required and payment dates, refund of deposits, payments for follow-up care and possible further costs for revision surgery or additional treatment'. See 12.1 'The patient must be provided with information in writing about the cost of the procedure, which should include: • total cost • details of deposits required and payment • dates • refund of deposits • payments for follow-up care • ossible further costs for revision surgery or additional treatment, and • advising the patient that most cosmetic procedures are not covered by Medicare'. There would be benefit to expanding the Cosmetic Guidelines to encourage practitioners to include more information about costs (or likely costs) of: • additional medical practitioners (such as the anaesthetist or assistant surgeon, if any) • the hospital or day procedure centre • any implants or other devices to be used • any after-care, including any garments or devices required to support recovery. It is acknowledged that not all of this information will be known by the practitioner. However, practitioners should be encouraged to take all reasonable steps to ascertain and provide this information to the patient (even if indicative only) and/or explain how the information can be obtained. The Cosmetic Guidelines should be amended to provide more detail on this matter.
Information on complaints and notifications processes, including the range of options available to consumers, escalation pathways and the roles and responsibilities of Ahpra and state/territory health complaints entities.	Partially	See 4.1 'The information must include [...] the complaints process and how to access it'. There is scope to enhance the Cosmetic Guidelines to include more details about the full range of complaints mechanisms available to the consumer, including how to resolve a complaint directly with the practitioner, the complaints process available through the health facility being used, information on the health complaints entity in the relevant jurisdiction, and information on making a notification to Ahpra. The Cosmetic Guidelines should be amended to provide more detail on these matters. There would be value in Ahpra and the Medical Board developing a document/pamphlet/poster that explains the complaint/notification pathways available to patients having cosmetic surgery. Practitioners could display this in their clinic and provide it directly to patients or refer to it when providing information to consumers about the complaints process.
Consumers should be provided with the TGA patient implant cards (PICs) and patient information leaflets (PILs) where surgery includes implants, to support informed consent.	No	Procedures involving medical devices, such as implants, require additional consent elements. The Cosmetic Guidelines should be amended to include more guidance regarding information on devices and implants (when used) that should be provided to consumers.

The review recommends that the Medical Board should review and update the current Cosmetic Guidelines as outlined in Table 8.

Compliance with the guidelines

While this review did not undertake any systematic audit of practitioners' consenting practices and information they provide to consumers, the review of a sample of notifications to Ahpra suggests that practice is mixed and submitters to the review indicate that universal compliance is a problem.

In practice, poor consumer understanding in this area is likely to be caused by one or more of the following factors: a lack of adequate and clear preoperative information being provided to a consumer; a consumer's failure to read, comprehend and/or understand the material; and a failure on the part of the practitioner to adequately explain the information or ascertain whether the consumer understands the information. While the review is aware that some practitioners in the sector have excellent consenting processes, the information received by the review indicates this approach is not universal.

Compliance is the responsibility of the practitioner. While it has been submitted that Ahpra and the Medical Board should be proactive in this space and audit compliance with the consenting

requirements, the review considers that Ahpra and the Medical Board lack the power to do this, indicating that such activity is beyond their legislative remit.

However, as is noted in 'Chapter 2 – Managing Notifications', a consistent approach to managing notifications would require the proper analysis of compliance with the Cosmetic Guidelines (including of the consenting process) when assessing a notification.

Compliance is also likely to be improved through appropriate training. This underscores the importance of addressing minimum training and qualifications standards discussed elsewhere in this report.

Patient management

The provision of anaesthesia and sedation and postoperative care were raised by stakeholders and was a focus of the review under the Patient Management section of the Cosmetic Guidelines. Each topic will be dealt with separately below.

Sedation and anaesthesia

Current Cosmetic Guidelines

5. Patient management

5.3 When a patient may need sedation, anaesthesia and/or analgesia for a procedure, the medical practitioner who is performing the procedure must ensure that there are trained staff, facilities and equipment to deal with any emergencies, including resuscitation of the patient.

6. Provision of patient care by other health practitioners

6.1 The medical practitioner is responsible for ensuring that any other person participating in the patient's care has appropriate qualifications, training and experience, and is adequately supervised as required.

Stakeholder feedback

The feedback about the involvement of other health practitioners in cosmetic surgery was predominantly focused on anaesthesia, with concerns about the training and qualifications of practitioners providing anaesthesia for cosmetic surgery.

In its submission, the Australian and New Zealand College of Anaesthetists (ANZCA) stated that 'practitioners providing anaesthesia, sedation or analgesia as part of any cosmetic surgical procedures must be specifically qualified and trained'. ANZCA also advised that:

> *[...] its professional documents seek to promote uniform standards for high quality and safety in the administration of local anaesthesia, major regional anaesthesia, analgesia administered without sedation, general anaesthesia, and procedural sedation by all duly qualified health practitioners.*

Submissions from practitioners, as well as some TAG members also noted the ANZCA guidelines and position statements that set out the accepted standard for anaesthesia.

Several specialist anaesthetists who made submissions suggested that all anaesthesia for cosmetic surgery should be provided by specialist anaesthetists (with fellowship of ANZCA). The majority of TAG members supported the provision of general anaesthesia and sedation by specialist anaesthetists, but also noted the role of practitioners such as GP anaesthetists who have received further training in anaesthesia.

The importance of appropriate anaesthesia or sedation to patients is reflected in the results from the consumer survey. Survey respondents whose anaesthetic allowed them to sleep during the procedure were more likely to have identified as being happy with the surgical experience,

compared to those who were awake for the procedure.[156] Some survey respondents also raised concerns about the type of anaesthesia they were given and the environment in which it was provided.

Observations and analysis

Stakeholder feedback noted that the provision of anaesthesia is an area of risk for patient safety in cosmetic surgery. However, in all the circumstances, the review considers that the Cosmetic Guidelines generally set appropriate expectations about those practitioners involved in sedation, anaesthesia and/or analgesia, including that they are appropriately trained.

Given the wide spectrum of sedation and anaesthesia applied to the wide variety of cosmetic surgical procedures, the review was unable to reach a conclusion about what further detail could be provided here. While not a recommendation of this review, the Medical Board may wish to consider further engagement with key stakeholders on this issue in an attempt to provide greater clarity in the Cosmetic Guidelines.

Postoperative care

Current Cosmetic Guidelines

5. Patient management

5.1 The medical practitioner who will perform the procedure is responsible for the management of the patient, including ensuring the patient receives appropriate post-procedure care

5.2 If the medical practitioner who performed the procedure is not personally available to provide post-procedure care, they must have formal alternative arrangements in place. These arrangements should be made in advance where possible, and made known to the patient, other treating practitioners and the relevant facility or hospital

[…]

5.4 There should be protocols in place for managing complications and emergencies that may arise during the procedure or in the immediate post-procedure phase

5.5 Written instructions must be given to the patient on discharge including:

- the contact details for the medical practitioner who performed the procedure
- alternative contact details in case the medical practitioner is not available
- the usual range of post-procedure symptoms
- instructions for the patient if they experience unusual pain or symptoms
- instructions for medication and self-care, and
- dates and details of follow-up visits.

Stakeholder feedback

Postoperative care was also an area that the TAG identified as critical for patient safety and they noted some elements where more guidance could be provided. Some members had concerns about cases when consumers had seemingly been left to manage their own complications and determine when escalation of care was required and how to access it. The potential for consumers suffering complications to be unloaded on the public emergency health system, particularly without appropriate coordination by the practitioner who undertook the surgery, was seen as very problematic.

[156] When asked what type of anaesthetic was used for their procedure, 89% of respondents who reported being happy with the surgery selected 'I was asleep or unconscious during the surgery' – compared with 68% of respondents who were not happy with their surgery. A further 9% of respondents who reported being happy with the surgery selected 'I was awake during the procedure and had part of my body numbed' – compared to 17% who were not happy with their surgery.

During a meeting between the review team and state and territory health commissioners, the issue of poor postoperative care was identified by one commissioner as a serious issue of concern based on evidence from complaints received by them.

The TAG reiterated the importance of the practitioner who performs the procedure being available for postoperative care and postoperative complications. It was their view that if the practitioner is not available there should be another suitably qualified medical practitioner on call to cover the absence.

The TAG also discussed the issue of practitioners' admitting rights, and most members noted the treating medical practitioner should really have admitting rights to a local hospital, or if not, have made prior arrangements with another medical practitioner who has those rights and is able to take over care.

In the procedure guides, the TAG identified the minimum information that should be included in discharge instructions to ensure the patient is aware of expected outcomes and when to seek emergency care.

The ASPS noted that the formal alternative arrangements referenced in 5.2 'must include a medical practitioner'. They also suggested the alternative contact details in section 5.5 should be 'a qualified medical practitioner' and 'instructions of when it is appropriate to present to the emergency department' (rather than contacting the medical practitioner).

