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

Consultation Regulation Impact Statement

OFFICIAL

Health Council – December 2021

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Glossary

Australian Health Practitioner Regulation Agency (Ahpra): The national body that works in partnership with 15 National Boards to register and regulate the 16 health professions in the National Registration and Accreditation Scheme.

Australian Medical Council (AMC): An independent national standards body for medical education and training. The AMC accredits specialist medical training programs and develops accreditation standards and policies for medical specialist programs of study in Australia and New Zealand, and for assessment of international medical graduates for registration in Australia. It acts as an external accreditation entity for the purposes of the Health Practitioner Regulation National Law and advises ministers and regulators on medical program accreditation matters and standards, medical practitioner registration matters, and the recognition of medical specialities.

Beauty therapist: An unregistered practitioner performing cosmetic procedures. Some may have completed training to administer laser hair removal or intense pulsed light hair removal, for example.[1]

Cosmetic doctor: A medical practitioner who may have some further training in cosmetic procedures.[2]

Cosmetic injectables: Also known as Schedule 4 medicines (see below); prescription only medicines such as 'Botox' (Botulinum toxin) or dermal fillers for facial features, most commonly lips, cheeks and nose to mouth lines (nasolabial folds). By law, only an authorised registered health practitioner can prescribe injectables.[3]

Cosmetic procedures: Procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features to achieve a more desirable appearance or boost the recipient's self-esteem.[4]

Cosmetic medical procedures: Procedures that do not involve cutting beneath the skin, although they may involve skin piercing. Examples include non-surgical cosmetic varicose vein treatment, laser skin treatments, laser hair removal, mole removal, dermabrasion, chemical peels, injections, and hair replacement therapy.[5] These procedures are often described as 'non-invasive'.

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[1] Australian Health Ministers' Advisory Council's Inter-Jurisdictional Cosmetic Surgery Working Group (AHMAC) (2011) 'Cosmetic Medical and Surgical Procedures: A National Framework' ('Cosmetic Procedures: A National Framework'), p. 20.

[2] Queensland Health Quality and Complaints Commission (QHQCC) (2013) 'Great expectations: a spotlight report on complaints about cosmetic surgical and medical procedures in Queensland' ('Great expectations').

[2] QHQCC (2013) 'Great expectations', p. 37.

[3] Ahpra and National Boards, 'Fact sheet on injectables', retrieved 22 December 2020, https://www.ahpra.gov.au/Publications/Cosmetic-surgery-and-procedures/Injectables.aspx.

[4] Adapted from the definition (abridged grammatically only) provided in the Medical Board of Australia (Medical Board) (2016) 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures', p. 2, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

[5] Medical Board (2016) 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures', p. 2, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

Cosmetic surgeon: A medical practitioner who may have further training in surgery and cosmetic procedures but whose training – as a *cosmetic* surgeon – is not recognised by the AMC or the Royal Australasian College of Surgery (RACS).[6]

Cosmetic surgery: Major cosmetic surgical procedures that involve cutting beneath the skin. Examples include breast augmentation and reduction, rhinoplasty, surgical face lifts, and liposuction.[7] This form of surgery is often described as 'invasive'. Cosmetic surgical procedures may also entail the invasive use of lasers and light-emitting diode (LED) photodynamic therapy for such purposes as body contouring.[8] Purely cosmetic surgical procedures do not attract a Medicare rebate.

Cosmetic tourism (or medical tourism): The practice of consumers travelling internationally in order to access cosmetic procedures.

Fellows of the Royal Australasian College of Surgery (FRACS): Fellows of the College (FRACS) have completed further training in one of nine surgical specialties recognised by the regulatory authorities: the AMC, the Medical Council of New Zealand (MCNZ), and the Australian Health Practitioner Regulation Agency (Ahpra). Plastic and Reconstructive Surgery is one of the nine specialities, as is General Surgery. Ear, Nose and Throat surgeons may also perform procedures that are at least in part cosmetic.[9]

Health Practitioner Regulation National Law (National Law): The uniform legislation in force across all states and territories that governs the National Registration and Accreditation Scheme (National Scheme).

Medical Board Guidelines, the: *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures*, issued by the Medical Board of Australia. The Guidelines came into effect on 1 October 2016.

Ministerial Council: The council comprising health ministers given jurisdiction under the Health Practitioner Regulation National Law to deliver policy directions to specific entities, approve registration standards and approve specialist titles. Until June 2020 this was known as the Council of Australian Governments (COAG) Health Council.

National Registration and Accreditation Scheme (National Scheme): The National Scheme regulates and registers health practitioners across all states and territories, allowing cross-jurisdictional practice. The National Scheme ensures that all regulated health professions practise in line with national standards.

Plastic surgeon: A medical practitioner with postgraduate training in reconstructive surgery, which is recognised by the AMC and the Medical Board as a specialty. Holds the protected title 'plastic surgeon' and is a Fellow of the Royal Australasian College of Surgery (FRACS). Plastic surgeons may specialise in cosmetic (aesthetic) surgery.[10]

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[6] QHQCC (2013) 'Great expectations', p. 37.

[7] Medical Board of Australia (Medical Board) (2016) 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures', p. 2, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

[8] Australian Radiation and Protection and Nuclear Safety Agency (ARPANSA), 'What is a cosmetic treatment?', *Advice for consumers: Lasers, IPL devices and LED phototherapy for cosmetic treatments and beauty therapy*, retrieved 3 August 2020, https://www.arpansa.gov.au/understanding-radiation/sources-radiation/more-radiation-sources/lasers-and-intense-pulsed-light-0.

[9] See for example the RACS website, https://www.surgeons.org/become-a-surgeon/about-specialist-surgeons.

[10] QHQCC (2013) 'Great expectations', p. 37.

Plastic surgery: A medical specialty accredited by the AMC that includes 'cosmetic' and 'reconstructive' surgery.[11]

Reconstructive surgery: Surgery that restores form and function as well as normality of appearance, which may incorporate aesthetic techniques to restore normal appearance.[12] Unlike 'cosmetic' procedures, reconstructive surgery may be performed in a public hospital and attract (at least partially) a Medicare rebate.

Schedule 4 medicines: Specifically, prescription only cosmetic injectables for which requirements relating to permits, supply, storage and transport are set by state and territory legislation. If prescribed by a medical practitioner, cosmetic schedule 4 medicines can only be supplied to a patient or consumer after that person has had a consultation with a medical practitioner, in person or by video.[13]

[11] Medical Board (2016) 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures', p. 2, https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

[12] Ibid.

[13] Ibid, p. 5.

Executive Summary

Rationale for this Consultation Regulation Impact Statement (RIS): Problem statement

All medical practitioners registered under the National Registration and Accreditation Scheme (National Scheme) may use the title 'surgeon' in their practice regardless of whether they have obtained entry-level surgical training or advanced surgical qualifications. This is because the Health Practitioner Regulation National Law[14] (National Law) does not protect the title 'surgeon' as a stand-alone title. Rather, it is protected only when it is coupled with another word for a recognised surgical specialty, such as 'specialist orthopaedic surgeon', 'specialist paediatric surgeon' or 'specialist plastic surgeon'.

Health ministers are concerned that use of the title 'surgeon' by medical practitioners may be confusing the general public, which may expect and believe that all medical practitioners who use the title have obtained comparable surgical training and qualifications. Health ministers are concerned that current regulation is not helping members of the general public to understand how the regulation of cosmetic surgery differs with that for other surgery. They are also concerned that the expectation and/or belief that regulation of all surgery is similar or identical may be creating risks and harm to members of the public. Ministers are particularly concerned that the practice of cosmetic surgery and widespread use of the informal title 'cosmetic surgeon' may be strongly and/or disproportionately associated with these risks and harm.

If these suppositions are confirmed by the consultation process, then the current approach to regulating the practice of surgery, and of cosmetic surgery in particular, will demonstrably not be contributing as fully to public safety and confidence in the health system as it should.

This circumstance in turn will raise further questions about whether market forces can be expected to resolve issues such as those highlighted in the 'Problem Statement' and 'Public harm and risks' sections of this RIS.

A broad range of medical and industry characteristics of cosmetic surgery may heighten the association of the cosmetic surgery sector with risks and harm. Unlike most other areas of medicine, cosmetic surgical proceduralists operate in a commercial market where providers seek financial gain and consumers undergo procedures as a matter of choice, rather than for treatment of a recognised medical trauma or disease.[15] The cosmetic surgery market is defined by the:

- nature of the surgery (elective only)
- cost of procedures (solely borne by the consumer and subject to greater cost competition between providers than many other areas of medicine)
- commercial service delivery models (involving corporate providers who advertise in and primarily attract business through social media platforms and who may not be licensed to carry a full range of appropriate sedative medicines)

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[14] *Health Practitioner Regulation National Law Act 2009* (Qld) sch (National Law). For the purposes of this inquiry, it should be noted that references to provisions of the National Law derive from the Act as passed in Queensland, though not as in force in Queensland. Queensland and New South Wales devolve administration of health, performance and disciplinary matters to state law.

[15] QHQCC (2013) 'Great expectations', p. 9.

- absence of referral or involvement by independent, third parties such as GPs.

These conditions can create perverse incentives for medical practitioners to work outside of their competence and deliver substandard services.

Generally, the National Law regulates what professional titles health practitioners may use but it does not – with just a few exceptions – restrict what procedures they can perform. Medical practitioners are instead advised – again in general terms – by the Medical Board to:

- perform only those procedures for which they have appropriate training, expertise and experience, and
- not make misleading claims about their qualifications, experience or expertise.[16]

Members of the public seeking advice about whom to consult to perform a given procedure generally obtain this information from a GP. Most cosmetic surgery consumers however do not discuss getting a procedure with a GP and source a cosmetic surgeon through other channels. Health regulators rely, therefore, on the title protection provisions of the National Law to encourage consumers to consult appropriate practitioners. This reliance can create information and power asymmetry between the public and practitioners. There are numerous documented cases of cosmetic surgical practitioners taking advantage of this asymmetry and performing procedures:

- without providing appropriate counselling about potential and actual risks and outcomes
- in inappropriate premises
- of inappropriate duration and timing
- without adequate pre, intra and post-surgery management
- resulting in post-operative complications and un-aesthetic and/or adverse outcomes.[17]

Hence this RIS is seeking data and information from stakeholders to help determine whether patients and consumers:

- can reasonably source the information that is required to comprehend the risks involved with certain procedures, and particularly cosmetic surgical procedures
- can reasonably be expected to make adequate sense of the information about surgical risks that is readily available.

A wide variety of harms have been caused by poor cosmetic surgery and post-surgery practices, and in cases where practitioners have performed cosmetic surgery outside their competence. This RIS will present evidence (see 'Evidence of consumer harm: Case studies') of practitioners performing procedures such as laser lipolysis, liposuction, abdominoplasty and breast augmentation without adequate:

- training
- pre-surgical assessment
- pre-surgical informed consent
- sedation

resulting in such adverse outcomes as:

- cyanosis (deoxygenation of the skin)

[16] See https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

[17] See case study examples in 'Evidence of consumer harm: Case studies'.

- split wounds
- fevers and infections
- excruciating pain
- haemorrhage
- excessive tissue trauma
- scarring
- local anaesthetic toxicity
- sepsis
- pneumothorax (collapsed lung)
- central nervous depression
- cardiac arrest
- death.

The title protections provisions of the National Law

The Title Protections section of the National Law helps to protect the public by ensuring that only health practitioners who are suitably trained and qualified are permitted to use designated professional titles.[18] Individuals who are not registered health practitioners or who are not qualified in a particular area of practice are forbidden from 'holding themselves out' as having qualifications and skills that they do not have. One way to hold oneself out is to misuse a protected title.[19] The reckless or knowing misuse of a protected title carries heavy penalties for individuals and body corporates.[20]

In the medical profession, only the title 'medical practitioner' is protected.[21] A range of 'specialist' titles are also protected.[22] In the medical profession the number and range of specialist titles far outnumbers 'protected' titles; 86 specialist titles are associated with 23 specialties and 64 fields of specialty practice.[23]

The entitlement to use specific medical specialist titles is gained through completion of accredited training courses, such as bachelor and specialist training programs. The right to use the title 'medical practitioner' and practise under general registration stems from completion of approved Bachelor of Medicine/Bachelor of Surgery study programs, as well as Doctor of Medicine and Surgery, Bachelor of Medical Studies/Doctor of Medicine, and Doctor of Medicines qualifications.[24]

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[18] National Law pt 7 div 10 sub-div 1.

[19] Ibid pt 7 div 10.

[20] Ibid s 113.

[21] Ibid s 113(3).

[22] Ibid s 115.

[23] Medical Board of Australia, 'List of specialities, fields of specialty practice and related specialist titles' (1 June 2018).

[24] Ahpra and National Boards, 'Approved Programs of Study', retrieved 26 June 2020, https://www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx.

Cosmetic surgery is not a recognised medical specialty

Cosmetic surgery is not recognised as a medical specialty by the Medical Board or the Australian Medical Council, the independent national standards body for medical education and training that accredits standards and policies for medical specialist programs of study in Australia.

Consequently, the title 'cosmetic surgeon' has no standing under the National Law and the practice of cosmetic surgery is not restricted by the title protection provisions of the National Law in the same way as the practice of neurosurgery, or plastic or cardio-thoracic surgery, to give just three examples.

Any registered medical practitioner may therefore call themselves a 'cosmetic surgeon' and the practice of 'cosmetic surgery' cannot therefore be regulated by authorities to the same degree as specialist surgical practices. Health ministers are interested to know if this means that the practice of cosmetic surgery is not being regulated to the extent expected or assumed by the public. They further wish to learn if the general public understands that there is no legal requirement for 'cosmetic surgeons' to undergo further or advanced surgical training in order to describe themselves as such. In short, ministers want to know if the public understands 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.

The National Law relies on title rather than practice restrictions

The lay reader may wonder why health ministers do not simply restrict some medical practitioners from practicing cosmetic and other types of surgery if public confusion about medical qualifications and current use of the title 'surgeon' by medical practitioners is indeed associated with risks and harm. The simple answer to this question is that the National Law functions by restricting the use by registered health practitioners of protected professional titles rather than by restricting types of practice.[25] This means that the National Law – with a very few exceptions – is designed to regulate what practitioners may call themselves, rather than specifying what they can do.

The National Law generally opts to restrict use of titles rather than practices because practices evolve and can do so rapidly, in response for example to technological and disciplinary innovations. This makes prescribing practices in legislation impractical.

'Cosmetic surgery', for example, encompasses a wide range of elective surgical procedures designed to alter an individual's appearance. The scope of procedures that can be considered cosmetic surgery changes as the relationships between medical technology, surgical technique and consumer demand expand the range of available procedures and alter the ways in which they are performed.

The Medical Board describes 'cosmetic surgery' as procedures, such as breast reductions and facial lifts, that involve cutting beneath the skin (for more information see Glossary and sources).[26]

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[25] The practice protections are set out in Part 7, Division 10, subdivision 2 of the National Law and include: restricted dental acts, restriction on prescription of optical appliances, and restriction on spinal manipulation

[26] Medical Board (2016) 'Guidelines for registered Medical practitioners who perform cosmetic surgical procedures', p. 2.

How practitioner conduct is managed

Judgments about whether a practitioner's conduct meets required standards are made by National Boards and state and territory tribunals who refer to the National Law and other instruments in order to determine whether those standards were met. The National Law describes mandatory notification requirements for reporting registered health practitioners who fail to meet required professional standards, regardless of what procedure or care they are providing.[27]

The other instruments that are used under the National Law to assess medical practitioner conduct include the Medical Board's Code of Conduct. The Code outlines the professional values, qualities and ethical practices expected of medical practitioners and outlines principles of good medical practice.[28]

Dissatisfied patients and consumers can make a notification to the national regulator (Australian Health Practitioner Regulation Authority; Ahpra) or a health complaints entity (such as the NSW Health Care Complaints Commission) or take civil action for negligence. Health professionals are also accountable in criminal law for negligent acts or omissions (for more information on these entities and instruments see 'Other elements in the regulatory framework for the performance of surgical procedures').

How cosmetic surgical practice is managed

The Medical Board's guidelines for the performance of cosmetic surgical procedures reinforce and expand the requirements outlined in the Code.[29]

The provision of cosmetic surgical procedures is also regulated by other measures that vary across Australia.

In some states procedures may not be performed on children for reasons other than therapeutic, or a mandatory cooling off period is required. Some states also require that designated cosmetic surgical practices be performed in prescribed health service facilities that are licensed to hold and administer Schedule 4 medicines (see Glossary for definition).[30]

Public harm and risks that arise from the current regulatory regime

Between members of the public and practitioners there can be information and power asymmetry. This contributes to the risk of consumer harm. Prospective patients in cosmetic surgery are advised to consider whether a practitioner has undertaken appropriate training in a given field when they are considering having a procedure.[31] Title protection aims to provide guidance to patients on practitioner capacity to perform given procedures. However, it can be difficult for the public to obtain information from neutral and informed sources, particularly as

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[27] National Law div 2.

