Maurice Blackburn Lawyers
Since 1919

Maurice Blackburn Pty Limited
ABN 21 105 657 949
Level 21
380 Latrobe Street
Melbourne VIC 3000

DX 466 Melbourne
T (03) 9605 2700
F (03) 9258 9600

14 April 2022

Mr Andrew Brown
Independent Reviewer
Independent review of the regulation of health practitioners in cosmetic surgery
c/o Ahpra
GPO Box 9958
Melbourne VIC 3001

By email: CSReview@ahpra.gov.au

Dear Mr Brown,

We welcome the opportunity to provide a response in relation to the Consultation Paper for the independent review of the regulation of health practitioners in cosmetic surgery.

Please do not hesitate to contact me and my colleagues on [redacted] or at [redacted] if we can further assist with the Inquiry's important work.

Yours faithfully,

[redacted]

Dimitra Dubrow
Principal Lawyer
Medical Negligence Practice
MAURICE BLACKBURN LAWYERS
Accredited Specialist Personal Injury Law

Submission in Response to the Consultation Paper for the Independent Review of the Regulation of Health Practitioners in Cosmetic Surgery.

April 2022

TABLE OF CONTENTS

Page

Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 33 permanent offices and 30 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Our Submission

Maurice Blackburn welcomes the opportunity to contribute to this very important review.

Our response to the questions in the Consultation Paper are based on the lived experience of the clients we serve, and the observations of Maurice Blackburn staff who assist them to access justice.

To this end, we have restricted our comments to those areas of the Review which overlap with our service provision, namely:

- **Codes and Guidelines** – we believe that the current guidelines need strengthening. We argue that GPs can and should play a far greater role in assessing the appropriateness of patients for cosmetic surgery.

- **Management of Notifications** – we believe that Ahpra needs to continue to focus its risk-based assessment process on ensuring that a comprehensive regulatory history of the medical practitioner is obtained. We also note the importance of civil litigation processes in providing an additional layer of scrutiny of practice.

- **Advertising Restrictions** – we believe that the current onus on the consumer to understand, then commence complaint processes related to advertising (including upselling) is wrong-minded, and that Ahpra should have a far greater role in policing such practices.

- **Title Protection and Endorsement for Approved Areas of Practice** – we believe that the use of the term ‘surgeon’ in relation to cosmetic surgery is confusing and misleading for consumers. We argue that the continuing lack of clarity is putting consumers at risk, has no identifiable benefit for patients and patient safety, and only benefits the financial position of cosmetic surgeons.

- **Information to Consumers** – we believe that informed consent processes for cosmetic surgery often lack the rigour of other areas of medicine and need to be strengthened beyond the wording of the guidelines. We continue to believe that while the Ahpra website and register provides appropriate information around qualifications and area of specialty of medical practitioners, the public is not sufficiently aware of this as a resource that can be drawn upon. Consequently patients do not have sufficient information about a practitioner upon which to make informed choices. We argue that more work is also needed to raise public awareness of Ahpra’s role and resources, as well as the notification and complaints process.

We would welcome the opportunity to meet with the Review team to discuss the contents of our submission in more detail, if that would be beneficial. We believe that our experience and expertise in assisting wronged patients of cosmetic surgery gives us a unique perspective, which we would be pleased to make available to the Reviewers.

Responses to Consultation Questions

Codes and Guidelines

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?

Maurice Blackburn believes that the current guidelines provide useful and relevant information for medical practitioners on current regulatory settings. When introduced, they were a much-needed response to concerns about cosmetic surgery and patient safety.[1]

We do, however, also believe they will need to be adjusted for future use if sensible, consumer-focused changes are to be made to how cosmetic surgery is regulated.

For example, we believe that General Practitioners (GPs) should play a far greater role in providing referrals to cosmetic surgeons. This issue is discussed to some degree in the Consultation Paper:

> *The consumer initiates a request for cosmetic surgery, often directly to the medical practitioner who will be providing the procedure. General practitioners (GPs) ordinarily play a central role in coordinating care and referral. However, with cosmetic surgery, no GP involvement or referral is required. The consumer often decides the specific procedure they want before choosing the doctor, in contrast to other areas of medicine where the doctor may recommend a procedure as part of a doctor-patient consultation.* (p.7)

The current Guidelines[2] contain the following description of the role of GPs:

> *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.*

This limits GP or other input to only the cohort of patients who may have "*significant underlying psychological problems*". It also limits the assessment of patient suitability to the cosmetic surgeon, when this task, we believe, should be shared with a treating practitioner who may also have greater knowledge of the patient and may be better equipped in assessing their suitability as a candidate for a cosmetic procedure.