The TAG also commented on record keeping. The Medical Board's Code of conduct has clear guidance on medical records and what they must include.[157] However, for cosmetic surgery some TAG members noted the additional importance of ensuring that the procedure not only be named but described in detail – particularly so that another practitioner could take over postoperative care and/or operate on the patient in the future with an adequate understanding of what has been done. The GMC's guidelines also reference the need for sufficient information to enable another medical practitioner to take over the patient's care. The European Standards provide a list of information that must be recorded to ensure other doctors and hospitals are aware of the exact nature of the procedure should something go wrong.

Some stakeholders also noted that ensuring availability of postoperative care can be difficult when practitioners provide surgery across multiple states and territories. Ensuring access to appropriate care may also be an issue when patients access surgery away from their usual location.

The VPCC had concerns about fly-in, fly-out practice and suggested that 'the treating medical practitioner should be available for at least 24 hours'.

On this issue, one survey respondent said:

> *There were bleeding complications post-surgery and the doctor could not be contacted as he was already on a plane back to Sydney.*

Observations and analysis

Inadequate postoperative care in cosmetic surgery puts patients at risk. The review considers that more guidance is needed to ensure a high standard of care about the care patients receive after their procedure, both immediately and in the subsequent days, particularly for patients who experience an adverse event or complications.

Section 5.4 of the Cosmetic Guidelines sets a general expectation that protocols should be put in place for managing complications and emergencies. However, the review considers that the Medical Board should amend the Cosmetic Guidelines to provide more guidance on postoperative care, taking into consideration the relevant practice guidance in the TAG procedure guides. The review considers that there is scope to provide more detail about arrangements that should be put in place to manage complications and emergencies.

Section 5.5 provides a reasonable list of matters that should be included in postoperative instructions. However, again the review considers that there is scope for more detail. The Medical Board should amend the Cosmetic Guidelines and provide more guidance for practitioners on the minimum detail that should be provided in discharge instructions for patients, taking into consideration the relevant practice guidance in the TAG procedure guides. This should include

[157] Section 10.5 in Medical Board of Australia, Good medical practice: a code of conduct for doctors in Australia.

clear information on what to do if the patient experiences adverse reactions or complications after the procedure, and escalation points if the patient's surgeon is not available (who to contact and when).

Additionally, noting that the Cosmetic Guidelines currently do not include detail on some areas raised as areas of concern by stakeholders, the Medical Board should consider providing guidance specific to cosmetic surgery on:

1. record keeping
2. when the procedure is provided in a location that is not the practitioner and/or the patient's usual location (that is, fly-in/fly-out practitioners for interstate or rural and remote patients).

Facilities

Current Cosmetic Guidelines

11. Facilities

11.1 The Board expects that medical practitioners are familiar with relevant legislation, regulations and standards of the jurisdiction in relation to facilities where the procedure will be performed

11.2 Procedures should be performed in a facility that is appropriate for the level of risk involved in the procedure. Facilities should be appropriately staffed and equipped to manage possible complications and emergencies.

Stakeholder feedback

While there is a section in the Cosmetic Guidelines about Facilities (section 11), the Board's current guidance is understandably limited as it is state and territory health authorities who regulate the facilities where cosmetic surgery is performed. There was less feedback about this section from stakeholders.

A medical indemnity insurer queried why the Board would not expect practitioners to 'comply with' facility regulations rather than 'be familiar with' as is the current guidance. They and many others also noted the current inconsistencies in facility regulation across states and territories and the problems associated with such variation.

Many organisations and medical practitioners highlighted patient safety concerns about where cosmetic surgery can be provided. A specialist anaesthetist stated, 'cosmetic surgery needs to be performed [...] in a properly accredited facility where it is accredited for anaesthesia even though only "sedation" may be given'. A specialist plastic surgeon suggested that 'procedures are done under local anaesthetic and "sedation" to avoid accredited facilities'.

Other stakeholders also raised concerns about the rigour of the clinical governance in some facilities where the facility is owned and operated by the practitioner performing the surgery.

The importance of the facility to consumers is reflected in the results from the consumer survey. Survey respondents who were happy with their procedure were more likely to have had surgery in a hospital where they could stay overnight; while survey respondents who were unhappy with their procedure were more likely to have had surgery in the doctor's clinic or a day procedure centre.[158]

Some survey respondents raised serious concerns about the safety and quality of the facilities in which their procedures were performed. For example, statements from survey respondents included:

- *The clinic [...] is so unhygienic and unprofessional standard for a hospital. There's blood stains on curtains, boxes everywhere, dirty seats*

[158] When asked 'where was your procedure performed', 53% of respondents who reported being happy with their surgery selected in 'a hospital where you can stay overnight' – compared with 38% of unhappy respondents who answered in that manner. A further 9% of respondents who reported being happy with the surgery selected in a 'day hospital run/owned by the doctor' – compared to 24% of the unhappy respondents who answered in that manner. 5% of respondents who reported being happy with the surgery selected in the 'doctor's rooms' – compared to 14% of unhappy respondents who answered in that manner.

- *The private hospital [was] understaffed. [...] I deteriorated. [...] eventually [...] [they] [...] called an ambulance*
- *The doctor also heavily [marketed] that the surgery would be cheaper than going to see a specialist because the surgery can be done as a day procedure and doesn't require admission to a hospital.*

Observations and analysis

The review found significant differences in approaches between different states and territories about which procedures can be performed in which facilities. This is a particular concern as there are risks to patients when cosmetic surgery is undertaken in facilities that are not appropriate for the procedure.

As has been discussed in 'Chapter 2 – Management of Notifications', some jurisdictions have a list of named procedures that must be undertaken in certain facilities and other jurisdictions determine this by reference to the type of anaesthesia used. Also, for example, with liposuction, in some jurisdictions, facility determination is based on volume of lipoaspirate removed but the actual volumes also vary (that is, 200 ml in one state[159] and 2500 ml in some others[160]) and some other states/territories do not specify a volume at all.

The state-by-state variation in approach to facility regulation is a matter obviously outside of the control of Ahpra and the Medical Board. However, the review remains concerned that gaps in facility regulation potentially expose patient safety to undue risk. Therefore, the review considers that Ahpra and the Medical Board could take this opportunity to raise this issue and encourage jurisdictions to strengthen consistent facility regulation. The review considers that there is an opportunity for Ahpra and the Medical Board to take a lead role in attempting to facilitate reform in areas outside its powers where patient safety issues have been identified.

The review also considers that the language in section 11.1 should be amended from medical practitioners being 'familiar with relevant legislation, regulations and standards [...] in relation to facilities' to 'must comply with' those requirements, making it clear that compliance is mandatory.

Training and experience

Current Cosmetic Guidelines

8. Training and experience

8.1 Procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure and deal with all routine aspects of care and any likely complications

8.2 A medical practitioner who is changing their scope of practice to include cosmetic medical and surgical procedures is expected to undertake the necessary training before providing cosmetic medical and surgical procedures.

Stakeholder feedback

The majority of the feedback about the Cosmetic Guidelines was related to section 8, *Training and experience*, with most organisations and medical practitioners providing some feedback on this issue.

Stakeholder feedback on this issue is discussed in more detail in 'Chapter 1 – Education, Training and Qualifications'. However, the general theme of the submissions was that while the Cosmetic Guidelines state that 'procedures should only be provided if the medical practitioner has the appropriate training, expertise, and experience to perform the procedure', they do not specify what training would be considered to be appropriate.

[159] Victoria specified in the Health Services (Health Service Establishments) Regulations 2013 (Vic) reg 6(c)(i) and (v).

[160] New South Wales specified in the Private Health Facilities Regulation 2017 (NSW) regs 3–4. and Queensland specified in the Private Health Facilities Regulation 2016 (Qld) reg 3(2).

Stakeholders noted that referring to 'appropriate training, expertise and experience' has limited usefulness when cosmetic surgery is not a recognised specialty and there is not agreement within the profession on which training program(s) are appropriate.

Observations and analysis

Many stakeholders were critical of the generality of the wording in the Medical Board's current Cosmetic Guidelines about the Medical Board's expectations for training and qualifications for medical practitioners providing cosmetic surgery. The Cosmetic Guidelines state practitioners should have 'appropriate training' and 'necessary training' but do not provide any guidance as to what might be considered appropriate or necessary.

As the National Law is based on a title protection model, and not a model that regulates scope of practice, the Medical Board is not able to specify in a guideline which practitioners can or cannot provide which cosmetic surgery procedures. Guidelines can provide general guidance however of the expectations of the Medical Board about training, qualifications and experience.

If an endorsement is approved for cosmetic surgery, section 8 of the Cosmetic Guidelines could be updated and strengthened to include endorsement as 'appropriate training'.