[28] Available at https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

[29] Medical Board of Australia (2016) 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures'.

[30] *Public Health Act 2005* (Qld) div 11 ch 5A; https://www.mcnsw.org.au/sites/default/files/dd10_10886_policy_-_cosmetic_surgery_including_cooling_off_period_for_persons_under_18_years_of_age_c25.pdf; *Private Health Facilities Regulation 2016* (Qld) & *Health Care Regulations 2008* (SA).

[31] COAG Health Council (2018) 'Regulation of Australia's health professions: keeping the national law up to date and fit for purpose', pp. 58–59.

most cosmetic surgery consumers obtain information about prospective procedures from the practitioners that perform those procedures and from social media. These ways of sourcing information differ from the way in which most patients are referred to a specialist surgeon or other practitioner by a GP.[32]

Risks such as harm and ongoing complications are inherent in any surgery. This RIS is interested to discover how widespread cosmetic surgery resulting in significant harm and complications may be, and whether medical practitioners' qualifications are contributing to potential harm. A series of questions addressing these issues are posed for stakeholders' consideration (see 'Consultation questions').

Medical and industry characteristics of cosmetic surgery

As cosmetic surgery is elective, perverse incentives may be created for registered medical practitioners to work outside their competence. Cosmetic surgery may also be more corporatized than many other areas of medicine. Information on potential linkages between corporatisation and financial incentives and cosmetic surgery, and whether this is leading to significant public risk and harm is sought from stakeholders (see 'Consultation questions').

Members of the public also generally bear the costs of procedures, including out-of-pocket expenses for revision surgeries. Poorly performed cosmetic surgical procedures may be significant for both individuals and communities in terms of mental[33] and physical[34] wellbeing and economic impact. Stakeholder feedback is sought on the extent to which these costs may be affecting individual consumers and the broader community (see 'Consultation questions').

The current regulatory framework largely facilitates intervention only after an adverse event, where the provision of surgical services may fall below standards expected by the Medical Board and the public. This RIS poses a series of questions about whether and how current regulatory laws and instruments are doing enough to protect the public and deter practitioners from exaggerating or inadequately explaining their skills and qualifications (see 'Consultation questions'). These laws and instruments include the title protection provisions of the National Law, advertising law and the public register of practitioners maintained by Ahpra, as well as laws prescribing certain cosmetic surgical procedures, private health facility licensing laws, state and territory health care complaints entities, consumer law and regulation, the law of negligence, civil liability legislation and criminal law. Information on the current structure, functions and effects of these laws and instruments is provided in 'Other elements in the regulatory framework for the performance of surgical procedures' section of this RIS.

Options and cost-benefit analyses

Stakeholder feedback is sought on four main options in response to the issues identified in the RIS. These options are regulatory and non-regulatory and comprise:

- ***maintaining the status quo*** with existing regulatory and other tools, with no legislative action or other options undertaken

[32] Medical Board (2015) 'Public consultation paper and Regulation Impact Statement' ('Public consultation paper and RIS'), p. 14; QHQCC (2013) 'Great expectations', p. 37.

[33] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 71.

[34] QHQCC (2013) 'Great expectations', p. 19.

- ***reform options other than amending the National Law*** to help patients and consumers to make informed choices about undergoing surgical procedures and with which practitioners, regulators may consider options that incentivise practitioners to perform within the bounds of their competency, training and expertise, as well as:
    - major public information campaigns
    - increased provider liability for non-economic damages
- ***strengthening the existing regulatory framework*** with little or no legislative change
- ***restricting the title 'surgeon' under the National Law***, either to:
    - the 10 surgical specialty fields of practice approved by the Ministerial Council, or
    - specialist medical practitioners with significant surgical training.

The potential consequences of the proposed reforms and the capacity of the reforms to meet the stated policy aims must be balanced with the consequences of maintaining the status quo.

Each option is explained in detail in a stand-alone sub-section. The benefits and costs of each option are also outlined, and consultation questions are posed in relation to both.

Consultation process and responses

The full list of consultation questions is available in the 'Consultation questions' section of this RIS that precedes this executive summary.

Further information about the data that health ministers are seeking in this RIS is provided in the following 'Why this consultation process is occurring, and what information is the Health Council seeking' section.

Stakeholders are not obliged or asked to respond to every consultation question but are invited to respond to any question they wish to, and to share any useful personal or professional experience or knowledge they may have, as well as qualitative and quantitative data.

Providing feedback to this RIS

Stakeholders are invited to provide feedback on the RIS. Details on how to provide a response to the consultation can be found at https://engage.vic.gov.au/medical-practitioners-use-title-surgeon-under-national-law.

All respondents must consider the relevant collection notices below before completing a submission.

Individual members of the public survey privacy collection notice

Participation in this consultation is voluntary and by completing this survey, you consent to the Department of Health (department) collecting and using the information you provide in accordance with this notice.

The department collects and handles the information you provide in this consultation as part of a Consultation Regulation Impact Statement (RIS) process it is managing on behalf of all Australian health departments and the Australian Health Practitioner Regulation Agency (Ahpra).

When you make your submission, you will be asked to provide demographic information about your consumption of cosmetic surgical products and procedures and other surgical procedures. This information will not be used in any way that compromises your anonymity. The information will be used to better understand general social trends in cosmetic surgery consumption, such as age, gender and income of consumers as well as with relation to other types of surgical procedures.

Your feedback (provided on an anonymous basis) may be used by the department as well as other Australian health departments and Ahpra, to inform government decisions about regulation of the title 'surgeon' under the Health Practitioner Regulation National Law and contribute to the development of a Decision RIS for public release. It may, for example, lead to changes in the law that restrict which medical practitioners will be entitled to use that title.

We ask you not to provide any personally identifying information. If personally identifying information is inadvertently provided/collected, we will take reasonable steps to delete it. As your responses will not contain personally identifying information, it will not be possible to give you access to them after collection.

Respondents should not include any identifying information including about themselves, or a medical practitioner or facility. Any reservations or concerns about the treatment you may have received from a particular medical practitioner, or about a medical practitioner's conduct should be reported directly in a notification to Ahpra, or a health complaints commission or similar entity in your state or territory.

Your anonymous feedback will be collected, analysed and interpreted by an external research party, and the department. We will not publish any personally identifying information or individual submissions. Reports which may contain aggregated/anonymised information from the survey may be shared with other government entities, both in Victoria and other Australian jurisdictions.

This survey is voluntary. You may exit at any time. Partial responses will not be collected or used. However, where you do not wish to or are unable to respond to a particular question, you can select the relevant response to indicate this to ensure all other responses are collected and/or used.

For more information on the department's privacy collection practices, please refer to the department's privacy policy or visit our website on https://www.health.vic.gov.au/privacy.

The project team supervising the consultation can be contacted by emailing NRAS.Consultation@health.vic.gov.au or you may contact the department's Information Sharing and Privacy team by emailing privacy@health.vic.gov.au.

Direct submissions privacy collection notice (workforce entities, other organisations and individual practitioners)

Participation in this consultation is voluntary and by providing your responses, you/your organisation will be taken to have provided consent for collection and use of the information provided. You/your organisation will also have the option of requesting that your submission remains anonymous.

The Department of Health (department) is committed to protecting your privacy. The department collects and handles the information you/your organisation provide/s in this consultation as part of a Consultation Regulation Impact Statement (RIS) process it is managing on behalf of all Australian health departments and the Australian Health Practitioner Regulation Agency (Ahpra).

When making a submission, you/your organisation will be asked to provide information about patients' consumption of cosmetic surgical procedures. This information is not intended to compromise patient anonymity, and will be used to better understand general social trends in patient access to cosmetic surgical procedures and patient outcomes.

Your/your organisation's feedback, including qualitative and quantitative data provided, will inform government decisions about regulation of the title 'surgeon' under the Health Practitioner Regulation National Law and contribute to the development of a Decision RIS for public release. It may, for example, lead to changes in the law that restrict which medical practitioners will be entitled to use that title.

The consultation requests information relating to cosmetic and/or other surgery and does not ask organisations to provide any identifying information about patients, practitioners or facilities. You/organisations are asked not to include such information in your/their answers.

Respondents should not include any identifying information such as information about patients, medical practitioners or facilities in responses, as reservations or concerns about the treatment patients may have received from a particular medical practitioner, or about a medical practitioner's conduct should be reported directly in a notification to Ahpra, or a health complaints commission or similar entity in the relevant state or territory.

Your/your organisation's feedback will be collected, analysed and interpreted by the National Registration and Accreditation Scheme Review Implementation Project Team (NRAS project team) on behalf of health ministers. It may also be disclosed to health ministers and the health departments of other states and territories for this purpose.

The NRAS project team will not publish organisations' individual submissions where organisations request to remain anonymous but may publish information provided by organisations in their submissions in the Decision RIS. Your organisation may be identified in the Decision RIS, unless your organisation advises it wishes to remain anonymous. Where your organisation does not request to remain anonymous, your organisation's submission may be published by health ministers. Your feedback may be shared with other government entities, both in Victoria and other Australian jurisdictions.

Completion of submissions by organisations is voluntary. There are no consequences for non-completion or for providing submissions which address all or some of the questions presented.

For more information on the department's privacy collection practices, please refer to the department's privacy policy or visit our website on https://www.health.vic.gov.au/privacy.

The NRAS project team supervising the consultation can be contacted by emailing NRAS.Consultation@health.vic.gov.au or you may contact the department's Information Sharing and Privacy team by emailing privacy@health.vic.gov.au. You can request that changes be made to information you have been provided by contacting us using the above details.

Consultation questions

Title protection and its functions

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

1.2 Prior to reading this RIS did you believe that cosmetic surgery is regulated in the same way as other surgery?

1.3 Does current regulation help you understand the differences between the regulation of cosmetic and other surgery?

1.4 Do you think the risks, potential harms or level of adverse outcomes associated with cosmetic surgery are higher than for other areas of medical practice? If so, what is the basis for this view?

Cosmetic surgery is not a recognised specialty under the National Law

2.1 Prior to reading this RIS were you aware of the different training regimen for specialist surgeons as opposed to 'cosmetic surgeons'?

2.2 If you were unaware of this difference and have engaged a cosmetic surgical practitioner, would this knowledge have influenced your choice of practitioner? If you have not engaged a cosmetic surgical practitioner, would this knowledge impact your choice?

Other elements in the regulatory framework for the performance of surgical procedures

3.1 Are current guidelines, laws and regulations effectively deterring patient harm that may arise from practitioners performing cosmetic surgical procedures outside their level of competency?

3.2 Prior to reading this RIS were you aware of Ahpra's register of practitioners, and if so, have you found its information useful to help you make informed decisions about choosing a proceduralist? What additional information do you think it should include?

Public harm and risks that arise from the current regulatory regime

4.1 Have you experienced difficulty getting cosmetic surgical practitioners to explain professional title, the risks and rewards of surgery, and their capacity to perform a given procedure? Was this more difficult than with other surgical practitioners?

4.2 Do you have any evidence of harms or complications resulting from procedures performed by practitioners who do not have advanced surgical training, or who are practising outside their scope of competence? Can these harms and complications be quantified?

4.3 Do you have any evidence of harms arising from cosmetic surgeries that are the result of unethical or substandard practices or unethical conduct?

4.4 Can you provide information about the relationship between corporatisation and cosmetic surgery? If a relationship exists, is this more common in cosmetic surgery than in other surgical fields?

4.5 If corporatisation is more common in cosmetic surgery, is this is having any discernible effects on patient risk and harm?

4.6 Can you provide evidence to show that financial incentives are attracting medical practitioners to the field of cosmetic surgery? If financial incentives exist, is this leading to greater risk and harm to patients?

4.7 Please provide any evidence you have about the volume of patients accessing cosmetic surgical procedures.

4.8 Can you provide evidence that demonstrates any broader costs of post-operative outcomes of cosmetic surgeries on the health system and the broader economy? This includes any data that quantifies the cost to the public health system of revision surgeries for consumers who have suffered poor outcomes from cosmetic procedures.

4.9 Are you aware of adverse impacts to cosmetic surgery patients due to there being no requirements to involve a GP in referrals? Does this have material effects on the quality of care being provided by cosmetic surgical proceduralists? If so, how this might reasonably be demonstrated?

4.10 Can you provide any evidence demonstrating the effectiveness or ineffectiveness of the National Law's advertising provisions, particularly in relation to the cosmetic surgery industry?

4.11 Can you provide any information about whether Ahpra's public register of practitioners helps to address any identified cosmetic surgery regulatory issues?

Available data: quantitative and qualitative

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

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

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

Options and cost-benefit analyses

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

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

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

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

6.5 Will restricting the title 'surgeon' prevent medical practitioners who cannot use that title from using other titles that imply they are expert providers of cosmetic surgical services?

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

6.7 Is it likely that cosmetic surgery consumption patterns will change because of title restriction (whether option 4.1 or 4.2)? In what way? Will they be changed by options 2 and 3? In what way?

6.8 Is the regulatory burden estimate provided in this RIS realistic? How likely is it that medical practitioners would embark on advanced studies solely in order to call themselves a 'surgeon'? Do you expect option 4.1 or 4.2 to heighten demand for advanced surgical qualifications? If so by what number? What evidence do you have to support this view?

6.9 Should any options be implemented alongside other options, as a package? If so, please explain why this would be ideal and how any potential impediments might be overcome?

6.10 Should Australian lawmakers be mindful of the potential for regulatory change in Australia to shift cosmetic surgery consumption to other jurisdictions abroad? What would the impacts be?

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

Information the Health Council is seeking

Health ministers are concerned that use of the title 'surgeon' by medical practitioners may be confusing for the public and, more important may be creating risks and harm to the public. Ministers are particularly concerned that the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' may be associated with these risks and harm.

The Health Council is publishing this consultation RIS to help determine if current policy settings regulating use by medical practitioners of the title 'surgeon' are effective or should be augmented or changed. To help answer these questions, the Council is inviting all interested stakeholders,

including members of the general public, to read the RIS and respond to the Consultation Questions.

Health ministers are particularly keen to broaden and deepen the empirical data that authorities currently hold to help inform decision-making about these Questions. Ministers appreciate the difficulty in sourcing this data but emphasise the importance of collecting and collating whatever available data exists. Ministers welcome additional data that will help substantiate the:

- total expenditure in Australia on cosmetic surgical procedures, per annum and per capita, over time
- gross number of cosmetic surgical procedures performed in Australia
- popularity of particular cosmetic surgical procedures
- incidence of public confusion is experienced more commonly or widely in relation to cosmetic as opposed to other forms of surgery
- gross number and proportion of cosmetic surgical procedures that have adverse consequences
- associations of procedure with adverse outcomes
- proportions of adverse outcomes from procedures performed by:
    - medical practitioners with advanced surgical qualifications
    - medical practitioners without advanced surgical qualifications
- gross number, and total and mean cost of reparative surgeries performed to address adverse cosmetic surgical outcomes
- total number and average cost of emergency procedures performed when a cosmetic surgical procedure must be abandoned to save the life of a patient
- trend data relating to gross number, range, severity and trends of complaints about cosmetic surgical procedures
- gross number of referrals for cosmetic surgical procedures for minors
- trend data that can demonstrate public awareness and use (including type) of the Ahpra public register of health practitioners
- gross number of cosmetic medical tourism trips by Australians.

Health ministers are more immediately concerned, however, with the practice of ‘cosmetic surgery’ by many different kinds of medical practitioners. This activity represents a unique problem with the scope of the title protection provisions of the National Law. Health authorities are not aware of other surgical practices where a similarly broad range of practitioners are operating, or of similar levels of public confusion about the competence and appropriate activity of other surgeons, because they are more clearly designated and regulated by the Medical Board and professional colleges. ‘Cosmetic surgery’ is not a designated field of specialty under the National Law and cannot therefore be regulated by the same authorities to the same degree, and to the degree expected or assumed by the public.

Problem statement: use of the title ‘surgeon’ by medical practitioners in the National Law

Health ministers are concerned that use of the title ‘surgeon’ by medical practitioners may be confusing for the public and, more important may be creating risks and harm to the public. Ministers are particularly concerned that the practice of cosmetic surgery and use of the informal title ‘cosmetic surgeon’ may be associated with these risks and harm.

All medical practitioners registered under the National Registration and Accreditation Scheme (National Scheme) may use the title ‘surgeon’ in their practice regardless of whether they have obtained entry-level surgical training or advanced surgical qualifications. This is because the Health Practitioner Regulation National Law[35] (National Law) does not protect the title ‘surgeon’ as a stand-alone title. Rather, it is protected only when it is coupled with another word for a recognised surgical specialty, such as ‘specialist orthopaedic surgeon’, ‘specialist paediatric surgeon’ or ‘specialist plastic surgeon’.