We suggest that the lack of GP involvement *at the start of the process* makes it easier for inappropriate procedures to be offered and undertaken, and for poorly skilled practitioners to

[1] Ref: https://www.abc.net.au/news/2015-08-24/scott-and-armitage-botched-cosmetic-surgery/6719748
[2] Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures: p.3

fly 'under the radar'. It also removes the opportunity for patients to seek a more independent opinion.

Thus, we urge Ahpra to advocate for GP referral to become a required part of the cosmetic surgery process for all major procedures, as it is for other forms of surgery. The current Guidelines could continue to apply for minor, non-surgical procedures.

Not only would such a change deliver greater protection for patients, it has the potential to assist the medical practitioners as it would ensure that they are also provided with relevant patient history as part of the referral. Without this, they are solely reliant on the patient providing such a history in the consultation.

We recognise that introducing GP referrals for major procedures would have the effect of 'slowing down' the industry and may frustrate some consumers who may have clear intentions as to the procedure they are seeking. However, given the array of concerning outcomes we have seen and concerning practices amongst some cosmetic surgeons (which, from time to time, and again more recently, are made public through media reporting) such a step has the potential to better protect consumers.

There may also be concerns raised around referral relationships forming between GPs and cosmetic surgeons. However, we would argue that similar issues may arise in relation to patient referrals in other fields of practice. We believe that it would be preferable for patients to have the input of their GP than to arrive at their own conclusion as to the appropriateness of the procedure they wish to undergo.

There may also be concerns raised around GPs not being prepared to refer patients for purely cosmetic procedures which may result in doctor-shopping by patients. Nonetheless, we believe that this step, along with the articulation of base level qualifications and training for those carrying out cosmetic procedures (addressed below) has the potential to deliver stronger patient protections, whose safety must be the paramount consideration.

It is important to note that a GP referral would be required if a Plastic Surgeon was to perform the same cosmetic procedure. It is therefore a perverse situation to have two different requirements depending on who is performing the procedure (particularly given the less rigorous process applies to the less experienced practitioner).

Once this has been implemented as standard practice, the Guidelines will need to be adjusted to make this clear for providers.

Another potential matter for consideration by this Review is medical practitioners self-referring. For example, in one matter[3] a medical practitioner in a GP clinic undertook a skin check and then referred the patient for removal of a nose lesion to a cosmetic clinic, at which that GP worked where she provided surgical procedures for that same patient.

Ultimately, the issue of concern to the Medical Board in this case was the admission that surgical tasks were delegated to an unregistered person - ie not a registered medical practitioner. However, we believe that this case study also emphasises the importance of a genuine referral - or at least the requirement that there be transparency and consent obtained if a self-referral is to take place, even in circumstances where the patient is being seen in a different location.

[3] Shvetsova v Medical Board of Australia [2018] VCAT 867

Further, while section 8 of the guidelines[4] deals with "Training and Experience" - which directs that procedures only be performed if the practitioner has the appropriate training and experience - we do not consider that this is sufficient to deter practitioners from performing procedures that they are not adequately qualified or experienced to perform. Maurice Blackburn believes that embedding this requirement in Guidelines is insufficient. We urge this Review to recommend that this be elevated to an enforceable requirement, rather than merely a guideline.

Management of Notifications

Consultation Questions:

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.

The Consultation Paper tells us that:

> *When assessing a notification about a medical practitioner, Ahpra and the Medical Board use a risk-based assessment that considers the:*
>
> *• specific concerns raised to assess if 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 the relevant standards or guidelines*
> *• practice setting, including the vulnerability of patient group and whether the practitioner has access to professional peers and support, and*
> *• practitioner themselves, **including their regulatory history** and the actions they have taken in response to the concern.* (p.15, our emphasis)

Maurice Blackburn submits that this remains problematic in practice, though we acknowledge that Ahpra's processes have shifted to more consistently reviewing past complaints about the same practitioner and to better capture data related to concerns raised in other forums.