As has been discussed in 'Chapter 1 – Education, Training and Qualifications', the complex and challenging processes involved with establishing an area of practice endorsement, it is likely to take some time. It also involves approval by the Ministerial Council. In the interim, the review considers that it would be beneficial for the Medical Board to strengthen the Cosmetic Guidelines to provide more direction on the minimum training, expertise and experience expected of medical practitioners providing cosmetic surgery. This could include, for example, reference to the expectation that practitioners have undertaken some foundational surgical skills training, training in the specific procedures being offered, and appropriate supervised practice. The guideline should also articulate the importance of ongoing CPD in this area.

The review appreciates that this too will not be a straightforward task. It will be necessary for the Medical Board to strike a balance between being too general and being overly specific in its approach. While it may not be possible to list specific qualifications, the review considers that the Board could clarify its expectations about training in this space by providing more detail.

Qualifications and titles

Current Cosmetic Guidelines

9. Qualifications and titles

9.1 A medical practitioner must not make claims about their qualifications, experience or expertise that could mislead patients by implying the practitioner is more skilled or more experienced than is the case. To do so is a breach of the National Law (sections 117–119).

The Cosmetic Guidelines state that a medical practitioner 'must not make claims about their qualifications, experience or expertise that could mislead patients by implying the practitioner is more skilled or more experienced than is the case'.

There was significant feedback in submissions about titles, who should be able to use which titles and many who thought that the use of the title 'surgeon' by those who do not have specialist surgical qualifications, is misleading. This feedback is detailed in Chapter 1 of the report.

Noting that Health Ministers are currently considering title protection and whether to protect the title 'surgeon', the review makes no recommendations for amendments to section 9 of the Cosmetic Guidelines.

Advertising and marketing

Current Cosmetic Guidelines

10. Advertising and marketing

10.1 Advertising material, including practice and practitioner websites, must comply with the Board's Guidelines for advertising of regulated health services, the current Therapeutic Goods Advertising (TGA) Code, any TGA guidance on advertising cosmetic injections and the advertising requirements of section 133 of the National Law

10.2 Advertising content and patient information material should not glamorise procedures, minimise the complexity of a procedure, overstate results or imply patients can achieve outcomes that are not realistic.

Section 10 of the Cosmetic Guidelines relates to *Advertising and marketing*. Currently the Medical Board's Cosmetic Guidelines reference the need to comply with guidance in the National Boards' *Guidelines for advertising of regulated health services* (the Advertising Guidelines). Many stakeholders made suggestions for strengthening the guidance about advertising, either in the Cosmetic Guidelines and/or in the Advertising Guidelines.

More detail about stakeholder feedback, analysis of the issues and recommendations made by this review is provided in 'Chapter 3 – Advertising Regulation'.

Financial arrangements

Current Cosmetic Guidelines

12. Financial arrangements

12.2 No deposit should be payable until after the cooling-off period

12.3 The medical practitioner should not provide or offer to provide financial inducements (e.g. a commission) to agents for recruitment of patients

12.4 The medical practitioner should not offer financing schemes to patients (other than credit card facilities), either directly or through a third party, such as loans or commercial payment plans, as part of the cosmetic medical or surgical services

12.5 Medical practitioners should not offer patients additional products or services that could act as an incentive to treatment (e.g. free or discounted flights or accommodation)

12.6 Medical practitioners should ensure that they do not have a financial conflict of interest that may influence the advice that they provide to their patients.

Stakeholder feedback

The majority of the feedback about section 12 *Financial arrangements* focused on the information that should be provided to consumers about the costs of surgery. This feedback is outlined above under 'Consent and financial consent'.

There was limited feedback about other aspects of financial arrangements. A small number of stakeholders raised concerns about practitioners advising their patients to access their superannuation, take out a loan or re-mortgage their home to pay for cosmetic surgery. One stakeholder also suggested that the Medical Board's guidance on financing schemes should be incorporated into the Cosmetic Guidelines.[161]

Observations and analysis

The review considers that it would be opportune for the Medical Board to review and incorporate the guidance from its *Information sheet – Cosmetic medical and surgical procedures – guidance on financing schemes* into the Cosmetic Guidelines.

Compliance

As has been discussed in this chapter, compliance by some practitioners in this sector with the Code of Conduct and the Cosmetic Guidelines has been identified as a serious concern.

Some submitters have argued that Ahpra and the Medical Board should be proactive and audit compliance with the codes and guidelines in this sector. However, as has also been stated above, the review considers that Ahpra and the Medical Board lack the power to take a proactive audit approach to compliance. Audits would require Ahpra and the Medical Board to obtain various documentation from practitioners (including medical records), to enter practice premises to undertake inspections and otherwise compel information from relevant parties. While there is a Board-initiated investigative power in the National Law, it is doubtful that it could be used to support a broad audit function. Undertaking proactive compliance auditing is also not outlined as a function or responsibility of Ahpra and/or the Medical Board in the National Law. All this indicates that proactive auditing and monitoring of compliance with the codes and guidelines is outside the remit of Ahpra and the Medical Board.

A distinction should be drawn between auditing practice against codes and guidelines and auditing advertising conduct (which is dealt with in 'Chapter 3 – Advertising Regulation'). Monitoring or auditing a practitioner's advertising can be done through open-source enquiries and without requesting information or documentation from the practitioner. If advertising is identified that may be in breach of section 133 or the Advertising Guidelines, Ahpra has the power to commence an investigation which can then compel information.

Notwithstanding the inability to audit compliance, as is noted in 'Chapter 2 – Managing Notifications', a consistent approach to managing notifications would require the proper analysis of a practitioner's compliance with the relevant codes and guidelines when assessing a notification. This provides the Medical Board with some ability to identify and take appropriate action when non-compliance with codes and guidelines is identified.

Finally, noting the issues regarding poor compliance with the Cosmetic Guidelines by some medical practitioners, the review recommends that the Medical Board and Ahpra consider ways to increase awareness of the Cosmetic Guidelines for medical practitioners practising in this area. Increasing awareness of the guidelines could also be beneficial for consumers as it can help them understand the standard of care they should be able to expect from a registered medical practitioner.

In these circumstances the review considers that it would be beneficial for Ahpra and the Medical Board to periodically publish lessons learned about cosmetic surgery using deidentified data, outcomes of notifications and other information sources as an educative tool for practitioners and to further inform consumers. Observations from any audits of advertising of cosmetic surgery as recommended in 'Chapter 3 – Advertising Regulation' could also be published.

[161] Medical Board of Australia, *Information Sheet Cosmetic medical and surgical procedures – guidance on financing schemes*, 2019, accessed 26 July 2022.

Recommendations

13. The Medical Board review, consult on and update its Guidelines for medical practitioners who perform cosmetic medical and surgical procedures to clarify expectations, including amending the following sections as detailed in 'Chapter 4 – Influencing Practice':
    a) definition
    b) section 2 – Patient assessment (including preoperative screening, cooling-off period, video consultations)
    c) section 4 – Consent (including informed financial consent)
    d) section 5 – Patient management (including sedation and anaesthesia, and postoperative care)
    e) section 8 – Training and experience
    f) section 11 – Facilities
    g) section 12 – Financial arrangements.
14. The Medical Board strengthen the Cosmetic Guidelines by reviewing where 'should' is used and consider using 'must' to make expectations clearer.
15. The Medical Board and Ahpra take on a role in seeking to facilitate reform in areas outside its powers and responsibilities where patient safety issues have been identified (for example, writing to the Ministerial Council recommending work be undertaken to develop a standardised national approach to health facility licensing and accreditation, including what types of cosmetic procedures can be done in each type of facility).
16. The Medical Board consider periodically publishing lessons learned in cosmetic surgery using deidentified data, outcomes of notifications and other information sources as an educative tool for practitioners and to further inform consumers.

Conclusion

The unique nature of the cosmetic surgery sector poses regulatory challenges not normally experienced in other areas of medical practice. Further, it tends to sit outside of the traditional health systems, disrupting the traditional specialist medical practice model. Regulatory responsibility is dispersed through a patchwork of national and state/territory agencies, all with different roles to play to address consumer safety issues present in the sector. Ahpra and the Medical Board play an important role here but their powers and remit have limits.

The model of regulation provided for under the National Law, which is focused more on what practitioners are allowed to call themselves than what they are allowed to do, also poses challenges when responding to the issues that have been thrown up by this sector. This also means that the National Law provides no universal remedy to some of the more entrenched problems identified in this report.

However, notwithstanding these limitations, Ahpra and the Medical Board should do all that they reasonably can, including taking appropriate regulatory action within their sphere of influence. This report maps out the steps that they should take to seek to achieve this demanding goal.