Health ministers are concerned that use of the title ‘surgeon’ by medical practitioners may be confusing the general public, which may expect and believe that all medical practitioners who use the title have obtained comparable surgical training and qualifications. Health ministers are concerned that this expectation and/or belief may be creating risks and harm to members of the public. Ministers are particularly concerned that the practice of cosmetic surgery and widespread use of the informal title ‘cosmetic surgeon’ may be strongly and/or disproportionately associated with these risks and harm.

A broad range of medical and industry characteristics of cosmetic surgery may heighten the association of the cosmetic surgery sector with risks and harm. Unlike most other areas of medicine, cosmetic surgical proceduralists operate in a commercial market where providers seek financial gain and consumers undergo procedures as a matter of choice, rather than for treatment of a recognised medical trauma or disease.[36] The cosmetic surgery market is defined by the:

- nature of the surgery (elective only)
- cost of procedures (solely borne by the consumer and subject to greater cost competition between providers than many other areas of medicine)
- commercial service delivery models (involving corporate providers who advertise in and primarily attract business through social media platforms and who may not be licensed to carry a full range of appropriate sedative medicines)
- absence of referral or involvement by independent, third parties such as GPs.

These conditions can create perverse incentives for medical practitioners to work outside of their competence and deliver substandard services.

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[35] *Health Practitioner Regulation National Law Act 2009* (Qld) sch (National Law). For the purposes of this inquiry, it should be noted that references to provisions of the National Law derive from the Act as passed in Queensland, though not as in force in Queensland. Queensland and New South Wales devolve administration of health, performance and disciplinary matters to state law.

[36] QHQCC (2013) ‘Great expectations’, p. 9.

Generally, the National Law regulates what professional titles health practitioners may use but it does not – with just a few exceptions – restrict what procedures they can perform. Medical practitioners are instead advised – again in general terms – by the Medical Board to:

- perform only those procedures for which they have appropriate training, expertise and experience, and
- not make misleading claims about their qualifications, experience or expertise.[37]

Members of the public seeking advice about whom to consult to perform a given procedure generally obtain this information from a GP. Most cosmetic surgery consumers however do not discuss getting a procedure with a GP and source a cosmetic surgeon through other channels. Health regulators rely, therefore, on the title protection provisions of the National Law to encourage consumers to consult appropriate practitioners. This reliance can create information and power asymmetry between the public and practitioners. There are numerous documented cases of cosmetic surgical practitioners taking advantage of this asymmetry and performing procedures:

- without providing appropriate counselling about potential and actual risks and outcomes
- in inappropriate premises
- of inappropriate duration and timing
- without adequate pre, intra and post-surgery management
- resulting in post-operative complications and un-aesthetic and/or adverse outcomes.[38]

Hence this RIS is seeking data and information from stakeholders to help determine whether patients and consumers:

- can reasonably source the information that is required to comprehend the risks involved with certain procedures, and particularly cosmetic surgical procedures
- can reasonably be expected to make adequate sense of the information about surgical risks that is readily available.

A wide variety of harms have been caused by poor cosmetic surgery and post-surgery practices, in cases where practitioners have performed cosmetic surgery outside their competence. This RIS will present evidence (see 'Evidence of consumer harm: Case studies') of practitioners performing procedures such as laser lipolysis, liposuction, abdominoplasty and breast augmentation without adequate:

- training
- pre-surgical assessment
- pre-surgical informed consent
- sedation

resulting in such adverse outcomes as:

- cyanosis (deoxygenation of the skin)
- split wounds
- fevers and infections
- excruciating pain
- haemorrhage

[37] See https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

[38] See case study examples in 'Evidence of consumer harm: Case studies'.

- excessive tissue trauma
- scarring
- local anaesthetic toxicity
- sepsis
- pneumothorax (collapsed lung)
- central nervous depression
- cardiac arrest
- death.

Health ministers' concerns about use of the title 'surgeon' by medical practitioners and the public risks and harm this may be causing, has prompted them to seek feedback from members of the public to determine:

- if there is widespread belief that cosmetic surgery is regulated in the same way as other surgery
- and that current regulation may not be helping the public to understand the differences between the regulation of cosmetic and other surgery as effectively as ministers would hope
- if the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' associated with risks and harm to the public.

This section explores these issues and poses questions for stakeholders to respond to and begins by explaining the current regulatory regime and the place of cosmetic surgery within and outside of this framework. Stakeholders should further consider the evidence of risks and harm that can arise from this anomaly and provide comment and data that will help to substantiate the existence and level of these risks and harm.

Consultation questions

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

Question 1.2: Prior to reading this RIS did you believe that cosmetic surgery is regulated in the same way as other surgery?

Question 1.3: Does current regulation help you understand the differences between the regulation of cosmetic and other surgery?

Question 1.4: Do you think the risks, potential harms or level of adverse outcomes associated with cosmetic surgery are higher than for other areas of medical practice? If so, what is the basis for this view?

Title Protection and its functions

A principal objective of the National Law is to 'provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered'.[39]

[39] National Law s 3(2)(a).

The National Law also aims to prevent individuals who are not registered health practitioners or who are not qualified in a particular area of practice from 'holding out' as having qualifications and skills that they do not have.[40]

The Title and Practice Protections section of the National Law perform this regulatory function. It formally recognises the qualifications and expertise of health practitioners across 16 health professions in Australia and ensures that only those practitioners who have gained qualifications through accredited training programs and have been granted registration can use relevant titles.

The knowing or reckless use of a protected or specialist title by any person who is not a registered member of a designated profession or who is not a qualified specialist (where relevant) is expressly prohibited.[41] Strong penalties for breaching the title protection restriction provisions of the law are prescribed.[42]

Several other instruments are also used to help ensure that medical practitioners do not knowingly or reckless misrepresent their qualifications and capacity. In the medical profession, the principal such instrument is the Medical Board's Code of Conduct.[43] The Code is a general reference for medical practitioners that also helps the Board to set and maintain standards of practice against which professional conduct can be assessed. Conduct that varies significantly from this standard, particularly in serious and repeated cases, can have consequences for the practitioner's registration. The Board or in more serious cases a state or territory tribunal may discipline a practitioner for conduct that does not meet standards prescribed in the Code.

Boards also issue guidelines for specific areas of practice that they or other bodies can refer to when determining whether a practitioner's conduct has been of a required standard. The Medical Board, for example, has issued *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures* which are admissible in proceedings under the National Law or related law, as evidence of what constitutes professional conduct and practice.[44]

The National Law is built on a foundation of restricting the use by registered health practitioners of the various professional titles that are protected by the National Law rather than by restricting types of practice.[45] This means that the National Law – with a very few exceptions – is designed to regulate what practitioners may call themselves, rather than specifying in the law what they can and cannot do. The few practice protection provisions that are included under the National Law expressly prohibit anyone other than specific practitioners from performing identified practices and 'restricted acts' in just three areas of practice:

i. restricted dental acts

ii. prescription of optical appliances

iii. spinal manipulation.[46]

Judgments about whether a practitioner's conduct has met required standards are made by National Boards and higher authorities who refer to the Law and other instruments in order to

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[40] Ibid pt 7 div 10.

[41] Ibid ss 113, 115.

[42] Ibid.

[43] Available at https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

[44] Medical Board of Australia (2016) 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures'.

[45] The practice protections are set out in Part 7, Division 10, subdivision 2 of the National Law and include: restricted dental acts, restriction on prescription of optical appliances, and restriction on spinal manipulation

[46] National Law ss 121–123.

determine whether those standards were met. The Law describes mandatory notification requirements for reporting registered health practitioners who fail to meet required professional standards, regardless of what procedure or care they are providing.[47]

At the broadest level, title protection ensures that no person can call themselves a physiotherapist, for instance, if they are not registered in that profession. Determining whether a practitioner has improperly performed procedures, however, is a matter for National Boards. The National Law at the highest level delineates professional titles and leaves the determination of proper conduct to appropriate professional bodies. However, if there are problems relating to the use of a title or titles by registered health practitioners, health ministers and regulators may be able to address those problems by examining whether the regulation of a particular title or titles should be changed to better reflect community and professional needs and expectations.

Protected and specialist titles in the medical profession

Currently there are 40 reserved or 'protected' professional titles in the National Scheme.[48] In the medical profession, only the title 'medical practitioner' is protected.

The National Law also protects a range of 'specialist' titles.[49] In the medical profession the number and range of specialist titles far outnumbers 'protected' titles.

Practitioners who have undertaken surgical training accredited by the Australian Medical Council (AMC) are able to use one or more of the 11 specialist surgical titles approved by the Ministerial Council. These titles are reserved for use by 10 specialist fields approved by the Council (see Figure 1).

Figure 1: Surgical specialities and associated specialist titles

	Fields of specialty practice	**Specialist titles**
Specialty of surgery		Specialist surgeon
	Cardio-thoracic surgery	Specialist cardio-thoracic surgeon
	General surgery	Specialist general surgeon
	Neurosurgery	Specialist neurosurgeon
	Orthopaedic surgery	Specialist orthopaedic surgeon
	Otolaryngology – head and neck surgery	Specialist otolaryngologist – head and neck surgeon
	Oral and maxillofacial surgery	Specialist oral and maxillofacial surgeon
	Paediatric surgery	Specialist paediatric surgeon
	Plastic surgery	Specialist plastic surgeon
	Urology Specialist	Specialist urologist
	Vascular surgery	Specialist vascular surgeon

[47] Ibid div 2.

[48] Ibid s 113(3).

[49] Ibid s 115.

Source: Medical Board, List of Specialties, Fields of Specialty Practice and Related Specialist Titles (June 2018).[50]

There is no AMC-accredited training for 'cosmetic surgery' as the Ministerial Council does not recognise a specialist surgical title of 'cosmetic surgeon' or the practice 'cosmetic surgery' as a specialty.

The medical profession's protected title of 'medical practitioner' encompasses 23 specialties containing 64 fields of specialty practice, with 86 associated specialist titles.[51]

The entitlement to use specific medical specialist titles is gained through completion of accredited training courses, such as bachelor and specialist training programs.

The right to use the title 'medical practitioner' and practise under general registration stems from completion of approved Bachelor of Medicine/Bachelor of Surgery study programs, as well as Doctor of Medicine and Surgery, Bachelor of Medical Studies/Doctor of Medicine, and Doctor of Medicines qualifications.[52] Practitioners may obtain further qualifications in a specialty area but will still be registered under the profession of 'medical practitioner' with further information about specialist registration on the Ahpra register of practitioners.[53]

According to the most recent Ahpra Annual Report, there are over 75,800 medical practitioners in Australia who hold approved specialist registration and can use a specialist title under the National Law.[54] This comprises about almost 60% of the total number of registered medical practitioners in the National Scheme. [55]

'Surgeon' is not a protected or specialist title

The medical profession's protected title – 'medical practitioner' – does not refer to surgery or include the word 'surgeon'. Several specialist titles for medical practitioners do contain the word 'surgeon' and several types of medical specialists undertake advanced surgical training. They may sometimes use the title 'surgeon'.

Although the title 'surgeon' is a part of many specialist titles, there is no stand-alone title 'surgeon' that is protected by the National Law. This means that medical practitioners no matter their level of surgical training are not prohibited under the Law from describing themselves as surgeons. In this respect the National Law reflects the use of the term in the English language over many centuries, with the common understanding that it describes 'the treatment of disease, injury, etc. by operations with the hands or instruments'.[56] This common meaning is reflected also in the designation of general medical qualifications as a bachelor or doctor of both medicine and surgery.

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[50] Medical Board of Australia, 'List of specialities, fields of specialty practice and related specialist titles' (1 June 2018), p. 4.

[51] Ibid.

[52] Ahpra and National Boards, 'Approved Programs of Study', retrieved 26 June 2020, https://www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx.

[53] Ahpra and National Board, 'Register of Practitioners', retrieved 19 October 2020, https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx.

[54] Ahpra and National Boards, 'Medical Practitioners', *Annual Report 2020-21*, p. 20.

[55] Ibid.

[56] Collins Australian Pocket Dictionary of the English Language (Sydney, 1986). The term entered English c.1300 CE from the Anglo-Norman French term 'surgien', a contraction of 'serurgien', in turn based on the Latin 'chirurgia', itself derived from the Greek 'kheirourgia', meaning 'handiwork, surgery'. See Concise Oxford English Dictionary 11th Edition (2008).

A dermatologist or a GP, for example, can perform surgical procedures that they reasonably judge to be within their competence, as defined by their training, experience and continuing professional development. In addition, they may currently describe themselves as a 'surgeon' if they do not claim to be a kind of specialist surgeon listed in Figure 1. A dermatologist may, therefore, legitimately describe themselves as a 'Mohs surgeon' or 'dermatological surgeon'. An ophthalmologist, similarly, may describe themselves as an 'eye surgeon'. And a GP may state that they perform surgery and describe their premises as a 'surgery', and themselves as a 'surgeon', as has been customary for many decades; further, accredited specialist GPs undertake advanced surgical training.

Cosmetic surgery is not a recognised specialty under the National Law

Cosmetic surgery is not recognised by the AMC as a medical specialty. Therefore, the title 'cosmetic surgeon' does not legally exist and is not protected by the National Law, and practitioners are not required to obtain a specific set of qualifications to call themselves a 'cosmetic surgeon'. This means that the qualifications among medical practitioners performing cosmetic surgery range from entry to practice medical degrees to the completion of specialist surgical qualifications. This is significantly different to the practice of other areas of surgical specialty, outlined in Figure 1. The practice of those types of surgery and the entitlement to use the titles associated with those surgeries is accrued through many years of training additional to a general medical degree and is certified by surgical colleges whose capacity to accredit successful trainees is recognised by the Medical Board and the AMC.

Health ministers want to know if the general public understands that there is no legal requirement for 'cosmetic surgeons' to undergo further or advanced surgical training in order to describe themselves as such. They also want to know if the public understands 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.

Therefore, this RIS invites stakeholder feedback about consumer and public awareness of the different training regimen for specialist surgeons as opposed to 'cosmetic surgeons', as well as feedback about whether members of the public have been influenced by a lack of understanding of this difference in their choice of cosmetic surgical practitioners.

Consultation questions

Question 2.1: Are you aware of the different training regimen for specialist surgeons as opposed to 'cosmetic surgeons'?

Question 2.2: If you were unaware of this difference and have engaged a cosmetic surgical practitioner, would this knowledge have influenced your choice of practitioner? If you have not engaged a cosmetic surgical practitioner, would this knowledge impact your choice?

Cosmetic surgery in Australia

'Cosmetic surgery' encompasses a wide range of elective surgical procedures designed to alter an individual's appearance. The scope of procedures that can involve cosmetic surgery changes as the relationships between medical technology, surgical technique and consumer demand expand the range of available procedures and alter the ways in which they are performed. The

Medical Board *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures* (the Medical Board Guidelines) describe 'cosmetic surgery' as procedures that involve cutting beneath the skin. These include breast reductions and facial lifts. Non-surgical 'cosmetic medical procedures' that may involve piercing of the skin are not categorised as 'cosmetic surgery' (for more information see Glossary and sources).[57]

The medical specialty of plastic surgery includes performance of both cosmetic and reconstructive surgery. The Medical Board defines reconstructive surgery as aiming to '[restore] form and function as well as normality of appearance' and notes that the specialty incorporates aesthetic techniques.[58] Reconstructive plastic surgery is performed to restore abnormalities as a result of 'congenital defects, developmental abnormalities [and] injury or disease', not purely to alter appearances.[59]

Other elements in the regulatory framework for the performance of surgical procedures

Regulation of the provision of cosmetic surgical procedures varies across Australia and comprises numerous instruments and agencies other than the National Law. In addition to the National Law, the regulation of the performance of surgical procedures in Australia also involves:

1. codes and guidelines issued by regulators[60]
2. federal regulation of therapeutic goods and state and territory poisons laws and regulation
3. state and territory private health facility licensing laws
4. state and territory health care complaints entities
5. other legal frameworks.

While these instruments and agencies each contribute to the provision of safe surgical care, stakeholder feedback is sought as to whether the current framework is fit for purpose. Further information about identifying and remedying poor cosmetic surgical practice can be found at Appendix 1.

Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures (2016)

The Medical Board issued guidelines in 2016 for the performance of cosmetic procedures, to reinforce and expand upon the requirements of its Code of Conduct.[61] The guidelines are admissible in proceedings under the National Law or related law against a practitioner, as evidence of what constitutes professional conduct and practice. A practitioner whose conduct varies significantly and/or repeatedly from the guidelines may need to justify their conduct in a formal disciplinary proceeding. The guidelines instruct practitioners to be aware of and avoid

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[57] Medical Board (2016) 'Guidelines for registered Medical practitioners who perform cosmetic surgical procedures', p. 2.