We believe that it is essential that Ahpra continues to strengthen this aspect of its risk-assessment process so that data from each of the responsible entities is feeding into the information available to Ahpra to properly assess a practitioner's risk.

A more joined up response is required for Ahpra and the Medical Board to properly manage notifications.

We also draw the Reviewers' attention to a number of tangential issues related to the management of notifications about medical practitioners involved in cosmetic surgery.

[4] Ref: https://www.medicalboard.gov.au/documents/default.aspx?record=WD16%2f20201&dbid=AP&chksum=tbKW6fOl%2b4lhRW7Vo2QgDg%3d%3d: p.5

The Consultation Paper goes on to tell us that:

> *There are limitations under the National Law on the powers of Ahpra and the Medical Board and the possible outcomes that the notifications process can deliver. For example, the Medical Board has no legal power to order that a practitioner pay compensation to a consumer or undertake additional work to address an unsatisfactory outcome. These solutions may be available through private litigation or some may be facilitated through state-based health complaints entities.*

While Maurice Blackburn agrees that this is an accurate reflection of the current situation, we urge this Review to take the opportunity to revisit the importance of civil litigation processes in providing an additional layer of scrutiny of practice.

We believe that this Review is well placed to advocate for changes to laws related to liability for non-economic damages.

Currently, there are limits on the ability of patients to recover damages for non-economic loss (damages for pain and suffering) across Australia. While the technicalities vary, the effect is essentially the same – patients injured by negligent medical treatment can only recover such damages if they have been left with a permanent physical injury that gives rise to significant whole person impairment.

In practice, this severely limits the ability of cosmetic surgery patients to pursue compensation as the outcome often does not give rise to enough impairment. In our experience, even significant scarring and discomfort fails to meet the required threshold to pursue these damages because the legal focus is on functional impairment.

The difficulty arises because, without an entitlement to these damages, pursuing a claim over the remaining heads of damages is often not financially viable.

Similar issues arise whether a claim is pursued under common law, consumer law or for breach of contract. As a result, there is a significant cohort of consumers who are dissatisfied with the results of an aesthetic procedure (as opposed to functionally impaired as a result of that procedure), who have no legal recourse against the medical practitioner who performed the procedure. This is clearly unfair for patients who engaged a medical practitioner for aesthetic improvement but have been left with obvious disfigurements. It also undermines the role of litigation as a deterrence to poor behaviour and a mechanism to enforce standards.

In this respect, it is important to highlight the crucial role that medical indemnity insurers play in maintaining standards and minimising adverse outcomes. In other areas of medicine where compensation claims are more viable, the insurers have the greatest insight into doctors' performance and play a critical role in training, managing practice and highlighting areas of concern. However, if claims over negligent treatment are not viable, they are not pursued and the insurers role in enforcement and regulation is minimised.

Put simply, litigation plays a crucial role in deterrence and regulation but this function is undermined if claims are not viable due to structural issues unrelated to the quality of the actual treatment.

Maurice Blackburn believes that making practitioners more accountable for non-economic damages as a result of poor practice would reduce the number of under qualified practitioners seeking to offer these services. It would also provide greater deterrence and accountability for people who continue to practice in the area.

Advertising Restrictions

Consultation Question:

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?

The Consultation Paper tells us that:

> *The National Law creates an offence to advertise in a manner that, among other things:*
>
> *• is false, misleading, or deceptive*
> *• creates an unreasonable expectation of beneficial treatment, or*
> *• directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.* (p.17)

Ahpra's "Guidelines for advertising a regulated health service"[5] are comprehensive and highly informative. Similarly, the Ahpra website contains considerable helpful guidance. However, like issues around practice, Ahpra is reliant on a notification or complaint being made before an investigation can be undertaken.

This onus on the consumer to make a complaint is also apparent in Ahpra's "Advertising compliance and enforcement strategy"[6] where there is discussion of many effective strategies around guidance and education of practitioners, but there remains a consistent reference to *responding to* complaints.

This 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.