Owing to the challenging and entrenched nature of some of the issues presented in this sector, solutions will take time. The implementation of the recommendations is likely to be broken down into short-, medium- and long-term pieces of work.

Some recommendations, like improving internal guidance and training material for their staff about notification management, or educational material for consumer and practitioner notifiers could be implemented quite quickly. One would also expect that a methodology for a targeted cosmetic surgery advertising audit could be developed in the short term, although the actual audit is likely to be more time consuming. Changes to the way that Ahpra applies the current advertising enforcement strategy to escalate high-risk matters could also be enacted relatively quickly.

Enhancements to guidelines such as the Cosmetic Guidelines and Advertising Guidelines, are likely to be more of a medium-term endeavour. Under the National Law they require extensive consultation, and this will take time. A consultation process is likely to elicit a significant number of submissions and potentially opposing views.

The complete implementation of an endorsement model of practice for cosmetic surgery is a long-term undertaking. It is a highly complicated exercise with many complex parts. Among other things, it will also involve and be dependent upon Ministerial Council approval. The development of accreditation standards and the approval processes for programs of study will also take time. Finally, the challenges posed by 'grandparenting' arrangements may also mean that the true value of this process will not be realised for some years to come.

However, if a process such as this does not commence soon then there is a real possibility that the unsatisfactory situation of uncertainty and confusion around the appropriate minimum standards of education, training and qualifications that was identified over 20 years ago, will continue to exist for another 20 years. Further, it is likely that by then more and more practitioners, with varying degrees of training, qualifications and experience, will have entered the sector and the ability to take effective action to address the problem will be even more challenging than it is now.

Acronyms and abbreviations

ACCC	Australian Competition and Consumer Commission
ACCS	Australasian College of Cosmetic Surgery (now ACCSM)
ACCSM	Australasian College of Cosmetic Surgery and Medicine
ACD	Australasian College of Dermatologists
ACSQHC	Australian Commission on Safety and Quality in Health Care
Advertising Guidelines	Ahpra and National Boards' Guidelines for advertising a regulated health service
Ahpra	Australian Health Practitioner Regulation Agency
AHSSQA	Australian Health Service Safety and Quality Accreditation Scheme
AMA	Australian Medical Association
AMC	Australian Medical Council
ANZCA	Australian and New Zealand College of Anaesthetists
ARTG	Australian Register of Therapeutic Goods
ASAPS	Australasian Society of Aesthetic Plastic Surgeons
ASPS	Australian Society of Plastic Surgeons
BDD	Body dysmorphic disorder
CHF	Consumers Health Forum of Australia
Cosmetic Guidelines	Medical Board of Australia's Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures
CPD	Continuing professional development
CRAG	The review's Consumer Reference and Advisory Group
ENT surgeon	Specialist otolaryngologist (ear, nose and throat surgeon)
GMC	General Medical Council (UK)
Good medical practice	Medical Board of Australia's Good medical practice: a code of conduct for doctors in Australia
GP	General practitioner
FAQs	Frequently asked questions
HCCC	Health Care Complaints Commission
HCE	Health complaints entity
HQCC	Health Quality and Complaints Commission
Medical Board	Medical Board of Australia
MCNZ	Medical Council of New Zealand
National Law	The Health Practitioner Regulation National Law, as in force in each state and territory
NDA	Non-disclosure agreement
NFA	No further action
NHPO	National Health Practitioner Ombudsman
NRAS / National Scheme	National Registration and Accreditation Scheme
NSQHS	National Safety and Quality Health Service Standards
NSQPCH	National Safety and Quality Primary and Community Healthcare Standards
OHO	Office of the Health Ombudsman (Queensland)

RACDS	Royal Australasian College of Dental Surgeons
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RIS	Regulation impact statement
TAG	The review's Technical Advisory Group
TGA	Therapeutic Goods Administration
ToR	Terms of reference
VPCC	Victorian Perioperative Consultative Council

Glossary

Accreditation standards	Used to assess whether a program of study and the education provider that provides that program of study, provide people who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia. For medicine, accreditation standards are developed by the Medical Board of Australia's accreditation authority, the Australian Medical Council (AMC), and are approved by the Medical Board of Australia. The AMC uses accreditation standards to assess programs and their providers for accreditation purposes. The AMC also uses the accreditation standards for monitoring accredited programs and providers to ensure that they continue to meet the standards.
Approved qualification for endorsement of registration (for medical practitioners)	A program of study accredited by the AMC and approved by the Medical Board as providing a qualification relevant to the endorsement. A list of approved programs of study for endorsement of registration (would be) published on the Medical Board website.
Australian Medical Council	The accreditation authority for medicine, responsible for accrediting education providers and their programs of study for the medical profession.
Education provider	An organisation that is accredited to provide approved programs of study that lead to registration as a health practitioner.
Endorsement	An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board. There are a number of different types of endorsement available under the National Law, including: • scheduled medicines • Nurse Practitioner • acupuncture, and • approved area of practice.
Health complaints entity	Specific to each state and territory, an entity that is established by or under an Act of a participating jurisdiction to receive and manage health service complaints.
Ministerial Council	The Commonwealth, state and territory health ministers, who oversee the National Registration and Accreditation Scheme.
National Board	Appointed by the Ministerial Council to regulate the profession in the public interest and meet the responsibilities set down in the National Law. National Board members and/or state/territory board members and/or committee members are delegated the functions/powers of the National Board.
National Law	The Health Practitioner Regulation National Law, as in force in each state and territory.
Policy direction	The Ministerial Council may issue Ahpra and National Boards with binding policy directions and guidance about the National Scheme. Policy directions are issued under Section 11 of the National Law.

Public register	Ahpra publishes a list of every health practitioner who is registered to practise in Australia in the regulated professions. Also called the 'Register of practitioners'.
Registration standard	Defines the requirements that applicants, registrants or students need to meet to be registered. They are developed by the National Board and approved by the Ministerial Council.
Specialist medical college	An organisation whose program of study has been accredited by the AMC, and whose resultant qualification has been approved by the Medical Board as providing a qualification for the purposes of specialist registration.
Specialty	Any of the recognised medical specialties, fields of specialty practice and related specialist titles that have been approved by the Ministerial Council pursuant to the National Law.

Appendices

Appendix A: Terms of reference

Why this review?

Cosmetic surgery has rapidly grown as a multi-million dollar entrepreneurial industry. Its rapid growth has highlighted practices and methods of promotion by some registered health practitioners which raise both ethical dilemmas and significant patient safety concerns.

Regulation of cosmetic surgery is multifaceted, involving multiple state, territory and national regulators. Effective regulation requires clarity of roles and responsibilities and efficient information sharing.

Who regulates cosmetic surgery?

Ahpra and the Medical Board of Australia (MBA) are just one part of a complex system that regulates cosmetic surgery in Australia.

This type of surgery is generally required to be performed in private facilities which are licensed by State and Territory health authorities. State licensing laws require a comprehensive set of standards to be met, including proper infection control, appropriate resuscitation and other clinical infrastructure, and robust credentialing and scope of practice processes for medical practitioners and other clinical staff working in these facilities. State and territory authorities are responsible for compliance and enforcement of these licensing laws, including regular inspections and removal of licences for those found to be significantly breaching standards.

The Australian Commission for Safety and Quality in Health Care also plays a key national leadership role in developing national standards for accreditation of health facilities, and this forms an important part of the assurance processes to inform consumers whether a facility is appropriately equipped and operating to safely provide health services.

State and Commonwealth consumer law also has a part to play in providing a legal framework for the provision of cosmetic procedures, and the advertising thereof.

In NSW, health professional disciplinary regulation including of doctors, nurses and other involved in cosmetic surgery, are the responsibility of NSW State health professional councils and the NSW Health Care Complaints Commission, not Ahpra or National Boards.

Who can call themselves a cosmetic surgeon?

Some cosmetic surgical procedures are undertaken by medical practitioners who have completed advanced specialist surgical or medical training. Whilst professional codes of conduct set out expectations that practitioners will only practise within the limits of their education, training and competence, current regulatory provisions do not expressly prevent any registered medical practitioner from calling themselves a "cosmetic surgeon". This may convey the impression that they are specifically qualified or specialised in the area.

Traditionally, Ahpra has not considered the use of the term 'cosmetic surgeon' by, or about, a registered medical practitioner to be a title protection breach because there is no recognised medical specialty or specialty field of 'cosmetic surgery' or protected title relating to 'cosmetic surgery'. The title 'surgeon' is not currently protected.

Ministers have announced their intention to consult on protecting the title of 'surgeon' and the consultation is expected to commence by early 2022. Protection of title in this way would require amendment to the National Law and the consultation has been welcomed by National Boards and Ahpra. This review may assist in informing that consultation.

When can Ahpra and the Medical Board of Australia act?