[58] Ibid.

[59] Medical Board (2015) 'Public consultation paper and Regulation Impact Statement' ('Public consultation paper and RIS'), p. 7.

[60] National Boards may develop codes and guidelines for health practitioners under National Law s 39.

[61] Medical Board of Australia (2016) 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures'.

conflicts of interest – including financial stakes in cosmetic products or commissions – when advising prospective clients. They outline requirements for consultation with prospective clients, obtaining patient consent prior to procedures and background information on desired procedures including risks and complications.[62] Requirements are also outlined for referrals to other specialist practitioners (such as psychologists or psychiatrists) where a cooling off period for a patient is required prior to a procedure being performed.[63]

Additional protocols are stipulated for prospective clients who are minors including specific requirements to obtain consent and referrals to other practitioners prior to procedures.[64]

Medical practitioners are advised to perform only those cosmetic procedures for which they have appropriate training, expertise and experience to perform. They are instructed not to make misleading claims about their qualifications, experience or expertise, as this will constitute a breach of the National Law.

The Medical Board's Code of Conduct

The Medical Board's Code of Conduct describes 'the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community'.[65] Collecting standards that have long been central to good medical practice, the Code is applied according to circumstances but with unvarying application of key principles.

The Code outlines the professional values and qualities expected of doctors. The first value is to 'make the care of patients their first concern and to practise medicine safely and effectively'. Doctors are required to be 'ethical and trustworthy' and recognise that patients trust them to be medically competent and to behave with 'integrity, truthfulness, dependability and compassion'. Good medical practice is 'patient-centred' and involves 'working in partnership' with patients to address their needs and 'reasonable expectations'.[66]

Medical practitioners are also instructed to be 'honest and transparent in financial arrangements with patients' and not exploit a patient's 'vulnerability or lack of medical knowledge when providing or recommending treatment or services'.

If adverse events occur in their practice, practitioners are required 'to be open and honest in [their] communication' with the patient, review the circumstances and report 'appropriately'. A patient should receive a prompt and full explanation about the adverse event and the anticipated short-and-long-term consequences. The practitioner should acknowledge a patient's distress and provide appropriate support, while complying with relevant policies, procedures and reporting requirements. Post-event, the practitioner should implement changes to their practice to reduce the risk of recurrence and ensure patients have access to information about complaint-making processes and authorities. A practitioner must also ensure that a complaint does not adversely affect the further care of a patient.[67]

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[62] Ibid, p. 4.

[63] Ibid, p. 3.

[64] Ibid.

[65] Available at https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

[66] Medical Board, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (March 2014), p. 5.

[67] Ibid, pp. 10-11.

The Code instructs medical workplaces to ensure that risks to patients can be raised and that steps are taken, individually and within a practice, to reduce medical error and improve patient safety. If a practitioner becomes aware that a colleague may be performing poorly, they must observe the mandatory reporting requirements of the National Law.[68]

Advertising

Any advertising and marketing material issued by practitioners, including practice and practitioner websites, must comply with the advertising provisions in the National Law, the National Boards' advertising guidelines, the Therapeutic Goods Advertising Code and the Therapeutic Goods Administration guidance on advertising cosmetic injections.

The National Law outlines requirements for the advertising of health services. Breaches of the advertising offence provision of the law can incur financial penalties of $5,000 for each advertising offence for an individual and $10,000 for a body corporate.[69]

National Boards have also collaboratively developed guidance for practitioners outlining their obligations under the National Law in regard to advertising of regulated health services they provide.[70] The *Guidelines for advertising a regulated health service* apply to all health practitioners and aim to ensure that advertised information about the services provided to consumers is accurate.

The guidelines stipulate, in line with provisions under the National Law, that practitioners must not undertake advertising that:

- is considered, or likely to be considered, false, misleading or deceptive
- offers a gift, discount or other inducement without accompanying terms and conditions
- uses testimonials or purported testimonials about a service or business
- establishes an unreasonable expectation by consumers of beneficial treatment
- encourages the indiscriminate or unnecessary use of regulated health services in any way.[71]

Where practitioners breach advertising provisions under the National Law, they may be subject to financial penalties.[72]

In addition to provisions in the National Law regulating the advertising of procedures, there are specific provisions in some state laws relating to cosmetic surgical procedures, as well as provisions in consumer law and a code proclaimed by the Therapeutic Goods Administration that relate to cosmetic surgery. NSW, South Australia and Queensland have provisions in state legislation, relating to lotteries, prohibiting the offering of cosmetic surgical procedures as a prize or reward.[73]

To help persons and companies who provide regulated health services to apply these rules, Ahpra publishes an 'Advertising compliance and enforcement strategy for the National

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[68] Ibid, p. 16.

[69] National Law s 133(1).

[70] Ahpra and National Boards, 'Guidelines for advertising a regulated health service' (December 2020).

[71] Ibid, p. 4. See also National Law s 133(1).

[72] National Law s 133.

[73] *Lotteries and Art Unions Act 1901* (NSW), see definition of 'prohibited prize' in section 2A; *Lottery and Gaming Act 1936* (SA) and *Lottery and Gaming Regulations 2008* (SA); *Gaming and Wagering Commission Regulations 1988* (WA) sch 5; *Charitable and Non-Profit Gaming Act 1999* (QLD).

Scheme'.[74] The strategy applies a 'risk-based approach … to advertising compliance and enforcement' that encourages 'voluntary compliance'. The strategy outlines that the 'definition of a regulated health service is very broad and applies to public and private services'. It is not 'constrained to direct clinical services'.

As all National Boards have published *Guidelines for advertising of regulated health services*, a breach of the advertising provision committed by a registered practitioner also breaches the Medical Board Code of Conduct. This means that an offending practitioner's conduct is grounds for disciplinary action in relation to their registration.

Ahpra uses a risk-based approach to compliance enforcement for advertising provision offences. Non-compliance may lead to prosecution or disciplinary proceedings in a state or territory tribunal.

While these instruments may be effective in deterring instances of patient harm as a result of practitioners performing surgical procedures outside their level of competency, stakeholders are asked to provide feedback on whether these instruments are meeting this objective, particularly in the context of the public's understanding of the qualifications that are required for performing cosmetic surgery.

Stakeholders should further note that amendments to the National Law are currently being considered in relation to the use of testimonials in advertising of services. Health ministers are proposing to remove the current prohibition on the use of testimonials and regulate testimonials in the same way as other forms of health advertising. This means testimonials will be prohibited where they are false, misleading or deceptive, offer a gift or inducement without stating the terms and conditions, create an unreasonable expectation of beneficial treatment or encourage the unnecessary use of health services. Ministers are also proposing to raise the penalties for advertising offences to $60,000 for an individual and $120,000 for a body corporate.

Consultation questions

Question 3.1: Are current guidelines, laws and regulations effectively deterring patient harm that may arise from practitioners performing cosmetic surgical procedures outside their level of competency?

Ahpra register of practitioners

Ahpra's 'Register of practitioners' provides members of the public with information about whether a health practitioner is registered or has any conditions or undertakings placed on their practice.

Ahpra's 'Register of practitioners' (also known as the 'public register') is available to assist members of the public in accessing information about whether health practitioners:

- are registered to practice
- are registered as a specialist or generalist
- are currently suspended from practising
- have had conditions placed on their registration (typically prohibiting the performance of certain procedures until successful completion of remedial action is demonstrated)
- have any reprimands for previous conduct undertaken, or

[74] Available at https://www.ahpra.gov.au/Publications/Advertising-resources/Legislation-guidelines.aspx.

- have given a National Board an undertaking not to perform certain procedures or to provide services to a category or categories of patient/s.[75]

The rules governing disclosure of information in the public register, however, limit its capacity to help inform members of the public and facilitate the selection of suitable practitioners to perform procedures. Specifically, they influence the degree to which a user of the register can find out about any given practitioner's professional history.

Members of the public – if they are aware of the register[76] – may find it difficult to navigate the public register to find entries for health professionals who have common names or are practising in a location differing from that listed as their principal place of practice.[77]

The public register records only the legal names of practitioners. These names may be common or different from the names that a practitioner uses in their practice.[78] This can make it difficult to identify a practitioner. An amendment to the National Law has been prepared that would give practitioners the option of publishing an alternative name on the public register and practising under either their legal name or their alternative name. However, this amendment is not yet law and the problem of matching a practising name with a registered name remains.

Once a notification is made against a practitioner and relevant action taken by a National Board,[79] the Board may remove restrictions, including undertakings and conditions on a practitioner's registration when it deems that these are no longer required for public protection reasons.[80] Practitioners may also apply to the relevant National Board to have conditions or undertakings altered or removed from their registration, once a relevant review period has passed.[81] Some conditions or undertakings may also not be published on the public register, at the discretion of a National Board, if they were imposed due to an impairment.[82] Typically, this discretion is exercised by a Board to maintain the practitioner's privacy,[83] if there is no overriding public interest for recording the information,[84] or if publishing the information may pose a serious risk to the practitioner's health and safety.[85] Finally, cautions given to practitioners relating to their conduct may only be made available on the public register in circumstances that the relevant National Board deems necessary.[86]

Stakeholders are asked to consider whether the information that can be accessed through the public register is enough or does enough to help members of the public to make informed

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[75] Ahpra and National Boards, 'Register of practitioners', retrieved 3 February 2021, https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx.

[76] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 69.

[77] Ibid.

[78] Ibid.

[79] See National Law s 178.

[80] Ahpra and National Boards, 'Possible outcomes', *Concerns about practitioners*, retrieved 3 February 2021, https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Possible-outcomes.aspx.

[81] Ahpra and National Boards, 'Monitoring and compliance', *Concerns about practitioners*, retrieved 3 February 2021, https://www.ahpra.gov.au/Notifications/Further-information/Guides-and-fact-sheets/Monitoring-and-compliance.aspx. With some exceptions. See National Law s 125(2)(a).

[82] National Law s 226. Under National Law s 5, an impairment is defined as 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect … [a practitioner's] capacity to practise the profession'.

[83] National Law s 226(1)(a).

[84] Ibid s 226(1)(b).

[85] Ibid s 226(2).

[86] Ahpra and National Boards, 'Possible outcomes', *Concerns about practitioners*, retrieved 3 February 2021, https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Possible-outcomes.aspx.

decisions about choosing a proceduralist, particularly a cosmetic surgical proceduralist. Stakeholders are also invited to provide any trend data that can demonstrate public awareness and use (including type) of the register.

Consultation questions

Question 3.2: Prior to reading this RIS were you aware of Ahpra's register of practitioners, and if so, have you found its information useful to help you make informed decisions about choosing a proceduralist? What additional information do you think it should include?

Federal regulation of poisons and medicines

Regulation of essential elements to support the provision of cosmetic surgical procedures – such as administration of medicines – can differ across jurisdictions.[87]

Therapeutic goods in Australia are regulated by the Therapeutic Goods Administration under the *Therapeutic Goods Act 1989* (Cth) and *Therapeutic Goods Regulations 1990* (Cth). Therapeutic goods must be entered in the Australian Register of Therapeutic Goods before they can be imported, manufactured, used, or supplied in Australia.

Substances used for the performance of cosmetic surgical procedures are listed in Schedule 4 of the Poisons Standard, which is adopted across each State and Territory.[88] Each Act generally provides that a person must be authorised to obtain, possess, administer, dispense or supply any Schedule 4 products (such as 'Botox') with the authorised persons generally including medical practitioners and some registered nurses and nurse practitioners.

Advertising Schedule 4 (prescription only) products to consumers is unlawful under the TG Act. It is not an offence, however, to advertise general categories of therapeutic goods that may be Schedule 4 products. Hence it is lawful to advertise 'cosmetic injections', 'anti-wrinkle injections/treatments' or 'injections/treatments for lips', but it is not lawful to advertise Schedule 4 products that might be used for such purposes.

Stakeholder views on the effectiveness of federal regulation of medicines and poisons in ensuring the safety of consumers who access cosmetic surgical procedures are sought to help determine if reforms should be considered.

Prescribed cosmetic surgical procedures

In some jurisdictions, law requires that some cosmetic surgical procedures be performed in licenced facilities. However, requirements are unique to each jurisdiction and are not necessarily consistent, and regulations do not necessarily stipulate which practitioners must perform certain procedures.

In Queensland, regulation prescribes that surgical procedures such as breast augmentations or reductions, liposuctions, abdominoplasty and various implants be performed in day hospital

[87] Medical Board (2015) 'Public consultation and RIS', p. 9.

[88] *Poisons and Therapeutic Goods Act 1966* (NSW); *Drugs, Poisons and Controlled Substances Act 1981* (Vic); *Poisons Act 1971* (Tas); *Public Health Act 2005* (QLD); *Public Health Act 2011* (SA); Medicines, *Poisons and Therapeutic Goods Act 2012* (NT); *Poisons Act 1964* (WA); *Medicines, Poisons and Therapeutic Goods Act 1966* (ACT).

health services.[89] Such procedures are also classed as prescribed health services in South Australia that must be performed in licensed day procedure centres.[90] New South Wales regulation stipulates that cosmetic surgery must be performed in private health facilities.[91] In Victoria surgical procedures requiring provision of anaesthesia[92] and liposuction procedures involving removal of a minimum of 200 ml of lipoaspirate[93] must be performed in day procedure centres.

Private Health Facility Licencing

Requirements for the delivery of cosmetic surgery, including licencing of facilities, can differ across Australian jurisdictions, albeit moderately.[94]

Private hospitals are licensed in all jurisdictions. Most (but not all) jurisdictions license free-standing day procedure centres but medical practitioners' rooms are generally outside the scope of facilities-based licensing, except where the type of anaesthetic and sedation used brings them within the scope of the licensing requirements. Day procedure centre licensing tends to be based around the nature of the procedures performed and typically involves consideration of the types of anaesthetic and sedation used.

Several jurisdictions introduced changes to their private health facility licensing frameworks prior to 2017 to ensure that facilities providing certain surgical procedures, especially cosmetic procedures, are licensed. In NSW, 16 cosmetic surgical procedures must be performed in a licensed facility[95] and in Queensland and South Australia, 21 specific cosmetic surgical procedures must also be performed in these facilities.[96]

State and territory health care complaints entities

States and territories have independent health complaints entities (HCEs) with powers to regulate and to investigate complaints about health services and health professionals. Complaints relate to the healthcare that may have been provided as well as the handling of health information.[97] HCEs receive complaints made by anyone about any health provider covered by legislation and are generally required to consult with National Boards about complaints relating to the individuals that they register. HCEs have regulatory powers to take action against health care providers that provide services incompetently or unethically and pose a significant risk to public safety. The National Law stipulates that when an investigation, conciliation or other activity of the HCE raises concerns about possible health or performance issues, HCEs must give the relevant National Board written notice.[98]

HCEs may also hold valuable data of the volume and proportion of complaints they receive about cosmetic surgical procedures. Some evidence of complaints trends for these procedures is

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

[90] *Health Care Regulations 2008* (SA) reg 21C(1).

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

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

[93] Ibid reg 6(c)(v).

[94] Medical Board (2015) 'Public consultation and RIS', p. 10.

[95] *Private Health Facilities Regulation 2017* (NSW), Part 1, s 3 (b).

[96] *Private Health Facilities Regulation 2016* (Qld), s 3(2).

[97] In the ACT and Victoria for example.

[98] *Health Practitioner Regulation National Law Act 2009* (Qld) sch, s 150.

presented later in this Problem Statement. Health ministers welcome additional data stakeholders, including HCEs can provide to help determine the number, range and trends of complaints relating to cosmetic surgical procedures.

Restrictions on performing cosmetic surgery across jurisdictions

Since 2008, the carrying out of cosmetic medical and surgical procedures on children for reasons other than therapeutic has been restricted in Queensland.[99] Performance of defined cosmetic procedures on children is prohibited, unless it is in the 'best interests of the child'.[100]

In 2008, the New South Wales Medical Board issued a policy on cosmetic surgery requiring a mandatory 'cooling off' period of three months and additional consultation for cosmetic surgical procedures on legal minors.[101] The policy, which is now included in the Medical Board's current guidelines, stipulates requirements for assessment of prospective cosmetic surgery clients including reasons for the procedure, expectations, mental health considerations and referrals to specialists where relevant and cooling off requirements. Medical practitioners must provide advice on what a procedure involves; associated risks; potential outcomes; recovery time and requirements and alternate options to surgery.