The "Advertising compliance and enforcement strategy" tells us that:

> *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.*[7]

This is no doubt the case, however we would suggest that merely relying on education and assistance will not suffice in the area of cosmetic surgery advertising. We would suggest spot checks of advertising and social media posts are necessary to ensure compliance given the

[5] https://www.ahpra.gov.au/publications/advertising-hub/advertising-guidelines-and-other-guidance/advertising-guidelines.aspx
[6] Ref: https://www.ahpra.gov.au/documents/default.aspx?record=WD20/30468&dbid=AP&chksum=m0NDXBV52qHJSmg96Z5%2fkA%3d%3d
[7] Ibid: p.8

influencing power of the words and images used, particularly on more vulnerable patients and consumers.

As became apparent in the course of the media investigation[8] into the practices of Dr Lanzer in late 2021 (which we note prompted this review, according to CEO of Ahpra, Martin Fletcher[9]) there is extensive and far reaching use of television and social media to advertise services.

Maurice Blackburn also believes that work is required to ensure that advertising restrictions are broad enough to capture *internal* marketing practices, such as upselling.

Consider the following case study:

> *Our client originally sought assistance from a cosmetic surgeon for liposuction to her limbs. During this consultation the doctor suggested that she would be a very good candidate for additional liposuction and that this could be performed at the same time. Our client agreed to abdominal liposuction.*
>
> *Our client explained that, although the consultation was conducted in a clinic in an inner city location, the surgery took place in a facility in an outer metropolitan suburb which was not, as far as she understood, a hospital. She described the facility as being a day surgery on top of a gymnasium.*
>
> *Following the procedure (which was performed as day surgery) the client described severe shoulder tip discomfort. She was unable to breathe and had severe and excruciating pain all over her abdomen. Our client said that the doctor and the day surgery staff wanted to send her home in a taxi on multiple occasions.*
>
> *The ward staff at the day surgery insisted that she leave and it was not until she asked her husband to call an ambulance that the day surgery staff changed their position and arranged for her to be transferred to hospital.*
>
> *She was transferred to a hospital Emergency Department where it was found that the liposuction had been complicated by perforation of the abdominal cavity. She was diagnosed with acute peritonitis and had an emergency exploratory laparotomy which diagnosed lacerated internal organs.*

The commercial nature of cosmetic surgery encourages sharp or unethical business practices. Examples include practices offering ‘discounts’ (including through coupon websites), or, as mentioned above, ‘upselling’ additional procedures and treatments.

Such inducements are not appropriate in the context of invasive medical treatment and may lead to patients seeking out unnecessary or inappropriate medical procedures. They also serve to downplay the seriousness of the procedure and the associated risks.

Even if the procedure is performed in a satisfactory manner, there are still risks and adverse outcomes that can occur.

[8] See for example: https://www.abc.net.au/news/2021-12-04/daniel-lanzer-resigns-as-medical-practitioner-ahpra-four-corners/100674208
[9] See for example: https://www.smh.com.au/business/consumer-affairs/profit-over-patient-safety-health-regulator-launches-review-into-cosmetic-surgery-industry-20211130-p59dc1.html

We believe that it may be appropriate to have more onerous requirements around advertising in circumstances where the treatment is not therapeutic in nature.

Further, Maurice Blackburn submits that informed consent processes often lack the rigour of other areas of medicine. Informed consent has an ethical aspect to it and the process of selling (or upselling) a 'product', rather than a treatment, risks encouraging poor practice as there is a clear self-interest in the practitioner downplaying the risks and encouraging the patient to agree.

This problem may arise in other areas of medicine but we believe it is particularly pronounced in the cosmetic surgery industry.

This is clearly recognised by Ahpra, evidenced by the fact that "Recognising potential conflicts of interest" is the very first paragraph of the "Guidelines for registered practitioners who perform cosmetic medical and surgical procedures".[10]

Title Protection and Endorsement for Approved Areas of Practice

Consultation Questions:

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?