Where a cosmetic surgeon's performance is placing the public at risk or a practitioner is practising their profession in an unsafe way, the MBA and Ahpra expect concerns of other registered practitioners to be raised in accordance with their mandatory reporting obligations, through the notifications process. However, it appears that there is a weak reporting and safety culture in many

areas of cosmetic surgery and patient safety concerns are not being notified in a timely way as required by doctors, nurses or other health professionals who become aware of these practices.

Social media is increasingly being used to advertise and promote cosmetic medical and surgical procedures. This often focuses on the benefits for the consumer, downplaying or not mentioning the risks. Factual, easily understood information for consumers contemplating cosmetic medical or surgical procedures may not be readily available and there is significant information asymmetry for consumers. There is also an additional challenge where individuals who are committed to having cosmetic surgery do not want to learn about the risks, focusing on the benefits alone.

Ahpra considers any complaints about whether advertising of cosmetic surgery/cosmetic surgeons breaches the advertising requirements of the National Law, for example, misleading and deceptive claims about clinical outcomes unsupported by acceptable evidence. However, the explosion in social media raises new challenges for the regulatory response of Ahpra in this area.

Ahpra and relevant National Boards have done substantial work on the regulation of cosmetic surgery and procedures over a number of years which may assist the Review.

Ahpra and National Boards aim to ensure high quality and safe care with safe products, skilled practitioners and responsible providers, an informed and empowered public to ensure people get accurate advice and accessible redress and resolution in cases when things go wrong.

Purpose

To review the existing regulation and regulatory practices in use by Ahpra and the relevant National Boards to ensure they have kept pace with rapid changes in the cosmetic surgery industry and to make recommendations for any required changes.

This will be undertaken with reference to:

i. the National Registration and Accreditation Scheme's statutory objective to provide for the protection of the public, and

ii. the specific responsibilities of Ahpra and the National Boards' specific responsibilities within the broader regulatory framework in which cosmetic surgery occurs.

Scope

The review will inquire and report on:

1. The regulatory role of Ahpra and relevant National Boards in cosmetic surgery with particular attention to its risk-based approach focusing on:
   a) updates to codes of conduct and supporting guidance which aim to ensure that practitioners practise safely within the scope of their qualifications, training and experience;
   b) the methodology for risk assessment of cosmetic surgery notifications;
   c) the Ahpra investigation protocol;
   d) the management of advertising offences, and;
   e) opportunities for changes, clarifications or further actions in relation to the current regulatory approach to protected titles.
2. The way Ahpra works with other system regulators to ensure clear roles and responsibilities and appropriate information flows in support of the broader regulatory framework which involves a range of state, territory and national regulators.
3. The best means available to strengthen the safety reporting culture within cosmetic surgery to address barriers to health professionals raising concerns when a practitioner has practised in ways that depart from accepted professional standards.
4. Strategies relevant to the role of Ahpra and National Boards as a regulator of the registered health professions, to reduce information asymmetry for consumers in order to inform safer choices and informed consent.
5. Provide a contemporary view of current risks to patient safety in cosmetic surgery and how they should inform the work of Ahpra and relevant National Boards.

For the purpose of making its recommendations, the review is requested to consider approaches adopted by professional regulators in other countries.

The primary focus will be on cosmetic surgery because that poses the greatest risk. However, it is recognised that the recommendations of this review may have relevance for the work of Ahpra and relevant National Boards in the cosmetics sector more widely.

Reviewer

Mr Andrew Brown (former Queensland Health Ombudsman)

Expert Panel

Conjoint Professor Anne Duggan – Chief Medical Officer, Australian Commission on Safety and Quality in Health Care

Mr Alan Kirkland – CEO, Choice

Ms Richelle McCausland – National Health Practitioner Ombudsman

Advisory Group

An Advisory Group will be appointed and convened at key points to encompass people with lived experience of undertaking cosmetic surgery; relevant clinical and surgical expertise; jurisdictional health authorities; expertise in digital communications and social media, and nominees of relevant National Boards.

Key definitions

Cosmetic medical and surgical procedures are operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.

Major cosmetic medical and surgical procedures ('cosmetic surgery') involve cutting beneath the skin. Examples include; breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.

Minor (non-surgical) cosmetic medical procedures do not involve cutting beneath the skin, but may involve piercing the skin. Examples include: non-surgical cosmetic varicose vein treatment, laser skin treatments, use of CO2 lasers to cut the skin, mole removal for purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.

Appendix B: Promotion of the consultation stage

On 4 March 2022, a media release was published on the Ahpra website and sent to media organisations to announce that public consultation had commenced. This included reference to the consultation paper and an invitation to practitioners, consumers and other stakeholders to make a submission.

This resulted in coverage in a range of media, including *The Australian, Sydney Morning Herald, Australian Doctor, Herald Sun*, Nine radio network and Channel 10.

The media release was also translated into five languages (Arabic, Chinese (simplified), Greek, Italian and Vietnamese) and pitched to targeted media outlets. This resulted in coverage in *El-Telegraph, The Epoch Times, The Greek Herald, La Fiamma and Chiêu Dương Media*. Community members were invited to make submissions in their first language. Ahpra engaged a translation service to translate submissions into English.

A direct invitation to make a submission was sent to all registered medical practitioners and key stakeholders, such as medical colleges, professional associations and societies, medical defence organisations and insurers, health complaints entities and other regulators, as well as health consumer groups.

A review webpage was published, including regularly updated content and frequently asked questions.

Online advertising in *Women's Health* and *Men's Health* magazines was undertaken, including posts on *Women's Health* and *Men's Health* Instagram and Facebook accounts, with advertising banners linking directly to the consumer survey.

Ahpra ran a social media campaign from 4 March to 14 April 2022, encouraging members of the public to complete the consumer survey and practitioners and others to participate in the review by making submissions to the independent review panel.

Appendix C: Consultation questions

1. Do the current Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures adequately address issues relevant to the current and expected future practice of cosmetic surgery and contribute to safe practice that is within a practitioner's scope, qualifications, training and experience?
2. What changes are necessary and why? What additional areas should the guidelines address to achieve the above purpose?
3. Please provide any further comment in relation to the use of codes and guidelines relevant to the practice of cosmetic surgery.
4. Having regard to Ahpra and the Medical Board's powers and remit, what changes do you consider are necessary to the approach of Ahpra and the Medical Board in managing cosmetic surgery notifications, including their risk assessment process, and why?
5. Please provide any further relevant comment in relation to the management of notifications about medical practitioners involved in cosmetic surgery
6. Is Ahpra and the Medical Board's current approach to regulating advertising in cosmetic surgery sufficient?
7. What should be improved and why and how?
8. Do the current Guidelines for advertising a regulated health service adequately address risks in relation to advertising of cosmetic surgery, or is a more specific regulatory response required?
9. Does the promotion of cosmetic surgery via social media raise any issues that are not adequately addressed by the advertising guidelines, or that require any specific regulatory response?
10. Please provide any further relevant comment in relation to the regulation of advertising.
11. To what extent would establishing an endorsement in relation to the practice of cosmetic surgery address relevant issues of concern in the sector (including patient safety issues)?
12. Would establishing an endorsement in relation to cosmetic surgery provide more clarity about the specific skills and qualifications of practitioners holding the endorsement?
13. What programs of study (existing or new) would provide appropriate qualifications?
14. Please provide any further relevant comment in relation to specialist title protection and endorsement for approved areas of practice relevant to cosmetic surgery.
15. Are there barriers to effective information flow and referral of matters between Ahpra and the Medical Board and other regulators?
16. If yes, what are the barriers, and what could be improved?
17. Do roles and responsibilities require clarification?
18. Please provide any further relevant comment about cooperating with other regulators.
19. Do the Medical Board's current mandatory notifications guidelines adequately explain the mandatory reporting obligations?
20. Are there things that prevent health practitioners from making notifications? If so, what?
21. What could be improved to enhance the reporting of safety concerns in the cosmetic surgery sector?
22. Please provide any further relevant comment about facilitating notifications.
23. Do the Medical Board's current codes and guidelines adequately describe the obligations of practitioners who perform cosmetic surgery to provide sufficient information to consumers and obtain informed consent?
24. If not, what improvements could be made?
25. Should codes or guidelines include a requirement for practitioners to explain to patients how to make a complaint if dissatisfied?
26. In the context of cosmetic surgery, does the Ahpra website and public register of practitioners provide sufficient information about medical practitioners to inform consumer choices?
27. If not, what more could/should Ahpra and the Medical Board do to inform consumer choices?

28. Is the notification and complaints process understood by consumers?
29. If not, what more could/should Ahpra and the Medical Board do to improve consumer understanding?
30. Please provide any further relevant comment about the provision of information to consumers.
31. If you have any further comment relevant to Ahpra's and the Medical Board's regulation of cosmetic surgery including and/or suggestions for enhancements not mentioned in response to the above questions, please provide it here.