Consumer law and regulation

The *Competition and Consumer Act 2010* (Cth) promotes competition and fair trading and consumer protection. The Australian Consumer Law prohibits conduct that is misleading, dishonest or unfair. This includes:

- misrepresentation about the standard, quality, value of services
- conduct that is misleading or deceptive or likely to mislead or deceive
- false representations about the sponsorship, approval, performance characteristics, accessories, uses or benefits of goods or services.

It also requires service providers to warrant that their services are carried out with due care and skill and are fit for the purpose for which they are supplied. If a consumer feels cosmetic surgery providers have not adhered to these requirements, they may make a notification to Ahpra or a HCE or take civil legal action.

The law of negligence, civil liability legislation and criminal law

Civil liability legislation and the law of negligence

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 constitutes negligence.

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

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

[100] Ibid. These 'best interests' are defined by a set of guiding principles including the right of every child to be protected from harm.

[101] Available at https://www.mcnsw.org.au/sites/default/files/dd10_10886_policy_-_cosmetic_surgery_including_cooling_off_period_for_persons_under_18_years_of_age_c25.pdf.

with what is widely held by a significant number of respected practitioners in the relevant field to be competent practice.[102]

The compensation available to patients and consumers usually includes reimbursement for debts or payments related to the harm caused, and compensation for lost earnings and, where relevant, for pain and suffering. In common law, the professional duty of care owed by practitioners obliges them to provide such information as is necessary for a patient or consumer to give their informed consent to a procedure, including information about all 'material risks' of the proposed treatment. Courts have observed that this onus is heightened in cosmetic surgical procedures.[103]

Criminal law

The 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. While evidentiary standards vary between states and territories, in general a practitioner can be held to have been criminally negligent for failure to take reasonable care in the performance of surgery that results in grave health consequences or death.

Surgical training of medical practitioners

All registered medical practitioners receive some surgical training and the entry-level qualification for medical practitioners for many years was the Bachelor of Medicine and Surgery (MBBS).

The level of training of different medical practitioners varies greatly. Specialist surgeons undertake training through five stages of performance[104] across 10 competencies and are placed for training in hospital posts, undertake research as well as examinations and work-based assessments.[105] Plastic and reconstructive trainees, for example, are expected to complete at least five and no more than nine years' training.[106] Training for recognised specialties under the National Law is accredited by the AMC, which entitles specialist medical practitioners to use relevant surgical specialist titles approved by health ministers.

Specialist GPs undertake less extensive but still rigorous surgical training, particularly if they wish to qualify as Fellows in Advanced Rural General Practice with Advanced Rural Skills Training (ARST).[107] Trainee fellows may also complete two years of advanced specialist training.[108]

Cosmetic procedures do not form part of the formal training of GPs.

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[102] See example *Civil Liability Act 2002* (NSW) s 5O. See also *Wrongs Act 1958* (Vic) s 59(1).

[103] *F v R* (1983) 33 SASR 189 (King CJ), cited with approval in *Rogers v Whittaker* (1992) 175 CLR 479, 490.

[104] Royal Australasian College of Surgeons (2012) 'Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies', p. 1.

[105] See generally Royal Australasian College of Surgeons (2020) Surgical Competence and Performance: A guide to aid the assessment and development of surgeons'; Royal Australasian College of Surgeons (2021) 'Guide to SET: An Overview of Selection and Training 2021', p.8.

[106] Royal Australasian College of Surgeons (2021) 'Guide to SET: An Overview of Selection and Training 2021', p. 39.

[107] RACGP, 'The Fellowship in Advanced Rural General Practice (FARGP) Advanced Rural Skills Training: Curriculum for GP surgery', 2014, pp. 1-2.

[108] ACRRM, *Fellowship Training: Handbook* (March 2020) pp. 9, 19, 23 and 26 (available at https://www.acrrm.org.au/fellowship/discover-fellowship/core-training, accessed 23 March 2020).

Other specialist medical practitioners that receive extensive surgical training include dermatologists (sometimes called Mohs surgeons), obstetricians and gynaecologists, and ophthalmologists.

More information on this training is in Appendix 3.

Public harm and risks that arise from the current regulatory regime

The problem to be addressed relates to consumer harm. However, it has not been possible to identify the scale or scope of the problem and stakeholder input is sought in relation to the fundamental problem that needs to be addressed. Evidence of the problem and how it relates to the current rules about use of the title 'surgeon' is presented in this section.

Health regulators rely on the title protection powers of the National Law to encourage members of the public to consult appropriate practitioners and receive appropriate health and health-related advice. They do not, as a rule, deem medical practitioners unable to perform given procedures merely because they have not obtained a relevant specialist qualification. Rather, prospective patients or consumers are advised to consider whether a practitioner has undertaken appropriate training in a given field when they are considering having a procedure.[109]

Yet there can be significant information and power asymmetry between the public and practitioners. The title protection system in the National Law provides some guidance to patients and consumers. However, members of the public cannot always make sense of title and cannot always rely on practitioners to responsibly explain the risks and rewards of surgery, or the capacity of the practitioner being consulted to perform a given procedure.[110] Stakeholders are encouraged to comment whether this is especially the case with cosmetic surgery.

Medical Board Guidelines advise practitioners to perform only those procedures for which they have appropriate training, expertise and experience, and similarly instruct practitioners not to make misleading claims about their qualifications, experience or expertise. Stakeholders are advised to consider whether practitioners are sufficiently dissuaded from performing procedures beyond their competence and from making associated claims about their ability to perform them. While practitioners can be disciplined under the National Law after a procedure has gone wrong, stakeholder advice is sought as to whether this disciplinary action provides adequate preventive influence. Further, feedback is sought on whether the current title protection regime that permits any medical practitioner to describe themselves as a surgeon, competent to perform surgery confuses the public. Stakeholders are also invited to provide data that may indicate whether public confusion is experienced more commonly or widely in relation to cosmetic as opposed to other forms of surgery (see data requests in 'Consultation questions').

Risks are inherent in any surgery, including the risk of harm and ongoing complications. This RIS is interested to discover how widespread evidence of cosmetic surgery resulting in significant harm and complications is. Further, ministers are interested whether and to what extent there is evidence to show that cosmetic surgical harms and complications are resulting from procedures being performed by practitioners who do not have advanced surgical training, or who are

[109] COAG Health Council (2018) 'Regulation of Australia's health professions: Keeping the national law up to date and fit for purpose', pp. 58–59.

[110] See case study 4.

practising outside their scope of competence. It further asks if these harms and complications can be quantified.

Consultation questions

Question 4.1: Have you experienced difficulty getting cosmetic surgical practitioners to explain professional title, the risks and rewards of surgery, and their capacity to perform a given procedure? Was this more difficult than with other surgical practitioners?

Question 4.2: Do you have any evidence of harms or complications resulting from procedures performed by practitioners who do not have advanced surgical training, or who are practising outside their scope of competence? Can these harms and complications be quantified?

Question 4.3: Do you have any evidence of harms arising from cosmetic surgeries that are the result of unethical or substandard practices or unethical conduct?

Evidence of consumer harm: Case studies

The following case studies from tribunal hearings in states and territories demonstrate some of the potential severe-to-catastrophic outcomes of cosmetic surgery. They have been de-identified to focus on recorded types of consumer harm rather than the identity of practitioners involved.

Case study 1

In this case, a medical practitioner was deemed not competent to perform laser lipolysis[111] by the NSW Civil and Administrative Tribunal after a consumer suffered serious harm following the procedure. The practitioner was found to be 'inadequately trained in the procedure' and had administered inappropriate levels of morphine and failed to call an ambulance within a reasonable time after the patient became cyanosed. The tribunal ordered that the practitioner's registration be suspended for six months, and their registration be subject to conditions following reinstatement. These conditions prohibited the practitioner from performing both cosmetic procedures and surgical procedures, with minor exemptions. Before this order, the practitioner had general (i.e. not specialist) registration and had completed training to perform lipolysis procedures at the American Academy of Aesthetic Medicine in Thailand.

Case study 2

A registered specialist GP performed cosmetic surgical procedures that resulted in adverse patient outcomes.

The Health Complaints Commission (NSW) filed complaints against the practitioner for failing to adequately conduct assessments prior to surgery of patients. These complaints were supported by expert evidence. The practitioner did not obtain informed consent from prospective consumers prior to performing various procedures and used a formulaic approach to obtaining consent to serious procedures.

[111] See Glossary, definition of 'cosmetic surgery'.

The practitioner was also said to have woken and sat patients up during surgical procedures to enquire if patients were happy with the size and positioning of breast implants inserted or instead requested associates to enter the room to comment. Information provided about post-operative care was also deemed insufficient or not provided to patients at all.

Following breast augmentation procedures, patients reported being in extreme pain requiring medical intervention, developed fevers and infections, had wounds split open post-surgery and had stiches dissolve resulting in a streptococcus infection.

One patient alleged she arrived at the practitioner's surgery to undergo a breast augmentation and received no hospital gown or sedation and was in 'excruciating pain', stating:

> *He sewed me up and sent me out into another room. No observations were taken, and a staff member gave me Endone. I was told I could leave immediately after the procedure.*

The NSW Civil and Administrative Tribunal held that the practitioner 'engaged in a gross dereliction of his duty of care to' a particular patient upon twice removing and washing an infected implant and reinserting it into the patient. The tribunal held that the practitioner engaged in serious unprofessional conduct to the level that cancellation of his registration was required. The tribunal also held that the practitioner could not have his registration reinstated for a period of seven years.

Case study 3

The Medical Board (previously the Medical Practitioners Board of Victoria) referred a medical practitioner holding general registration who was working in general practice to the Victorian Civil and Administrative Tribunal (VCAT) for performing liposuction procedures on several patients[112] outside their scope of practice. The tribunal heard that the practitioner had asked her receptionist to help perform several lengthy liposuction operations and translate signed consent forms for a consumer with limited comprehension of English. The tribunal further heard that on several occasions the practitioner's performance of these procedures resulted in adverse patient outcomes that required review by other medical specialists. These specialists deemed that post-operative outcomes of several patients warranted notification to the Medical Board of Australia. VCAT determined that the practitioner had engaged in unprofessional conduct and was required to undergo additional training, and imposed restrictions and conditions on her registration.

Case study 4

The Medical Board took immediate action against a medical practitioner after several notifications were made in relation to their performance of cosmetic surgeries. The practitioner's performance of abdominoplasty and liposuction resulted in complications. The Board expressed concern that the practitioner had regularly administered sedation and/or analgesia in breach of guidelines published by the Australian and New Zealand College of Anaesthetists (ANZCA) on sedation and/or analgesia. The practitioner's conduct was said by the Board to have been deficient in relation to multiple aspects of care, including pre-operative care and obtaining informed consent, the duration of procedures, post-operative care, the administration of anaesthesia and operative outcomes. The practitioner also allegedly failed to identify potential complications prior to performing the procedures, discharged their clients just one hour after surgery and left them with 'very poor aesthetic outcomes'.

[112] See Glossary, definition of 'cosmetic surgery'.

Case study 5

At the time of publication, these proceedings are at a preliminary stage and the defendants have not yet filed a defence. No adverse findings have been made against any of the defendants. The summary below is drawn from the plaintiffs' materials, which have not yet been tested in court, and as such are allegations only. This case study is included for illustrative purposes only, and it is not suggested that any of the allegations are true.

Nevertheless, the case is worth highlighting as it involves allegations of many significant adverse patient outcomes from breast augmentation procedures performed at cosmetic surgery clinics. It involves allegations that breast augmentation procedural training undertaken by medical practitioners at these clinics was allegedly devised and provided by a qualified specialist plastic surgeon who had financial interest in and was a principal of the entity. There are further allegations that the plastic surgeon supervised some procedures. The plaintiffs' Statement of Claim contends that the procedures increased risk to consumers, as they were allegedly conducted in a template-like manner, regardless of individual clients' physiognomy. The plaintiffs also allege that in some instances serious surgical procedures were performed at premises which were not legally capable of administering general anaesthesia and that use of an apparent 'One Size Fits All Approach' increased the risk of local anaesthetic toxicity and other complications. The plaintiffs' Statement of Claim further contends that prospective clients were assured that the training provided to the medical practitioners by the plastic surgeon 'set [the surgeons] apart from other surgeons' and 'turned [them] into exceptional cosmetic surgeons'. The Claim also alleges that several applicants suffered operative or post-operative complications such as 'haemorrhage; excessive tissue trauma; infection; scarring; and local anaesthetic toxicity, leading to cardiac arrest; pneumothorax and death'. Although these proceedings do not focus on the individual medical practitioners that performed the procedures, the court will be required to analyse the training allegedly provided by the plastic surgeon and perhaps also whether the practitioners had obtained recognised specialist surgical or other relevant qualifications involving some advanced surgical training.

Case study 6

A registered specialist plastic surgeon was found to have engaged in serious unprofessional conduct after a liposuction resulted in the death of a patient. The VCAT heard that while the provision of the procedure itself was not the issue at law the Coroner classified the post-operative care provided by the practitioner as deficient and the consumer's death as preventable. Complications experienced by the consumer, as stated to the court, included pain, swelling, bleeding and blistering, to which the tribunal determined the practitioner had a responsibility to attend. The Coroner found that surgical complications resulting in the consumer's death comprised:

> *sepsis, decreased respiratory function secondary to microthrombi, fat emboli, probable inhalation of gastric contents and infection, and central nervous depression due to a combination of drugs (pethidine and proxyphene)*.

The practitioner agreed to a reprimand and had conditions imposed on their registration. The actions of the practitioner in this case and the regulatory actions available to authorities in cases such as these would not be affected by restriction of title, which would not provide additional protection to consumers or patients.

Medical and industry characteristics of cosmetic surgery

The provision of cosmetic surgical procedures is, as the Queensland Health Quality Complaints Commission (QHQCC) stated in 2013:

> *Unlike many other areas of medicine, [as] doctors and nurses practising cosmetic procedures operate in a commercial market where they are seeking financial gain (profit) and their patients are seeking procedures as a matter of choice (to boost self-esteem or make them feel better about their bodies) rather than for medical need (to treat trauma or disease).*[113]

Cosmetic surgery is not the only area of medicine or health care that is elective, expensive to purchase and lucrative to provide; assisted reproductive treatment (ART)[114] is another such area. Cosmetic surgery, however, is provided in a unique medico-commercial environment, where the:

- nature of the surgery (elective only)
- expense of the procedures (solely borne by the consumer)
- commercial service delivery models (involving corporate providers who advertise in and primarily attract business through social media platforms)

can create perverse incentives for registered medical practitioners to work outside of their competence and deliver substandard services.

Public consumption rates of cosmetic surgical and medical procedures are purely demand driven,[115] and demand is enlarged by the promotion of these procedures through a complex network of industrial and social influences, including advertising, and mass and social media that collectively glamorise and normalise cosmetic surgical procedures.

The profitability of cosmetic procedures can encourage corporatisation among providers. The corporate business model of some entities is built on providing comparatively low costs for customers in a competitive market. This model can be lucrative. The ABC program *7.30* reported in 2015 that a successful cosmetic procedure clinic was at that time performing more than 5,000 procedures each year.[116] In 2018, the New South Wales Parliamentary Inquiry (NSWP Inquiry) heard that several corporate clinics operate in various states and territories,[117] and that some had experienced extraordinary growth in revenue.[118]

Stakeholders are invited to comment on the relationship between corporatisation and cosmetic surgery. In particular, health ministers are interested to learn if this is incidental or more common in cosmetic surgery than in other surgical fields. If it is more common in cosmetic surgery, health ministers are interested to learn if this is having any discernible and important effects on patient risk and harm.

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[113] QHQCC (2013) 'Great expectations', p. 9.

[114] Commonly referred to as IVF treatment.

[115] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4.

[116] 'Knife's edge: cosmetic surgery has become a billion-dollar industry in Australia' *7.30* (ABC), broadcast 20 August 2015.

[117] Saxon Smith, testimony to NSW Committee on the Health Care Complaints Commission, Inquiry into Cosmetic Health Service Complaints in NSW, 1 August 2018, p. 15.

[118] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 5. See also Scott Turner, Board representative, Australasian Society of Aesthetic Plastic Surgeons, Testimony to NSW Parliament Committee, 1 August 2018, p. 14.

Consultation questions

Question 4.4: Can you provide information about the relationship between corporatisation and cosmetic surgery? If a relationship exists, is this more common in cosmetic surgery than in other surgical fields?

Question 4.5: If corporatisation is more common in cosmetic surgery, is this is having any discernible effects on patient risk and harm?