Maurice Blackburn understands that the current review is limited, through its terms of reference, in what it will consider in terms of the use of the term 'surgeon'. The Consultation Paper tells us:

> *While the review will not be considering the question of whether the term 'surgeon' should be protected….., it will seek to clarify the existing law and how it operates in the cosmetic surgery space.* (p.19)

We also note that the current review does not seek to impinge on the work currently being undertaken by the Health Ministers:

> *It should be noted that the question of whether the term 'surgeon' alone should be a protected title is currently under consideration by the Ministerial Council and currently subject to a regulation impact statement consultation process. For this reason, any detailed consideration of this issue is outside the scope of the review.* (p.19/20)

Maurice Blackburn believes that Ahpra has a significant role to play in protecting consumers from harm, through its regulation of the National Law as it stands. The Consultation Paper tells us that:

[10] Ref: Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures: Guideline 1, p.3

> *The National Law is based on a title protection model which means that, with very few exceptions, it 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 having qualifications and skills that they do not have.* (p.19)

It goes on to say:

> *All medical practitioners, regardless of their registration type, are expected to recognise and work within the limits of their competence and scope of practice and ensure they have the knowledge and skills to provide safe clinical care.*

Maurice Blackburn is concerned that allowing the use of a discreet title such as 'cosmetic surgeon' gives the impression that they are specialists, when their qualifications may be that of a GP or other medical practitioner without surgical training. It is a profoundly misleading title.

This is in direct contrast to Plastic Surgeons who must complete over a decade of training before being able to use the title.

A GP cannot reasonably hold themselves out as a specialist in, say, orthopaedics and perform certain procedures. The same restrictions that prevent this occurring should be applied to people who refer to themselves as 'surgeon', without the appropriate qualification.

Cosmetic medicine and surgery occupy a unique position within the healthcare profession. Normally, medical or surgical treatment is provided in the context of some illness, injury or disease. By contrast, cosmetic surgery or treatment is generally non-essential and instigated by the patient. More than any other area of medicine, it is a commercial arrangement usually carried out in a 'for profit' environment and this dramatically changes the dynamic and the relationship between doctor and patient.

Cosmetic surgery remains, however, an invasive medical treatment and, like all medical treatment, comes with risks and the potential for complications. In our experience, when medicine becomes a commercial transaction, the risks can be overlooked or ignored. Much of our case load in this area results from uncontrolled risks.

Concerns about the standard of post-operative care is another common issue associated with cosmetic surgeons, particularly in the context of surgical procedures being performed in day procedure clinics.

Maurice Blackburn has represented a number of patients and their families in cases and Coronial Inquiries where the adequacy of post-operative communication and care has been the central issue.

The term 'surgeon' carries enormous weight in the community and assumptions are invariably made about the expertise of the person using it. To allow people who have not undergone the appropriate training to use it is misleading, undermines informed consent and does nothing to protect the public.

The use of the term 'surgeon' in relation to cosmetic surgery is confusing and misleading for consumers. The continuing lack of clarity is putting consumers at risk, has no identifiable benefit for the patients and patient safety, and only benefits the financial position of cosmetic surgeons.

Maurice Blackburn supports any initiative which is within the scope of Ahpra and the Medical Board to reduce this confusion. We note from the Consultation Paper that:

> *….. the Medical Board may recommend that the Ministerial Council approve an area of practice in a health profession as being a specifically endorsed area of practice. Once an area of practice is endorsed, the Medical Board may endorse the registration of a health 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.*

Maurice Blackburn would support this course of action but on the basis that an endorsement would only be provided if there is accreditation by the Australian Medical Council (AMC) and qualifications and training in cosmetic surgery are approved by the Medical Board.

In addition, we urge Ahpra and the Medical Board to advocate that Health Ministers move quickly to approve the addition of 'cosmetic surgery' to the list of specialties, fields of specialty practice and related specialist titles.

Further, we urge Ahpra and the Medical Board to advocate strongly to the Health Ministers to limit the use of the term 'surgeon', and provide Ahpra with the powers it requires to ensure that only appropriately qualified practitioners can use this term in the context of cosmetic surgery.

Information to Consumers

Consultation Questions:

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?

As mentioned earlier, Maurice Blackburn believes that informed consent processes for cosmetic surgery often lack the rigour of other areas of medicine.

A tummy tuck, for example, comes with many of the risks and complications as other types of abdominal surgery. The same goes for a breast or face lift. It is crucial that patients understand this.

Botox is also now commonplace for many people but it remains a schedule 4, prescription-only poison and, even under the current regulations, should only be administered by a nurse after a doctor has assessed the patient.

Maurice Blackburn has received many calls from patients who have suffered a reaction or complication following botox treatment and a common complaint seems to be that a nurse

was administering it after little or no assessment by a doctor. Stricter rules surrounding its use to ensure medical supervision are needed.