Appendix D: List of submissions received

	Name	Category
1	Dr Erika Agius	1.Individuals
2	Bianca Aiono	1.Individuals
3	Dr Muhammad Alam	1.Individuals
4	Dr Walid Al-Bermani	1.Individuals
5	Dr Ahmed Alsultan	1.Individuals
6	Dr Mahyar Amjadi	1.Individuals
7	Dr Laurence Anderson	1.Individuals
8	Tassia Anderson	1.Individuals
9	Anonymous	1.Individuals
10	Dr Masood Ali Ansari	1.Individuals
11	Dr Yves Saint James Aquino	1.Individuals
12	Dr Jeremy Archer	1.Individuals
13	Prof Mark Ashton and Prof Anand Deva	1.Individuals
14	Dr Mark Attalla	1.Individuals
15	Dr Domit Azar	1.Individuals
16	Ash Batten	1.Individuals
17	Dr Adrian Bauze	1.Individuals
18	Dr Emily Bek	1.Individuals
19	Dr Bernard Beldholm	1.Individuals
20	Dr Chris Bennett	1.Individuals
21	Dr Ashley Berry	1.Individuals
22	Chris Black	1.Individuals
23	Victoria Blake	1.Individuals
24	Dr Umberto Boffo	1.Individuals
25	Dr Grant Brace	1.Individuals
26	Alesha Brewer	1.Individuals
27	Dr Tim Brown	1.Individuals
28	Dr Michael Butcher	1.Individuals
29	Dr Robert Byrne	1.Individuals
30	Dr George Calfas	1.Individuals
31	Dr Peter Philip Callan	1.Individuals
32	Dr Donald Cameron	1.Individuals
33	Alison Cawte	1.Individuals
34	Dr Yuk Man Chan	1.Individuals
35	Dr Dilip Chauhan	1.Individuals
36	Dr Autumn Chien	1.Individuals
37	Dr Martin Ching	1.Individuals
38	Dr Ian Chinsee	1.Individuals
39	Dr Alex Yen-Yu Chen	1.Individuals
40	Dr James Chen	1.Individuals
41	Dr Jack Cheng	1.Individuals
42	Dr Tony Chu	1.Individuals
43	Dominique Clingen	1.Individuals
44	Lydia Collins	1.Individuals
45	Dr Rodney Cooter	1.Individuals
46	Dr Andrew Danyluk	1.Individuals
47	Jacqueline Davies	1.Individuals
48	Simon Dawkins	1.Individuals
49	Dr Caroline Do	1.Individuals
50	Dr Eleanor Eastoe	1.Individuals
51	Dr Robert Edwards	1.Individuals
52	Dr Anthony Emmett	1.Individuals
53	Samantha Endell	1.Individuals
54	Dr Vivek Eranki	1.Individuals
55	Dr Gabrielle Fairfield Boshuis	1.Individuals
56	Dr Ronald Feiner	1.Individuals
57	Andrew Finley	1.Individuals
58	Julie Finley	1.Individuals
59	Samuel Finley	1.Individuals
60	Dr Daniel Fleming	1.Individuals
61	Kylie Fleming	1.Individuals

62	India Flint	1.Individuals
63	Dr Ho Wang Fung	1.Individuals
64	Dr Stephen Gaggin	1.Individuals
65	Dr Danushi Ganegoda	1.Individuals
66	Dr Daniela Gerber	1.Individuals
67	Dr Carla Ghisla	1.Individuals
68	Maryam Gholipour	1.Individuals
69	A/Prof Mark Gianoutsos	1.Individuals
70	Susan Goldner	1.Individuals
71	Michele Gould	1.Individuals
72	Dr Tony Hackland	1.Individuals
73	Prof Peter Haertsch	1.Individuals
74	Dr Neal Hamilton	1.Individuals
75	Dr Andrew Harper	1.Individuals
76	Katie Hartwick	1.Individuals
77	Dr Steven Hatcher	1.Individuals
78	Dr Susan Hawes	1.Individuals
79	Dr Meaghan Heckenberg	1.Individuals
80	Dr Meaghan Heckenberg (second submission received)	1.Individuals
81	Dr Russell Hills	1.Individuals
82	Dr Pedram Imani	1.Individuals
83	Dr Eugene Jackson	1.Individuals
84	Dr Shane Jackson	1.Individuals
85	Dr Sam Jaensch	1.Individuals
86	Dr Allen James	1.Individuals
87	Dr Peter Kim	1.Individuals
88	Dr Georgina Konrat	1.Individuals
89	Dr David Kosenko	1.Individuals
90	Costa Koulouris	1.Individuals
91	Costa Koulouris (second submission received)	1.Individuals
92	Dr Gordon Ku	1.Individuals
93	Dr Bobby Kumar	1.Individuals
94	Dr Sandeep Kumar	1.Individuals
95	Dr Irene Kushelew	1.Individuals
96	Dr Ban Lau	1.Individuals
97	Dr Carlos Perez Ledesma	1.Individuals
98	Dr Melissa Lee	1.Individuals
99	Dr Jennifer Leung	1.Individuals
100	Dr Soo-Keat Lim	1.Individuals
101	Dr Malcolm Linsell	1.Individuals
102	Dr David Lyall	1.Individuals
103	Dr Susan MacCallum	1.Individuals
104	Dr Amira Mahboub	1.Individuals
105	Dr Harsimran Malhi	1.Individuals
106	Dr Marcia Manning	1.Individuals
107	Ajay Manu	1.Individuals
108	Dr Mark Marshall	1.Individuals
109	Dr Kareem Marwan	1.Individuals
110	Dr Sue McCoy	1.Individuals
111	Dr David McIntosh	1.Individuals
112	Dr George McIvor	1.Individuals
113	Pauline Menczer	1.Individuals
114	Dr David Mills	1.Individuals
115	Dr Paul Miniter	1.Individuals
116	A/Prof Colin Moore	1.Individuals
117	Name removed	1.Individuals
118	Christina Nelson	1.Individuals
119	Dr Dennis Nguyen	1.Individuals
120	Dr Jayson Oates	1.Individuals
121	Dr Hudaifa Obaidi	1.Individuals
122	Carley O'Connell	1.Individuals
123	Dr Harpreet Singh Pannu	1.Individuals
124	Samantha Peacock	1.Individuals
125	Assoc Prof David Pennington	1.Individuals

126	Dr Shawn Perera	1.Individuals
127	Dr Toni Pikoos	1.Individuals
128	Dr Koonal Prasad and Komal Prasad	1.Individuals
129	Dr Harry Prevedoros	1.Individuals
130	Dr Antony Prochazka	1.Individuals
131	Dr George Quittner	1.Individuals
132	Dr Maria Rachinskaya	1.Individuals
133	Prof Ajay Rane	1.Individuals
134	Dr Anoop Rastogi	1.Individuals
135	Dr Shahram Sadeghi	1.Individuals
136	Amy Scott	1.Individuals
137	Dr Magdalena Simonis	1.Individuals
138	Prof Rodney Sinclair	1.Individuals
139	Dr Arushi Singh	1.Individuals
140	Kevin Skeen	1.Individuals
141	Mark Sowden	1.Individuals
142	Mark Sowden (second submission received)	1.Individuals
143	Dr Brian Stein	1.Individuals
144	Michael Sticka	1.Individuals
145	Sarah Sticka	1.Individuals
146	Professor Russell Strong	1.Individuals
147	Dr Wen-Shan Sung	1.Individuals
148	Rebecca Taylor	1.Individuals
149	Asha Thomson	1.Individuals
150	Katrina Tilbrook	1.Individuals
151	Dr Le Tong	1.Individuals
152	Beverley Town	1.Individuals
153	Dr Godfrey Town	1.Individuals
154	Mayra Treacy	1.Individuals
155	Dr Pedro Valente	1.Individuals
156	Dr Sanjay Verma	1.Individuals
157	Dr Peter Vickers	1.Individuals
158	Dr Shaun Walsh	1.Individuals
159	Dr Angela Webb	1.Individuals
160	Dr Beatrix Weiss	1.Individuals
161	Dr Hugh Welch	1.Individuals
162	Dr Melissa Wright	1.Individuals
163	Dr Argie Xaftellis	1.Individuals
164	Dr Charlotte Ying	1.Individuals
165	Name removed	1.Individuals
166	Name removed	1.Individuals
167	Name removed	1.Individuals
168	Aesthetic MET (AMET) - Aesthetic Medical Emergency Team	2.Organisations
169	Alfred Health	2.Organisations
170	Allergen Aesthetics	2.Organisations
171	Australasian College of Aesthetic Medicine	2.Organisations
172	Australasian College of Cosmetic Surgery and Medicine	2.Organisations
173	Australasian College of Dermatologists	2.Organisations
174	Australasian Foundation for Plastic Surgery	2.Organisations
175	Australasian Society of Aesthetic Plastic Surgeons	2.Organisations
176	Australian and New Zealand College of Anaesthetists	2.Organisations
177	Australian College of Nurse Practitioners	2.Organisations
178	Australian College of Rural and Remote Medicine	2.Organisations
179	Australian Federation of Medical Women	2.Organisations
180	Australian Medical Association	2.Organisations
181	Australian Nursing and Midwifery Federation	2.Organisations
182	Australian Society of Plastic Surgeons	2.Organisations
183	Avant Mutual	2.Organisations
184	Cosmos Clinic	2.Organisations
185	Consumers Health Forum of Australia	2.Organisations
186	Darbon Institute	2.Organisations
187	Day Hospitals Australia	2.Organisations
188	Joint submission from the Australian Dental Association, the Royal Australasian College of Dental Surgeons and the Australian Dental Council	2.Organisations