Advertising and affordability

The commercial basis for most cosmetic surgical procedures means that consumers rely – to a greater extent than in relation to any other surgery – on the advice of the prospective practitioner and on information drawn from social trends, media, peer pressure and well-resourced marketing campaigns.[119]

Affordability is a major motive for many consumers' choice of cosmetic surgical procedures and providers. Cost plays a much larger role determining the consumption patterns of cosmetic surgery as opposed to many other forms of surgery. Brain or heart surgery, for example, is not elective and a patient will choose their surgeon because of their expertise, experience and reputation. Importantly, they will be guided in these choices by their GP and/or other medical practitioners. This is seldom the case with cosmetic surgery, where a diverse range of influences strongly affect prospective cosmetic surgery consumers. These include:

- peer influence
- mass and social media stories
- advertising
- price competition between providers
- cultural factors (e.g. body fashions and trends within different demographic groups).

Advertising of cosmetic procedures frequently minimises or omits information regarding associated risks.[120] The NSWP Inquiry heard that corporate cosmetic entities use targeted campaigns to entice consumers from lower socio-economic cohorts to undergo cosmetic procedures.[121] The NSWP Inquiry was advised that one corporate provider of cosmetic surgical procedures, The Cosmetic Institute (TCI), advertised to potential consumers they could receive breast implants 'for the cost of a coffee a day'. The Inquiry also heard that some consumers from low socio-economic groups took loans of $20 a week to pay for these procedures.[122] One breast implant consumer in 2015 reported seeking the services of TCI because the advertised price ($5,990) was 'half of what [she] would have paid' in her home city, Melbourne. The woman was led to believe that the use of 'twilight' or conscious sedation, which made possible receiving the implants as a day procedure, was the principal reason why the institute's price was so competitive.[123]

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[119] Medical Board (2015) 'Public consultation paper and Regulation Impact Statement' ('Public consultation paper and RIS'), p. 14.

[120] QHQCC (2013) 'Great expectations', p. 19.

[121] Trusted Surgeons testimony to NSWP Inquiry, 1 August 2018, pp. 41, 44.

[122] Ibid, pp. 41, 41.

[123] 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network) broadcast 20 September 2015.

Cosmetic surgery is an unusually price-sensitive medical market, in which consumers respond far more to price signals than to other signals and influences, such as a referral from their GP or how qualified a practitioner is to conduct the procedure. The expectations of cosmetic surgical consumers for the outcomes of their procedures are elevated by the financial pressure they create (costs are met in full by the consumer without Medicare rebate) and by other influences such as social media, where post-operative images are posted.[124] Costs of procedures are sometimes lowered by providers who use staff that perform procedures outside their competence and/or socio-medical licence.[125] Procedures are also often performed in facilities that are not licensed to provide a full range of care, such as more powerful sedatives and anaesthetics.[126] Custom is also solicited by offers of counterfeit (or unregulated) products.[127]

Advertising and marketing of cosmetic services can sometimes be initiated by consumers. Young women, in particular, initiate contact with cosmetic surgery providers and offer to advertise their work in online platforms, in exchange for free procedures.[128] Practitioners and proceduralists must not initiate this contact and it creates ethical and professional dilemmas for practitioners. While the legal requirement in the National Law prohibiting practitioners from accepting such offers is clear, the ability of each and every medical practitioner currently registered in Australia to responsibly manage the financial incentives that such offers create must be suspect.

The performance of template procedures and inappropriate sedation on cosmetic surgery clients may be cost-related, as some practitioners may not wish to spend the necessary funds to ensure either that their facilities are licensed to carry appropriate anaesthetic and/or to engage the services of a qualified anaesthetist.

Health ministers are not suggesting that these various examples of harmful practice are unique to cosmetic surgery. They are asking stakeholders, however, if there is data demonstrating that the financial incentives attracting practitioners to the field, combined with the volume and eagerness of consumers, leads to a greater risk or occurrence of harm.

Consultation questions

Question 4.6: Can you provide evidence to show that financial incentives are attracting medical practitioners to the field of cosmetic surgery? If financial incentives exist, is this leading to greater risk and harm to patients?

Question 4.7: Please provide any evidence you have about the volume of patients accessing cosmetic surgical procedures.

Cosmetic surgery is elective only and consumers bear all costs

The absence of Medicare rebates for cosmetic procedures means that consumers pay all costs. The availability of lower-cost cosmetic procedures frequently masks the total costs incurred by

[124] Gogos, A. J., Clark, R.B., Bismark, M. M., Gruen, R. L. & Studdert, D. M (2011) 'When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints', *Medical Journal of Australia*, 195(6), pp. 340–344, 343.

[125] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 5.

[126] See for example 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network) broadcast 20 September 2015.

[127] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 6.

[128] 'Beauty's New Normal', *4 Corners* (ABC), 16 August 2018, https://www.abc.net.au/4corners/beautys-new-normal/10115838 (accessed 25 May 2020).

consumers, particularly – but not only – when procedures are unsuccessful and a consumer either wants or requires surgical revisions.

In 2013, the QHQCC noted that it received several complaints from consumers distressed by having to bear the costs of corrective procedures. It also received complaints from consumers who claimed to have received insufficient information about maintenance costs that would follow their procedures.[129]

The Australian Society of Aesthetic Plastic Surgeons also suggested in its response to the NSWP Inquiry that many consumers who purchase lower cost cosmetic procedures – who are often in lower socio-economic cohorts of the general population[130] – will end up incurring additional out of pocket expenses for revision surgeries.[131] Reporting on problems with cosmetic surgery in mass media also emphasise the financial toll of post-operative outcomes on consumers and their families.[132]

Unsuccessful procedures and subsequent problems

The flow-on effects of both dissatisfaction and poorly performed cosmetic surgery may be significant for both individuals and communities. Some consumers have been killed by unsuccessful cosmetic surgical procedures.[133] Far more commonly though, consumers may experience a range of mental health issues and negative physical and lifestyle impacts. They may seek or demand reparative surgery or may litigate. The QHQCC found that the costs borne by consumers for cosmetic surgery may heighten expectations of satisfactory or perfect outcomes and fuel post-operative complaint, action and litigation.[134]

When consumers are dissatisfied or harmed by cosmetic surgery society at large is harmed by the:

- distress and lost productivity of consumers who experience poor outcomes
- cost (in time, labour and money) of reparative surgery for consumers who have been operated on
- the risk of imported disease and infection, as well as poor surgical outcomes, in cases of cosmetic medical tourism gone bad.[135]

The cycle of flow-on outcomes from consumer dissatisfaction or harm suffered due to cosmetic surgeries is illustrated in Figure 2.

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[129] QHQCC (2013) 'Great expectations', p. 17.

[130] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 8.

[131] Ibid.

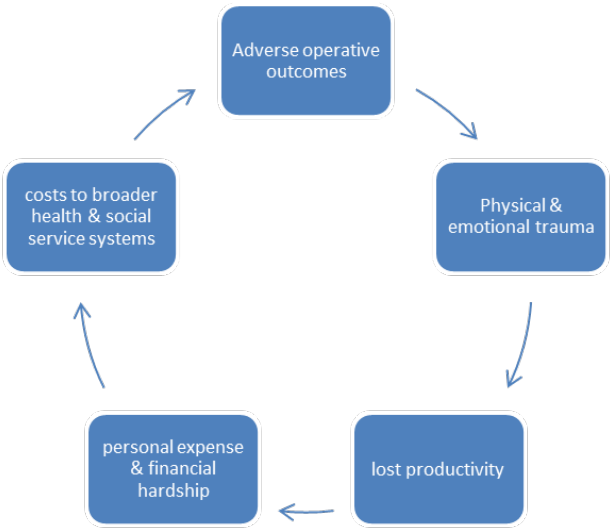
[132] 'Knife's edge: cosmetic surgery has become a billion-dollar industry in Australia' *7.30* (ABC), broadcast 20 August 2018; 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network) broadcast 20 September 2015.

[133] See example Cárdenas-Camarena, Lázaro; Bayter, Jorge Enrique; Aguirre-Serrano, Herley; Cuenca-Pardo, Jesús (2015) 'Deaths Caused by Gluteal Lipoinjection: What Are We Doing Wrong?', Plastic and Reconstructive Surgery, pp. 58-66. See also Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 11. Ms Jean Huang died on 1 September 2017 following an unsuccessful breast filler procedure performed by unregistered persons, resulting in a subsequent investigation by the HCCC.

[134] QHQCC (2013) 'Great expectations', p. 10.

[135] For more information about cosmetic medical tourism, see 'Cosmetic surgery complaints: trends'.

Figure 2: Cycle of harm following unsuccessful cosmetic surgical procedures



One well-documented harm is the cost of revision procedures for adverse outcomes, which can greatly exceed the costs of an original procedure[136] and further imperil the consumer's health, the health of their family relationships, and the housing security of themselves and their families.[137]

Post-operative adverse outcomes for both surgical and medical cosmetic procedures include such physical impacts as scarring, infection, blood clots and deformities.[138] Some recipients of cosmetic surgeries have been forced to undergo months of post-operative health checks, after nearly dying from seizures induced by local anaesthetics.[139] Complications experienced during procedures have also resulted in consumers going into cardiac arrest[140] and dying.[141]

Some consumers accessing cosmetic procedures are known to be more vulnerable, experiencing mental health conditions such as depression or body dysmorphia.[142] This vulnerable cohort of consumers may experience greater impacts to their mental health and wellbeing when outcomes are undesirable or not in line with expectations.

One notable case of post-operative harm from the QHQCC's 2013 report is highlighted below.[143]

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[136] QHQCC (2013) 'Great expectations', p. 26.

[137] 'Knife's edge: cosmetic surgery has become a billion-dollar industry in Australia' *7.30* (ABC), broadcast 20 August 2015.

[138] QHQCC (2013) 'Great expectations', p. 19.

[139] 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network); broadcast 20 September 2015.

[140] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, pp. 10–11.

[141] Medical Board (2015) 'Public consultation paper and RIS', p. 20.

[142] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 71.

[143] QHQCC (2013) 'Great expectations', p. 16.

Case study 7

A consumer underwent two unsuccessful bilateral breast augmentation surgeries. After her first surgery, the woman experienced considerable pain, swelling and oozing of fluid in her right breast. These complaints were reviewed by her surgeon, who decided to remove the right implant, drain and wash out the area and treat the woman with antibiotics. Shortly afterward, the woman began experiencing problems with the left breast implant and had this removed also, two weeks after the first procedure. The woman then requested new implants and was advised to wait for three months. She was told also that re-implantation under the pectoral muscle would be risky, and the new implants should be placed on top of the muscle. Four months after her first implants were removed, the woman received two new implants. Despite taking antibiotics, problems again developed with the left implant that were not resolved by daily wound irrigation and changed dressings. Once again, the surgeon recommended the left breast implant be removed and the consumer decided to have both implants excised. The woman eventually complained to the QHQCC about:

- what she regarded as an unreasonable number of post-operative visits due to complications
- having to endure five operations
- being left disfigured
- suffering depression due to surgical outcomes.

Health ministers welcome data from stakeholders that may demonstrate the volume and broader costs of post-operative outcomes of cosmetic surgeries to the health system and the broader economy. This includes any data that quantifies the cost to the public health system of revision surgeries for consumers who have suffered poor outcomes from cosmetic procedures.

Consultation questions

Question 4.8: Can you provide evidence that demonstrates any broader costs of post-operative outcomes of cosmetic surgeries the health system and the broader economy? This includes any data that quantifies the cost to the public health system of revision surgeries for consumers who have suffered poor outcomes from cosmetic procedures.

Referrals from third parties such as GPs are not required or sought

The commercial and elective nature of most cosmetic surgical procedures means that patients and consumers rarely consult primary health care providers – principally GPs – to gain important, third-party perspective on their plans. The lack of understanding about the meaning and significance of title in the medical profession may make consumers particularly vulnerable to making poor choices in the cosmetic surgery market, because they generally must navigate without disinterested professional guidance that a GP typically provides in relation to other areas of surgical healthcare.

Cosmetic surgical procedures are not covered by Medicare or most private health insurance, and adult consumers are therefore not required to obtain a referral from a GP prior to consulting with a cosmetic practitioner.[144] GPs are also less likely to be involved in post-procedural care.[145]

[144] Medical Board (2015) 'Public consultation paper and Regulation Impact Statement' ('Public consultation paper and RIS'), 14; QHQCC (2013) 'Great expectations', p. 37.

[145] AHMAC (2011) 'Cosmetic Procedures: A National Framework', p. 39.

Ministers are interested to learn if the lack of GP involvement has material effects on the quality of care being provided by cosmetic surgical proceduralists and, if so, how this might reasonably be demonstrated.

Consultation questions

Question 4.9: Are you aware of adverse impacts to cosmetic surgery patients due to there being no requirements to involve a GP in referrals? Does this have material effects on the quality of care being provided by cosmetic surgical proceduralists? If so, how this might reasonably be demonstrated?

Current regulation facilitates intervention only after an adverse event and often with limited effect

Case law from state and territory tribunals shows that some medical practitioners who are found to have performed cosmetic surgical procedures outside their competence are not appropriately trained to perform specialist surgical procedures. The cases show how regulators currently use legislation, regulations, the Ahpra register and industry codes to manage the provision of surgical services that fall below standards expected by the Medical Board and by patients and consumers. These tools generally allow only for intervention after an adverse event.

Case study 4 shows that while a practitioner can be suspended or subject to monitoring and performance audit requirements and conditions limiting their scope of practice – as this practitioner was at the time of writing – these actions necessarily follow the detection of poor practice that results in significant harm to consumers. Significant and detrimental outcomes were experienced by consumers who may have selected the practitioner as their surgeon on the basis that he or she was competent to perform 'cosmetic surgery'.

Case study 5 may also show that the regulation of advertising by medical practitioners may fail to deter wrongdoing. Plaintiffs in the case allege that messaging provided to them by the clinic explicitly claimed or created a reasonable impression that the training provided to medical practitioners at and by the clinic 'set them apart from other surgeons' and 'turned [them] into exceptional cosmetic surgeons'. The reasonableness of this claim is currently being examined by the court.

It is possible that some practitioners are not deterred by the penalties attached to breaching the advertising guidelines or conclude that the chances of being pursued for breaching those guidelines are very low. The effectiveness of the current advertising guidelines of the National Law have been questioned by stakeholders such as the Australian Lawyers' Alliance. In testimony provided to the NSWP Inquiry in 2018, ALA stated that advertising guidelines on cosmetic surgery are 'rarely adhered to' and that any quick Internet search will confirm this.[146] This RIS welcomes data stakeholders may have that demonstrates the effectiveness or ineffectiveness of the National Law's advertising provisions, particularly in the cosmetic surgery industry.

The absence of historical practice information in the Ahpra register of practitioners may also create singular risks in relation to cosmetic surgical procedures because the practice of cosmetic surgery is:

[146] Australian Lawyers' Alliance, Testimony to NSW Parliament Committee, 1 August 2018.

- attractive to a far greater number of prospective consumers than is therapeutic surgery
- likely to attract a greater number of proceduralists without advanced surgical training, because of high public demand and income potential
- not subject to title provisions in the National Law that could restrict claims made by some practitioners about their surgical expertise
- not vetted by GPs.

In short, the difficulties that can arise from limits placed on regulators' freedom to share information about practitioners with the public may be compounded by other regulatory issues in relation to the regulation of cosmetic surgery. Health ministers welcome feedback from stakeholders that indicates whether information absences in the register do compound other cosmetic surgery regulatory issues.

Consultation questions

Question 4.10: Can you provide any evidence demonstrating the effectiveness or ineffectiveness of the National Law's advertising provisions, particularly in relation to the cosmetic surgery industry?

Question 4.11: Can you provide any information about whether Ahpra's public register of practitioners helps to address any identified cosmetic surgery regulatory issues?

Available data: quantitative and qualitative

Demand for cosmetic surgical procedures provides an important tool for gauging the level of public risk that may be posed to consumers based on their knowledge and understanding when accessing these procedures.

Demand for procedures

Total volume of demand and expenditure

In 2017, stakeholders estimated that Australia surpassed the US in per capita expenditure on cosmetic procedures,[147] advising there is strong growth in demand for cosmetic plastic surgery.[148] This suggests that cosmetic procedures are becoming more commonly performed both in Australia and for Australians.

In 2018, the Australasian College of Cosmetic Surgery (ACCS) (now the Australasian College of Cosmetic Surgery and Medicine (ACCSM)) estimated that Australians spend approximately $1 billion annually on cosmetic procedures.[149]

[147] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4 citing Australian Medical Association, Submission 25.

[148] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4 citing Royal Australasian College of Surgeons, Submission 14.

[149] Australasian College of Cosmetic Surgery and Medicine, 'Patients Need to Be Protected Against Rogue Medical Practitioners Calling Themselves 'Cosmetic Surgeons'', *Media Release*, 12 May 2018,https://www.accsm.org.au/media/press.