Codes and Guidelines need to make clear that even procedures deemed 'minor' such as Botox injections require informed consent.

As noted earlier, informed consent has an ethical aspect to it and the process of selling a 'product', rather than a treatment, risks encouraging poor practice as there is a clear self-interest in the practitioner downplaying the risks and encouraging the patient to agree. This problem is particularly pronounced in the cosmetic surgery industry.

The "Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures" document well outlines the steps that "should" be taken - including in relation to patient assessment, the need to discuss options including not to have the procedure and to decline to perform the procedure if they consider that it is not in the patient's interest. The Guidelines also clearly set out steps that "must" be taken in relation to obtaining consent.

Our concern is less about the content of the Guidelines as adherence to them. 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.

How this can be mandated to ensure consistency is difficult to answer. A strengthening of the language in the Guidelines should be considered, with a focus on enforcement. In addition, the need for informed consent should form part of continuous professional development for health practitioners.

The current Guidelines relating to "Consent" include that the information provided to the patient must include "*the complaints process and how to access it*".[11] In addition to this, Maurice Blackburn suggests that a stand-alone section should be added with proforma wording referring to raising concerns internally and externally with the contact details of the state-based health complaint entities and Ahpra.

Such disclosure is provided by other professionals, for example, lawyers who include the contact details of the relevant legal services complaints body within cost and retainer disclosure statements.

Consultation Questions:

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?

[11] Ref: Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures: 4.1, p.4

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.

The Ahpra website and register of practitioners does include important information which (if known about) can assist in informing consumer choices. However, in our experience, the general public is not sufficiently aware of and lacks an understanding of the Ahpra's role and resources.

For example, the #besafefirst page on the website[12] includes important information but needs to be disseminated more widely. One suggestion might be for brochures to be placed in GP clinics. However, in the age of telehealth and the advertising traffic for cosmetic procedures, we would suggest that Ahpra undertake a more public campaign utilising social media and other outlets to outline the ability of consumers to check on practitioner qualifications with a simple name search on their website.

Given the lack of capacity for civil compensation processes to enforce accountability (as noted above), it is even more critical that Ahpra takes a proactive role in providing the above critical information in a way that reaches consumers.

In response to question 28, our experience tells us that consumer understanding of the notification and complaints process has improved, but needs to keep improving. We note that Ahpra has made significantly more public statements about its role - though many of these public statements have unfortunately been in the context of responding to concerning practices that have gained public attention.

Our main concern is that, from the consumers' perspective, the process continues to appear to be clinician-centred, not patient-centred or complainant-centred.

In our observation, there appears to be a continuing disconnect between community expectations, the legislative purpose / process, and the protections that are seemingly afforded to the medical practitioner involved.

Clearly Ahpra needs to balance the interests and rights of the medical practitioner but patients also have an expectation that they will be given some insight into the process.

Over many years, Maurice Blackburn staff have heard injured patients and their families refer to the frustration they experience in dealing with Ahpra once they have made a notification. They have reported that the process is slow, cumbersome and bureaucratic. Many patients have reported a lack of communication. Once a notification is made they are not adequately informed of the potential outcomes of the notification and are sometimes not given no or minimal information by way of updates. They report feeling disengaged and uninvolved in the process and fell more like bystanders.[13]

While there has been a reported improvement in Ahpra's communication with notifiers including advising them of outcomes, other communication concerns do not appear to have

[12] https://www.ahpra.gov.au/News/2020-02-20-consumer-safety-and-cosmetic-procedures.aspx#:~:text=In%20the%20'be%20safe%20first,national%20online%20register%20of%20practitioners.

[13] This perception has been prominent for a number of years: https://www.abc.net.au/news/2017-07-18/australian-health-practitioner-regulation-agency-rogue-doctors/8718572

significantly changed, despite the increased occurrence of public statements by Ahpra. The adoption of a more patient-focused approach would alleviate this.

Put simply, patients want to be informed. This is in line with the stipulated legislative objective, which is to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice, and practice in a competent and ethical manner are able to remain registered.

Ultimately, more effective public campaigns will not address the issue of competency and lack of surgical qualifications, and the ease with which an ‘entrepreneurial’ medical practitioner may opt to go into cosmetic surgery. It is only by addressing this issue that greater patient safety will be delivered.