189	Maurice Blackburn Lawyers	2.Organisations
190	MDA National Insurance	2.Organisations
191	Medibank Private Limited	2.Organisations
192	Medical Indemnity Protection Society	2.Organisations
193	MIGA	2.Organisations
194	Office of the Health Ombudsman, Queensland	2.Organisations
195	Operation Redress	2.Organisations
196	Royal Australasian College of Surgeons	2.Organisations
197	Royal Australian and New Zealand College of Ophthalmologists	2.Organisations
198	Royal Australian College of General Practitioners	2.Organisations
199	Rural Doctors Association of Australia	2.Organisations
200	Skin Cancer College Australasia	2.Organisations
201	Therapeutic Goods Administration	2.Organisations
202	Urological Society of Australia and New Zealand	2.Organisations
203	Victorian Perioperative Consultative Council	2.Organisations
204	Confidential	3.Confidential
205	Confidential	3.Confidential
206	Confidential	3.Confidential
207	Confidential	3.Confidential
208	Confidential	3.Confidential
209	Confidential	3.Confidential
210	Confidential	3.Confidential
211	Confidential	3.Confidential
212	Confidential	3.Confidential
213	Confidential	3.Confidential
214	Confidential	3.Confidential
215	Confidential	3.Confidential
216	Confidential	3.Confidential
217	Confidential	3.Confidential
218	Confidential	3.Confidential
219	Confidential	3.Confidential
220	Confidential	3.Confidential
221	Confidential	3.Confidential
222	Confidential	3.Confidential
223	Confidential	3.Confidential
224	Confidential	3.Confidential
225	Confidential	3.Confidential
226	Confidential	3.Confidential
227	Confidential	3.Confidential
228	Confidential	3.Confidential
229	Confidential	3.Confidential
230	Confidential	3.Confidential
231	Confidential	3.Confidential
232	Confidential	3.Confidential
233	Confidential	3.Confidential
234	Confidential	3.Confidential
235	Confidential	3.Confidential
236	Confidential	3.Confidential
237	Confidential	3.Confidential
238	Confidential	3.Confidential
239	Confidential	3.Confidential
240	Confidential	3.Confidential
241	Confidential	3.Confidential
242	Confidential	3.Confidential
243	Confidential	3.Confidential
244	Confidential	3.Confidential
245	Confidential	3.Confidential
246	Confidential	3.Confidential
247	Confidential	3.Confidential
248	Confidential	3.Confidential
249	Confidential	3.Confidential

Appendix E: Summary of consumer survey

The survey was designed for cosmetic surgery consumers and members of the public.

The Qualtrics online survey software was used. The survey included questions for those who had had surgery and those who had not had surgery. The survey used 'skip logic', so that the next question each respondent saw was based on how they had answered the previous question, for example, those who said they had had surgery were asked what they had, and whether they were happy. No questions were mandatory.

There was also a free text section at the end of the survey for any other comments.

A total of 710 responses to the survey were received, and 595 responses were included in the analysis. To be included in the analysis, respondents had to answer whether they had had cosmetic surgery or were booked for surgery and answer at least one other question in the survey. The survey results showed that there were 115 responses that did not meet these criteria, which was most likely due to some people clicking on the survey link but not answering any questions.

There were six main cohorts of respondents:

1. People who had not had cosmetic surgery (265 respondents)
2. People who had booked cosmetic surgery (19 respondents)
3. People who had had cosmetic surgery and were happy with it (173 respondents)
4. People who had had cosmetic surgery and were unhappy with it and did not make a complaint (42 respondents)
5. People who had had cosmetic surgery and were unhappy and made a complaint to someone other than Ahpra (57 respondents)
6. People who had had cosmetic surgery and were unhappy and made a complaint to Ahpra (14 respondents).

The remainder of respondents had had surgery but did not answer whether they were happy with it (25 respondents).

The sample survey was self-selecting so there was a need for some caution in applying the results, especially for smaller cohorts of respondents. For example, the reviewer has taken the following observations into account when referring to the survey results:

- While the survey was designed for cosmetic surgery consumers and members of the public, it was evident from some of the free text comments that some medical practitioners answered the survey, some as a consumer of cosmetic surgery and some as a practitioner
- A small number of respondents appeared to have had procedures that are outside the scope of the review
- The results rely on the responses entered. Some respondents may not have known, for example, what type of practitioner performed their surgery
- Respondents could select multiple responses when answering some survey questions, which means that some result areas total more than 100%.

In analysing the survey results, the following cohorts were compared:

- all respondents
- had cosmetic surgery – compared those who were happy and those who were unhappy
- had cosmetic surgery and were unhappy – compared those who made a complaint and those who did not make a complaint
- had cosmetic surgery and were unhappy – compared those who made a complaint to Ahpra and those who made a complaint to another person/complaints body.

Further information and analysis of survey data are included in sections of the report where relevant.

Appendix F: Summary of consumer focus groups

The Consumers Health Forum of Australia (CHF) was engaged to undertake two small focus groups, to facilitate consumer feedback from people who have had cosmetic surgery (group 1 – five participants) and people considering having cosmetic surgery (group 2 – seven participants).

Selection process

The CHF ran an expression of interest process for two weeks seeking participants who were willing to share their experiences about having cosmetic surgery or considering cosmetic surgery.

To be considered eligible for a focus group, participants needed to meet some criteria, including:

- ability to commit to a two-hour online meeting with a reliable internet or telephone connection
- confirmation that they had had, or were seriously considering having, cosmetic surgery (people who said they were not interested in having cosmetic surgery or had considered it and changed their mind, were not selected).

For the purposes of establishing diversity in the groups, prospective participants were also asked which gender they identified with (female, male, gender diverse, other, prefer not to say), and asked if they identified as Aboriginal or Torres Strait Islander; culturally and linguistically diverse; as a person with a disability; or as lesbian, gay, bisexual, transgender, intersex, queer, or asexual (LGBTIQA+).

Selected participants were paid a sitting fee of $83.60 per hour, based on the Commonwealth Remuneration Tribunal rates used by CHF.

Focus group methodology

Both groups were convened for two-hour sessions and discussed the following areas:

- consumers' level of understanding regarding health practitioner titles and qualifications, and how they selected (or would select) a practitioner
- impact of marketing and advertising on consumer choices (including the use of social media)
- preoperative information, including consent and expectations regarding surgery outcomes
- consumers' understanding and perceptions of complaints processes, including potential barriers to making a complaint.

CHF led the groups through a series of questions, recorded the sessions and analysed the data using Constructivist Grounded Theory (CGT) Methodology, which allowed for the coding of data such as transcribed interviews, sorted into categories to form themes.

At the completion of the process, CHF provided the review with a written report summarising the consumer feedback.

While the participant numbers were small, the consumer focus groups noted themes consistent with those arising from both the stakeholder submissions and consumer survey, particularly about:

- training and qualifications and selecting a doctor
- 'cooling-off' periods and psychological assessments
- advertising
- informed consent.

Further information and findings related to the focus group themes are included in sections of the report where relevant.