While demand for cosmetic procedures across Australia is thought to be increasing rapidly, firm evidence is difficult to source.[150] The International Society of Aesthetic Plastic Surgery (ISAPS) conducts a periodic survey of business. While survey data have been released for 2019, specific data was not included for Australia. This is likely due to provision of insufficient data to the survey because of impacts of the COVID-19 pandemic in Australia, including cessation of some plastic surgical procedures. In 2018, approximately 35,000 of an estimated 46,300 plastic surgeons were invited to participate, including Australian practitioners.[151] The survey found that in 2018, Australians underwent 202,642 surgical and medical cosmetic procedures.[152] This figure was actually less than reported for 2016, when ISAPS estimated that 225,002 cosmetic procedures were completed.[153] In 2018, most cosmetic procedures (72.1%) were performed in a hospital setting while 20% were undertaken in an office facility and a smaller number (7.9%) in a 'free-standing surgicentre'.[154]

Popular procedures

Respondents to the 2018 ISAPS survey identified the five most common cosmetic surgical procedures performed on Australians as:

1. Breast augmentation
2. Eyelid surgery
3. Liposuction
4. Abdominoplasty
5. Breast reduction.[155]

Surgical procedures comprised over 50% (102,404 of 202,642) of cosmetic procedures reported by respondents.[156] These findings are generally consistent with that of the 2018 NSWP Inquiry, which found that the most performed surgical procedures are breast enhancements, while other common procedures included breast reduction, liposuction, abdominoplasty (tummy tuck), eyelid surgery and facelifts.[157]

According to the ISAPS, Australia's total number of cosmetic surgical procedures performed in 2018 rose from 2016, which totalled 95,142.158. The RACS also advised the NSWP Inquiry that in 2017 one in ten Australians would seek to have plastic surgery in the next three years; the main procedures to be undertaken would be facial contouring (37%); other facial (31%); and breast/chest enhancement (27%).[159] The AMA has noted that while some cosmetic surgical (and

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[150] QHQCC (2013) 'Great expectations', p. 6; ABDR, Annual Report (2018).

[151] International Society of Aesthetic Plastic Surgeons (ISAPS), 'ISAPS Global Alliance Participating Societies', *Medical professionals*, retrieved 11 May 2020, https://www.isaps.org/medical-professionals/alliance-members. The Australian Society of Aesthetic Plastic Surgeons is a member of ISAPS.

[152] ISAPS (2018) 'Australia', ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018, p. 23.

[153] ISAPS (2016) 'Countries by Total Number of Procedures - 2016', *ISAPS The International Study* on Aesthetic/Cosmetic Procedures Performed in 2016, p. 39.

[154] ISAPS (2018) 'Cosmetic Procedures by Location', ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018, p. 44.

[155] Ibid, p. 23.

[156] Ibid.

[157] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4.

[158] ISAPS (2016) 'Procedures by Country', ISAPS The International Study on Aesthetic/Cosmetic Procedures Performed in 2016, p. 8.

[159] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4.

medical) procedures are reported, the number of procedures undertaken may be much greater.[160]

Another 2018 study by the then ACCS (now the ACCSM) stated that the five most popular cosmetic procedures in Australia were:

- anti-wrinkle injections
- fillers
- laser and Intense Pulsed Light (IPL)
- breast augmentation and reduction surgeries
- liposuction.[161]

In 2013, the QHQCC reported that 85-90% of procedures were performed on women, most commonly comprising breast enhancements. Other common procedures also included 'breast reduction, liposuction, tummy tucks, eyelid surgery, and facelifts'.[162]

In Australia, most cosmetic procedures are performed for female consumers aged 35-55.[163] Studies have found that women are approximately twice as likely to undergo a 'cosmetic surgical enhancement' than men[164] and that the popularity of cosmetic procedures continues to grow among younger women.[165]

International data suggests that this gender imbalance in several procedures has fallen, in some cases quite significantly. Nevertheless, the proportion of females undergoing any given surgical procedure has not been reported at less than around two thirds of all consumers, and medical procedures are typically requested by females at rates of 85-90%.[166] The international survey on which these figures are based receives data from Australian plastic surgeons and there is little reason to believe that the gender imbalance in procuring cosmetic procedures differs significantly in Australia relative to comparable nations. In addition, the Cosmetic Physicians College of Australasia reported in 2018 that cosmetic procedures in Australia are growing in popularity among men who represented approximately 7-8% of the total demographic of consumers undertaking procedures via its practice.[167]

International comparisons

The 2018 ISAPS survey found that Australian per capita demand for cosmetic surgical procedures is on par with comparable nations. In the US 4.5% of the population underwent a cosmetic surgical procedure. In Germany and Italy 4.6% and 4.7% respectively had a procedure.

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[160] Ibid, p. 5.

[161] Australasian College of Cosmetic Surgery and Medicine, 'Patients Need to Be Protected Against Rogue Medical Practitioners Calling Themselves 'Cosmetic Surgeons'', *Media Release*, 12 May 2018, https://www.accsm.org.au/media/press.

[162] QHQCC (2013) 'Great expectations', p. 6.

[163] ISAPS (2016) '2016 Gender Distribution for Cosmetic Procedures', *ISAPS The International Study on Aesthetic/Cosmetic Procedures Performed in 2016*, p. 52; Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 7.

[164] Tranter, B. and Hanson, D (2015) 'The social bases of cosmetic surgery in Australia', *Journal of Sociology*, 51(2), 189–206, p. 196.

[165] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 7.

[166] ISAPS (2018) 'Australia', ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018, pp. 41-42.

[167] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 7.

In Australia, 4.2% had a procedure. The proportions of consumers per capita in some Latin American countries are considerably higher (7.1% in Brazil; 6.3% in Argentina cf. only 4% in Mexico) and dramatically lower in India (0.3%).[168]

The global market for cosmetic surgical and medical procedures c. 2005-2020 has grown exponentially and has been widely estimated to generate hundreds of billions of dollars in economic activity each year. Much of this growth is experienced in non-surgical procedures. Commercial research published in 2017 forecast the global non-surgical cosmetic surgery market to grow at a compound annual growth rate of 7.87% from 2017-2021.[169] The impact of the COVID-19 global pandemic on this growth is not yet known.

Cosmetic surgery complaints: trends

It is difficult to measure the proportion of cosmetic surgical procedures in Australia with serious adverse consequences. Ahpra collects notification information about professions and specialties within professions, rather than on specific types of procedures. Ahpra cannot, therefore, provide reliable data relating to cosmetic surgical procedures brought to attention via a notification. In addition, not all state and territory HCEs tabulate the gross number of complaints that they have received in relation to these procedures. These HCEs are also comparatively new entities. Medical indemnity insurers have stated, however, that the number of medico-legal complaints made to regulators about cosmetic surgical procedures continues to rise.[170]

Complaints relating to registered practitioners may not provide a full picture of unsuccessful procedures. Some consumers who experience unsatisfactory results may not lodge a complaint, because they are apprehensive about the response they may receive or blame themselves for their predicament.[171]

The QHQCC's 2013 report on both cosmetic surgical and medical procedure complaints profiles 245 complaints made in Queensland over a six-year period. These represented 1% of overall healthcare complaints over the same six-year period.[172] Of the 245 complaints, 200 (just over 80%) were associated with cosmetic surgery. Most of these – approximately 40% and five times more than any other single procedure – concerned breast enhancements (lifts and implants), followed by face lifts, eye surgery, and abdominoplasty (tummy tucks).[173]

The QHQCC found that most complaints it reviewed where consumers reported permanent harm involved cosmetic surgery, amounting to about one third of the complaints the QHQCC reviewed. The harms reported mostly related to breast enhancement, followed by abdominal surgery, face and neck surgery, and breast reduction surgery.[174] The Commission also found that around one in five consumers perceive a poor outcome, even though that outcome is subsequently found to have been performed with good or at least competent skill.[175]

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[168] ISAPS (2018) 'Australia', ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018, p. 25.

[169] https://www.wiseguyreports.com/reports/1309356-global-non-surgical-cosmetic-surgery-market-2017-2021.

[170] Avant Mutual, 'Compensation claims take top spot for plastic surgeons and complaints rise', retrieved 22 May 2020, https://www.avant.org.au/news/compensation-claims-for-plastic-surgeons.

[171] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, pp. 57, 63–64.

[172] Approximately 24,500 in total and 4,800 per year. See QHQCC (2013) 'Great expectations', p. 1.

[173] QHQCC (2013) 'Great expectations', pp. 3, 14.

[174] Ibid, p. 19.

[175] Ibid, p. 10.

Some datasets made available by regulators collectively comprise adverse patient events as a result of cosmetic surgical and medical procedures.

In early 2018 the Health Complaints Commissioner of Victoria (HCC) stated that over the previous year it had received over 50 complaints regarding cosmetic surgical and medical procedures services.[176] In 2018-19, approximately a quarter of the 38 investigations started by the HCC[177] were associated with cosmetic service providers.[178] In 2019-20, the HCC issued 30 interim prohibition orders and 10 prohibition orders relating to the provision of cosmetic services generally.[179] The HCC noted that in 2019-20, cosmetic procedures remained 'an area of concern' with regard to investigations it had undertaken.[180]

The NSW Health Care Complaints Commission (HCCC) advised the 2018 NSWP Inquiry that in 2016-17 it received 94 complaints associated with cosmetic surgical and medical procedures.[181] The HCCC noted that this data may not be indicative of the true number of cosmetic services complaints as these may be classified under other categories, such as issues associated with day surgery anaesthetisation.[182] Other stakeholder submissions to the Inquiry inferred that official complaints data may not be representative of the true extent of adverse outcomes for consumers, based on assessing this data in correlation with the number of consumers requiring medical intervention post-procedure,[183] and that many consumers may not be aware of their rights to complain.[184]

Stakeholder input that can provide greater evidence about cosmetic surgery complaints is sought by this RIS.

Association between surgical skill, consumer disappointment and adverse outcomes

The failure to meet a consumer's expectations for a cosmetic surgical procedure may be attributable to a failing of or lack of clinical skill. Sometimes, however, this is not the case. The QHQCC, for example, found that almost half of the practitioners identified in the complaints it reviewed were surgical specialists.

Of the 94 surgical specialists the QHQCC received cosmetic surgery complaints about, nearly 80% were plastic surgery specialists, while another 10% were general and plastic surgery specialists. In addition, 12 of 14 reviewed specialists who were the subject of four or more complaints were specialists in plastic surgery (11 of 12) or general and plastic surgery (1 of 12).[185]

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[176] Health Complaints Commissioner (Victoria), *Cosmetic Services Complaints*, retrieved 25 May 2020, https://hcc.vic.gov.au/news/104-cosmetic-services-complaints.

[177] Health Complaints Commissioner (Victoria), 'Our investigations', *Annual Report 2018-19*, 24.

[178] Health Complaints Commissioner (Victoria), 'Keeping the community safe', *Annual Report 2018-19*, 27.

[179] Health Complaints Commissioner (Victoria), see https://hcc.vic.gov.au/prohibition-orders-warnings/prohibition-orders (accessed 21 September 2020).

[180] Health Complaints Commissioner (Victoria), 'Keeping the community safe', *Annual Report 2019-20*, 30.

[181] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 13.

[182] Ibid, pp. 13–14.

[183] Ibid, p. 14.

[184] Ibid.

[185] QHQCC (2013) 'Great expectations', 21, 23.

Cosmetic medical tourism

Demand for cosmetic surgical procedures has promoted the growth of 'medical tourism', as Australian consumers travel to foreign destinations to undergo procedures at prices vastly cheaper than in Australia.

Determining the numbers of consumers who purchase cosmetic surgical procedures as medical tourists is difficult.[186] It is important, however, to attempt to do so, because these numbers are relevant to determining the total demand in the Australian public for these procedures, as well as the proportion of consumers that might be affected by any changes in domestic regulation.

In 2015, Dr Meredith Jones of the University of Technology Sydney, estimated the annual spend by Australians on cosmetic surgery tourism to be around $300 million. She calculated the number of Australians travelling each year to undergo cosmetic procedures at around 15,000 per annum; more than 40 per day on average.[187] The financial comparison website Canstar, in 2017 agreed the size of the spend was likely around $300 million per year and that the numbers of travelling Australians was steadily growing.[188]

Further information about demand for cosmetic procedures and cosmetic medical tourism can be found at Appendix 4.

Consultation questions

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

Question 5.2: How do you currently satisfy yourself that your practitioner is qualified to perform their desired surgery, cosmetic or otherwise? How did you satisfy yourself that a practitioner was qualified prior to reading this RIS?

Question 5.3: Does this RIS accurately describe surgical procedures (cosmetic or otherwise) performed by practitioners, the types of specialists and other registered practitioners that perform them and the accepted parameters of practice for these practitioners?

Objectives of this consultation RIS

This consultation RIS seeks to help determine if:

- there is widespread belief that cosmetic surgery is regulated in the same way as other surgery
- current regulation is not helping members of the general public to understand how the regulation of cosmetic surgery differs with that for other surgery
- the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' is associated with serious risks and harm to the public.

[186] See for example Franzblau, L. E. and Chung, K. C. (2013) 'Impact of Medical Tourism on Cosmetic Surgery', p. 1; OECD, *Medical Tourism*, p. 2.

[187] See https://www.sbs.com.au/news/why-is-medical-tourism-from-australia-booming (accessed 31 March 2020).

[188] See https://www.canstar.com.au/health-insurance/medical-tourism-yes-or-no/ (originally published 27 February 2017, accessed 31 March 2020).

If these suppositions are confirmed by the consultation process, then the current approach to regulating the practice of surgery and of cosmetic surgery in particular will demonstrably not be contributing as fully to public safety and confidence in the health system as it should.

This circumstance in turn will raise further questions about whether market forces can be expected to resolve issues such as those highlighted in the 'Problem Statement' and 'Public harm and risks' sections of this RIS.

As a preliminary position, this RIS is proceeding with the view that the market cannot be expected to correct the range of problems and harms and risks that it identifies.

Medical practitioners currently have considerable freedom or licence to describe their skills and expertise. The current regulatory regime permits any registered practitioner to describe themselves in general terms as a 'surgeon' if they choose and evidence suggests that this right is exercised more in relation to the performance of cosmetic than other forms of surgery. Further, it is exercised more in relation to the performance of cosmetic surgery due to market forces, namely the profits that can be gleaned from providing these services to a large and ever-growing cohort of clients eager to purchase these elective products.

The National Law does not as a rule prohibit the practice of various procedures by designated practitioners and as development of medical technology, surgical technique and consumer demand expand the range of surgical procedures and alter the ways in which they are performed, it is impractical to attempt to define in legislation the surgical procedures certain practitioners may perform.

These realities taken together show that prospective patients and consumers are currently left essentially to their own devices to determine whether they should purchase a cosmetic surgical procedure and whom they should employ to perform it. While they attempt these determinations, this task is made more difficult by a fundamental disconnection between the law of title protection and common understanding of crucial medical terms such as 'surgeon'.

This information asymmetry is not likely to be effectively addressed by the market. In the current cosmetic surgery market, cosmetic surgical practitioners are taking advantage of this asymmetry and performing procedures:

- without providing appropriate counselling about potential and actual risks and outcomes
- in inappropriate premises
- without adequate pre-, intra- and post-surgery management
- resulting in post-operative complications and un-aesthetic and/or adverse outcomes that are disfiguring, discomfiting, painful, grave and lethal.

In addition, the cosmetic surgery market is different to almost all other surgical services 'markets'. It is exclusively commercial, and consumers rely on the advice of the prospective practitioner and on information drawn from social media, peer groups and well-resourced marketing campaigns. The affordability of cosmetic surgical procedures plays a much larger role in determining the consumption patterns of cosmetic surgery than most other forms of surgery, which are not elective, are mediated by a GP and involve the choice of a surgeon based on expertise, experience and reputation, and whose costs are met, in significant part, by Medicare and – where relevant - private health insurance. These safety nets are absent in cosmetic surgery. Further, cosmetic surgery providers in Australia compete for affordability with providers based in foreign economies where Australian dollars have greater purchasing power. This also makes cosmetic surgery an extraordinary surgical product, as outbound medical tourism for general health issues is not a documented phenomenon in Australia.

Finally, current regulation facilitates intervention against poor surgical performance only after an adverse event and often with limited effect. If the market is not performing well in preventing adverse events, then additional or different regulation may be required to prevent more adverse outcomes before they occur. If this regulation is to be effective, it should heighten the onus that is placed on practitioners to better protect the public. One way to do this – without necessitating major legislative reform - is to require medical practitioners to describe their skills and qualifications with more detail and in a more restricted way.

Such a requirement would make it more likely that public expectations that medical practitioners using the title 'surgeon' will have some form of advanced surgical training are met.

Penalties for medical practitioners misusing the term 'cosmetic surgeon' will be greater than they currently are, as they will fall under the holding out provisions of the National Law. This can be expected to heighten the deterrent effects of regulation on practitioner misconduct or unethical conduct in relation to the use of title, in comparison with current regulation and market conditions.