Appendix G: Summary of stakeholder meetings

Ahpra, National Boards and Committees

- Ahpra Agency Management Committee
- Ahpra Community Advisory Council
- Forum of National Registration and Accreditation Scheme Chairs
- Medical Board of Australia

Individual meetings with Ahpra and National Board members

- Dr Anne Tonkin, Chair, Medical Board of Australia
- Adjunct Professor Veronica Casey, Chair, Nursing and Midwifery Board of Australia
- Dr Murray Thomas, Chair, Dental Board of Australia
- Mr Martin Fletcher, Chief Executive Officer, Ahpra
- Dr Jamie Orchard, General Counsel, Ahpra
- Mr Jason McHeyzer, National Director, Compliance, Ahpra
- Mr Matthew Hardy, National Director, Notifications, Ahpra

Other Australian regulators

- Therapeutic Goods Administration (TGA)
- New South Wales Health Care Complaints Commission
- State and Territory Health Complaints Commissioners
- Medical Council of New South Wales
- New South Wales Health Regulators Forum

Government

- State, territory and Australian Government health departments (through the Ahpra Jurisdictional Advisory Committee comprising senior executives from all health departments)
- Victorian Perioperative Consultative Council

Accreditation bodies

- Australian Medical Council

Plastic surgery societies/cosmetic colleges

- Australian Society of Plastic Surgeons (ASPS)
- Australasian Society of Aesthetic Plastic Surgeons (ASAPS)
- Australasian College of Cosmetic Surgery and Medicine (ACCSM)

Some medical indemnity insurers

International regulators

- Medical Council of New Zealand
- General Medical Council

Other stakeholders

- LGBTIQ+ Health Australia
- Operation Redress, advocacy organisation
- Adele Ferguson AM, investigative journalist for The Age and The Sydney Morning Herald
- Dr Margaret Faux, CEO, Synapse Medical Services
- Dr Toni Pikoos, Clinical Psychologist and member of the review's Community Reference and Advisory Group

Appendix H: State and territory health facility licensing

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Public Health (Health Care Facility) Code of Practice 2021 (No1) (ACT) (commenced 27 March 2022). sec 3.2 The Code of Practice declares six public health risk procedures – one of which is cosmetic procedures. These must be performed in a hospital or day procedure centre that are licensed and approved to perform health risk procedures. Public Health (Health Care Facility) Risk Declaration 2021 (No1) (ACT) (commenced 27 March 2022) Schedule 1 Cosmetic procedures include the following: • abdominoplasty (tummy tuck) • belt lipectomy • brachioplasty (armlift) • bicep implants, tricep implants, calf implants, deltoid implants, pectoral implants • breast augmentation or reduction • buttock augmentation, reduction or lift • facelift, other than a mini-lift that does not involve the superficial mus-culoaponeurotic system (SMAS);	Private Health Facilities Regulation 2017 (NSW) regs 3–4. Prescribed services must be carried out in a licensed private health facility. These include anaesthesia and cosmetic surgery. ***anaesthesia*** means the administration of general, epidural or major regional anaesthetic or sedation resulting in deeper than conscious sedation, other than – (a) sedation provided in connection with dental procedures, or (b) diagnostic imaging practice anaesthesia. Cosmetic surgery is defined as (a) any cosmetic surgical procedure that is intended to alter or modify a person's appearance or body and that involves anaesthesia (including a Bier block), or (b) any of the following surgical procedures (how- ever described– (i) abdominoplasty (tummy tuck), (ii) belt lipectomy, (iii) brachioplasty (armlift), (iv) breast augmentation or reduction, (v) buttock augmentation, reduction or lift, (vi) calf implants, (vii) facial implants that	Nil	Private Health Facilities Regulation 2016 (Qld) reg 3(2). These must be performed in a day hospital health service: Prescribed surgical procedures include: (a) abdominoplasty (b) belt lipectomy (c) biceps implants (d) brachioplasty (e) breast augmentation or reduction (f) buttock augmentation, reduction or lift (g) calf implants (h) deltoid implants (i) facelift, other than a mini-lift that does not involve the superficial musculoaponeurotic system (SMAS); (j) facial implants that involve— (i) inserting an implant on the bone; or (ii) surgical exposure to deep tissue (k) fat transfer of more than 500 millilitres of lipoaspirate (l) labiaplasty (m) liposuction that involves removing more than 2.5 litres of lipoaspirate (n) mastopexy or mastopexy augmentation (o) monsplasty (p) neck lift (q) pectoral implants	Prescribed health services are defined in the *Health Care Act 2008* and prescribed by the Health Care Regulations 2008 and must only be performed in a licensed private hospital or a licensed private day procedure centre. Cosmetic medicine which requires local anaesthesia and is performed by a medical practitioner, but not in the course of general practice, would be considered a 'prescribed health service' under the legislation in SA. *The Health Care Act 2008*, s89 (1) (2) establishes the requirement for prescribed health services to be performed in a licensed day procedure centre: prescribed health service means— (a) a health service that involves the administration of general, spinal, epidural or major regional block anaesthetic; or (b) a health service that involves intravenous sedation (other than conscious sedation); or (c) a health service that involves the administration of local anaesthetic; or (d) a health service, or health service of a class, prescribed by the regulations for the	*Health Service Establishments Act 2006* (HSE Act). No prescribed services, however under the HSE Act 2006 *section 5(4)* there is provision for licensing as per: Any premises where no type A, type B or type C procedures are undertaken do not require licensing as a private hospital or a day-procedure centre unless the Secretary is satisfied that, having regard to considerations of public safety and the quality of service to be provided, the premises should be licensed as a private hospital or a day-procedure centre. Health Service Establishments Regulations 2021.	Health Services (Health Service Establishments) Regulations 2013 (Vic) reg 6(c)(i). Anaesthesia must be performed in a registered private hospital or day procedure centre Anaesthesia means any of the following: (i) general anaesthesia (ii) a major regional anaesthetic block (iii) intravenous sedation (iv) high dose of local anaesthetic that has the potential to cause systemic toxicity (does not include dental nerve block). Surgical health services that require one or more of the following must be performed in a registered private hospital or day procedure centre. (i) anaesthesia; or (ii) the attendance of at least one other health practitioner; or (iii) post operative observation of the patient by nursing staff Liposuction removing in total at least 200 ml of lipoaspirate must be performed in a registered private hospital or day procedure centre.	*Private Hospitals and Health Services Act 1927* and Private Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987. Surgical procedures requiring the provision of anaesthesia or procedures defined as per the Health Services (Day Hospital Facility) Determination 2016. The following health services are determined for the purpose of the definition of day hospital facility in Section 8 (1) of the Act – (a) A procedure that involves the administration of a general, spinal or epidural anaesthetic (b) A procedure performed under sedation, plexus blockade or Biers Block (c) A procedure that involves the invasion of a sterile body (d) Peritoneal dialysis and haemodialysis for the treatment of end stage renal failure (e) A psychiatric treatment program that (i) is for a patient who has a mental illness; and (ii) is provided by a multi-disciplinary team under the direction and

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
• facial implants that involve inserting an implant on the bone, or surgical exposure to deep tissue • fat transfer that involves the transfer of more than 100 millilitres litres of lipoaspirate • labiaplasty • liposuction that involves the removal of more than 1000 millilitres of lipoaspirate • mastopexy or mastopexy augmentation • monsplasty • neck lift • penis augmentation • rhinoplasty • vaginoplasty.	involve inserting an implant on the bone or surgical exposure to deep tissue, (viii) fat transfer that involves the transfer of more than 2.5 litres of lipoaspirate, (ix) liposuction that involves the removal of more than 2.5 litres of lipoaspirate, (x) mastopexy or mastopexy augmentation, (xi) necklift, (xii) pectoral implants, (xiii) penis augmentation, (xiv) rhinoplasty (other than revision rhinoplasty), (xv) superficial musculoaponeurotic system facelift (SMAS facelift), (xvi) vaginoplasty or labiaplasty, but does not include any dental procedure.		(r) penis augmentation (s) rhinoplasty (t) triceps implants (u) vaginoplasty.	purposes of this definition (2) Paragraph (c) of the definition of prescribed health service does not apply in relation to the following health services involving the administration of local anaesthetic: (a) a health service provided by a medical practitioner in the course of practice as a general practitioner; (b) a health service provided by a dentist in the course of general dentistry practice; (c) a health service, or health service of a kind, prescribed by the regulations The Health Care Regulations (SA) reg 21C(1) include the following cosmetic procedures which are considered prescribed health services: (i) abdominoplasty (ii) belt lipectomy (iii) biceps implants (iv) brachioplasty (v) breast augmentation or reduction (vi) buttock augmentation, reduction or lift (vii) calf implants (viii) deltoid implants (ix) facelift (other than a mini-lift that does not involve the superficial musculoaponeurotic system (SMAS)) (x) facial implants that involve— (A) inserting an			direction and supervision of a psychiatrist; and (iii) is half or full day programme that consists of more than one type of mainstream therapeutic activity.

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
				implant on the bone; or (B) surgical exposure to deep tissue (xi) fat transfer that involves the transfer of more than 500 millilitres of lipoaspirate (xii) labiaplasty (xiii) liposuction that involves the removal of more than 2.5 litres of lipoaspirate (xiv) mastopexy or mastopexy augmentation (xv) monsplasty (xvi) neck lift (xvii) pectoral implants (xviii) penis augmentation (xix) rhinoplasty (xx) triceps implants (xxi) vaginoplasty.			