If consumers of cosmetic surgery are directed toward more highly qualified surgical practitioners, this may result in reduced rates of surgical harm and expenses that are associated with these harms. Aside from grave personal harms which can include chronic physical pain, psychological distress and decreased social interaction, the social harms and expenses of poor surgical outcomes include lost productivity, economic distress, family breakdown, housing distress, and risks associated with the importation of diseases and organisms by cosmetic medical tourists requiring reparative surgery in Australia.

While title restriction may have some inflationary effects on prices for some cosmetic surgical procedures, higher prices may encourage prospective consumers to take more care when deciding whether to have a cosmetic surgical procedure and whom they will engage to provide it. There may well be net social and economic benefits from reduced demand for reparative surgeries and reduced socio-economic costs associated with poor surgical outcomes.

The continuation of current regulation or a reliance on market forces to improve current conditions is likely to result in continuing and greater risk and harm. Consumers cannot realistically be expected to understand the significance of the nuances of professional titles in the medical profession and current market conditions have provided some unscrupulous providers with too much latitude to perform dangerous surgeries for which they have inadequate skill.

Policy options for consideration

Stakeholder feedback is sought on four main options in response to the identified issues that the general public expects cosmetic surgery to be regulated in the same way as surgical specialties under the National Law, and that this expectation, and regulatory differences may be leading to and/or exacerbating risks and harm. These options are regulatory and non-regulatory in nature and comprise:

1. maintaining the status quo and existing regulatory and other tools, and using other methods to address issues
2. increasing public awareness about the use of titles and provision of cosmetic procedures, and increasing opportunities for patient redress following adverse events
3. strengthening the existing regulatory framework, including existing mechanisms designed to protect the public from harm

4. restricting the title ‘surgeon’ under the National Law, with feedback sought on which practitioners should be eligible to use the title.

None of these options are exclusive. Stakeholders may consider that health ministers would be best advised to adopt a combination of options, or just the one.

The potential consequences of the proposed reforms and the capacity of the reforms to meet the stated policy aims must be balanced with the consequences of maintaining the status quo.

Option 1: Maintain status quo

A status quo option would not see any legislative action or other options undertaken and the current regulatory framework will continue to apply.

Medical practitioners could continue to use the title ‘surgeon’ as they do currently, regardless of whether they have obtained a specialist qualification and no educational material, in addition to what has previously been communicated, will be provided to members of the public. Medical practitioners will still be required to practise in accordance with code of conduct requirements set out by the Medical Board,[189] and those performing cosmetic surgical procedures must continue to abide by the Board’s guidelines for performing cosmetic procedures.[190]

In addition, relevant specialist colleges will continue to require members to follow their organisations’ conduct codes, while many professional groups and bodies that represent practitioners who perform cosmetic procedures also have various codes and guidelines that members must adhere to in practice.[191]

The mechanisms for consumers to claim non-economic damages from practitioners and the thresholds for redress will remain as they currently are in each jurisdiction.

Option 2: Alternatives to amending the National Law

To help patients and consumers to make informed choices about undergoing surgical procedures and which practitioners are likely best qualified to perform them, regulators may consider options other than National Law reform. Options that incentivise practitioners to perform safely within the bounds of their competency, training and expertise could also be considered including:

- **Option 2.1**: Major public information campaigns
- **Option 2.2**: Increased provider liability for non-economic damages.

Option 2.1

Under option 2.1, no changes to the National Law would occur. Governments and regulators would commission and implement education campaigns to increase consumer knowledge about

[189] Medical Board, ‘Good Medical Practice: A Code of Conduct for Doctors in Australia’ (March 2020).

[190] Medical Board (2016) ‘Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures’.

[191] See example Australian College of Cosmetic Surgery and Medicine, ‘ACCSM Policies and Codes’, retrieved 22 November 20201, https://www.accsm.org.au/codes. See also Australian Society of Plastic Surgeons, ‘ASPS Code of Practice’, retrieved 13 July 2020, https://plasticsurgery.org.au/information-for-patients/asps-code-of-practice.

medical practitioner qualifications and titles, as well as information about the cosmetic services sector generally, perhaps along the lines of Ahpra's 'Be safe first' campaign.[192]

Option 2.2

Option 2.2 would also result in no amendments to the National Law. However, significant stakeholder and/or public support for increasing patients' and consumers' access to damages in instances of adverse outcomes following surgical procedures would require other (harmonised) legislative change in states and territories and would be reported to governments for consideration.

2.1 Major public information campaigns

Public information initiatives may help patients and consumers to navigate the pre-operative, operative and post-operative aspects of their health or cosmetic services care. For example, some current educational campaigns inform consumers about what to expect from certain cosmetic and other surgical procedures – before and after surgery – and who they may contact if they experience adverse outcomes. These 'one-stop-shop' information platforms may be used in future campaigns, to help members of the public to access critical information more easily about surgical procedures, types of providers and harm remediation options.

Governments and regulators may benefit from seeking expert advice for content development and distribution to maximise public engagement, should they decide to support public education campaigns. As discussed in more detail below, the effectiveness of consumer education is often limited by:

- lack of consumer awareness of educational content, because unpopular platforms or sites are used as distribution points
- content design that fails to 'cut through' to target audiences.

Greater consumer education about the meaning and significance of titles

Education campaigns may improve public knowledge about the meaning and significance of the titles that are used in the medical profession. Patients and consumers have a limited understanding of the intricacies of the health care and services industry, particularly in relation to the provision of cosmetic surgical procedures.[193] Inquiries have also noted that practitioners' use of the title 'cosmetic surgeon' is leading many consumers to conclude that the practitioner is registered as a surgical specialist.[194]

Public information campaigns can undoubtedly support important public policy outcomes. Transport safety campaigns are a notable success, helping to reduce the rates of road deaths in Australia from 30 to 5.4 per 100,000 from 1970 - 2016.[195] Tobacco campaigns have also been

[192] Ahpra and National Boards, 'Consumer safety and cosmetic procedures: 'Be safe first'', 20 February 2020, retrieved 4 May 2020, https://www.ahpra.gov.au/News/2020-02-20-consumer-safety-and-cosmetic-procedures.aspx.

[193] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, pp. 57, 60; 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network); broadcast 20 September 2015.

[194] NSW Health, 'Report on the Review of the Regulation of Cosmetic Procedures', April 2018, p. 8.

[195] Australian Institute of Health and Welfare (2018) 'Australia's health 2018: in brief', Cat. no. AUS 222. Canberra: AIHW, p. 40.

largely successful over several decades, helping to reduce smoking rates of adults from 25% to 11.6% from 1991 - 2019.[196]

Effective education campaigns must reach target audiences and influence their actions. As advertising for cosmetic surgery has evolved to reach consumers through various social media platforms,[197] education campaigns about medical professional titles will be more effective if the same platforms are used to reach specific demographic groups.

Conducting major educational campaigns to increase public knowledge about cosmetic surgical procedures and providers aligns with NSWP Inquiry recommendations. Numerous stakeholders who provided submissions to that inquiry emphasised the benefits of such campaigns, including consumer empowerment and improved health outcomes. Stakeholders also emphasised the importance of campaigning through social media platforms to reach campaign audiences aged 18-30 years, citing the NSW Cancer Institute's 'Pretty Shady' campaign as an effective example of such work.[198]

The NSWP Inquiry also heard that many consumers have trouble using Ahpra's register of practitioners.[199] Future campaigns might therefore publicise the register and instruct users how to locate and identify relevant information about practitioners and their qualifications and, where relevant, notations that may influence a patient or consumer's choice of proceduralist. Government could also consider providing Ahpra with financial assistance to improve the register.

Cosmetic procedures safety awareness

Another way to address the public's misconceptions about medical practitioner titles, qualifications and experience may involve increasing consumer awareness of safe cosmetic procedures and practitioners that may be best qualified to perform them. Regulators and governments may consider using similar approaches of the below examples of current consumer awareness campaigns, to encourage consumers to be more mindful about the risks of cosmetic surgical procedures and of entrusting different kinds of practitioners to perform these procedures.

Victorian Government campaign 2019

The Victorian Government's Better Health Channel website provides information about current and emerging health issues, national and state health priorities and evidence-based research, as well as a range of services and support.[200]

In February 2020, the Victorian Government unveiled a social media campaign to inform consumers about risks associated with cosmetic surgical procedures and underqualified practitioners who provide these services.[201] The material on the Better Health Channel website includes:

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[196] Australian Institute of Health and Welfare (2020) 'Australia's health 2020: in brief', Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW, p. 23.

[197] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, pp. 12, 68–69. See also Beauty's new normal', *Four Corners* (ABC), posted 13 August 2018, https://www.abc.net.au/4corners/beautys-new-normal/10115838.

[198] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, pp. 64, 70.

[199] Trusted Surgeons, Testimony to NSW Parliament Committee, 1 August 2018, p. 40.

[200] See Better Health Channel, 'Services and support, retrieved 4 August 2020, https://www.betterhealth.vic.gov.au/servicesandsupport.

[201] Premier of Victoria, The Hon Daniel Andrews, 'Protecting Victorians From Dodgy Cosmetic Surgery', *Media Release*, 9 February 2020, https://www.premier.vic.gov.au/protecting-victorians-dodgy-cosmetic-surgery-0.

- accessible videos in several languages
- information on how consumers can confirm that a health practitioner and a facility are registered
- information about various types of cosmetic procedures,[202] including detailed information about particular cosmetic surgical procedures and post-procedural expectations and potential complications.[203]

It is difficult to assess the effectiveness of this campaign, given its recency. Consumption of cosmetic services and monitoring of the Better Health Channel have also been disrupted by the COVID-19 pandemic.

However, it is worth noting that while the messaging of these campaigns may be beneficial for consumers, the message may not be reaching an effective let alone optimal number of consumers. At the time of writing, the Better Health Channel's YouTube channel has approximately 5,000 subscribers,[204] who might choose to access a specific playlist dedicated to cosmetic treatments,[205] including videos relating to cosmetic surgery, in various languages.[206] Many of these videos have been viewed only around 20 or, at most, 200 times. Increased advertising may ensure public health messages reach more consumers.

Ahpra 'Be safe first' campaign 2020

In February 2020, Ahpra launched an educational campaign about safe cosmetic medical and surgical practices.[207] Ahpra's 'Be safe first' campaign informs consumers who may use a protected title under the National Law, and also provides information about:

- which practitioners may be best qualified to perform various cosmetic procedures
- scheduled medicines
- infection control standards
- permitted locations for performing procedures
- what consumers should be informed of prior to undergoing a cosmetic procedure.[208]

The campaign highlights requirements cosmetic providers must adhere to when performing surgical procedures, including compliance with state-based regulation, and reminds consumers of the importance of being able to give their informed consent before undergoing cosmetic surgical procedures.[209]

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[202] Better Health Channel, 'Cosmetic Procedures', *Surgery*, retrieved 5 August 2020, https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/cosmetic-surgery.

[203] See Better Health Channel, 'Blepharoplasty (eyelid surgery)', *Surgery*, retrieved 5 August 2020, https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/blepharoplasty-eyelid-surgery.

[204] YouTube, Better Health Channel, retrieved 24 August 2020, https://www.youtube.com/user/betterhealthchannel/featured.

[205] YouTube, Better Health Channel, *Cosmetic treatments*, retrieved 24 August 2020, https://www.youtube.com/playlist?list=PLplfF3Uu2rPeRnER_x-pzrG-C13BSCT9v.

[206] See example YouTube, Better Health Channel, 'Cosmetic Surgery in Private Hospitals (English)', retrieved 24 August 2020, https://www.youtube.com/watch?v=GS7EYP80NhI&list=PLplfF3Uu2rPeRnER_x-pzrG-C13BSCT9v&index=17.

[207] Ahpra and National Boards, 'Consumer safety and cosmetic procedures: 'Be safe first'', 20 February 2020, retrieved 4 May 2020, https://www.ahpra.gov.au/News/2020-02-20-consumer-safety-and-cosmetic-procedures.aspx.

[208] Ahpra and National Boards, 'Cosmetic procedures: 'Be safe first'', retrieved 4 May 2020, https://www.ahpra.gov.au/publications/cosmetic-surgery-and-procedures.aspx.

[209] Ibid.

It is not possible currently to fully assess the effectiveness of Ahpra's campaign. However, this campaign may also be made more effective by promotion on appropriate social media.

Both campaigns may provide valuable data for regulators about how public safety and confidence in the National Scheme may be enlarged by reforms that work within the scheme's existing structure.

Social media marketing

Research in Australia notes that social media growth has led to greater and more diverse promotion of cosmetic surgery, particularly to younger consumers.[210] Research also shows that younger consumers are influenced by cosmetic surgery advertising on social media, and regard cosmetic service providers who have their own social media platforms as more appealing than those who do not.[211]

Younger audiences – and possibly many people in other age groups – are far more likely to access educational information via these platforms, rather than through an active search of government or regulator websites. Noting the limited consumer engagement with some existing education campaigns, it may be useful to consider hiring external advertising providers to assist future publicity activities.

Public information campaign design

The salience of any public education or information campaign depends on the quality of its content and the quality of its delivery. As the philosopher Marshall McLuhan famously emphasised, 'in a culture like ours … in operational and practical fact, the medium is the message'.[212]

The success and failure of numerous public education campaigns bears out McLuhan's theory. Much of the success of campaigns such as the 'Dumb Ways to Die' train safety awareness campaign, designed for Metro Trains in Melbourne in 2012, was directly attributable to its innovative design by advertising professionals.

The designers of the campaign used, in their words, 'a mix of offbeat humour, a catchy tune and a collection of amiable animated characters' to launch the message, not as a dreary and 'typically earnest public service announcement' but, rather, 'as an online music video under [a] compelling title'.[213]

Within 24 hours of its launch, the 'Dumb Ways to Die' song reached the top 10 chart of iTunes and was ranked number six on the singer/songwriter category on the global iTunes chart just 48 hours later. By 2015, the video had been viewed more than 150 million times and shared almost 5 million times. The video also spawned parodies and spin-offs around the world, with many million views. A game app was also developed and downloaded over 100 million times worldwide. 'Dumb Ways to Die' won a swag of industry and film awards and led more than 125 million people to state that their awareness of train safety had been increased by the campaign.[214]

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[210] Penna, A., Chan Q. and Marucci DD. (2019) 'Compliance of plastic surgeons with advertising guidelines', *Australasian Journal of Plastic Surgery*. 2(1), pp. 37–43, 38, https://doi.org/10.34239/ajops.v2i1.103.

[211] Arab, K. et al. (2019) 'Influence of Social Media on the Decision to Undergo a Cosmetic Procedure', *Plastic and Reconstructive Surgery: Global Open*, 7(8): e2333, https://doi.org/10.1097/GOX.0000000000002333.

[212] Marshall McLuhan, *Understanding Media: The Extensions of Man* (Routledge, 1964), p. 7.

[213] McCann Australia, 'Transformation', *Dumb Ways to Die*, retrieved 26 November 2020, https://mccann.com.au/work/dumb-ways-to-die.

[214] Ibid.

It is likely that a truly effective public education campaign about the relevance of medical practitioners' titles, qualifications, training and practise experience to the safe consumption of medical and cosmetic surgical services would require similar lateral thinking that could be provided only by advertising industry expertise.

2.2 Increased provider liability for non-economic damages

While Ahpra and the National Boards can investigate and, where warranted, address instances of practitioners performing surgical procedures outside their competency, other measures that put more onus on medical practitioners to practise responsibly could also be considered. Another mechanism for addressing public confusion about medical practitioner titles and competence might be increasing the liability of surgeons for non-economic damages at law. In testimony relating to consumer satisfaction with the HCCC's cosmetic health services complaints resolution processes provided to the NSWP Inquiry, the ALA recommended that the *Civil Liability Act 2002* (NSW) be amended to support greater compensation being made available to those who had suffered physical and mental harm from surgical procedures in particular situations.[215] This would involve removing strict limitations on financial redress for non-economic loss when proceduralists operate outside the law by performing prohibited surgical procedures (including procedures performed on ineligible parties), and when adverse outcomes occur.[216]

These changes could further discourage the performance of procedures outside a practitioner's competence and ethical area of practice, as a practitioner would potentially have greater legal and financial exposure to the consequences of poorly performing a surgical procedure that they could not easily demonstrate they were considered competent to perform. Such changes could also discourage the performance of procedures contrary to legal requirements for registration and to licensing requirements for facilities used to perform procedures. The ALA argues that a more significant threat of compensation payments for poor non-economic outcomes would create an effective discipline on the behaviour of cosmetic surgical proceduralists.[217]

Currently, legislative avenues available to the public to obtain compensation for non-economic loss differ. In Victoria, for example, individuals may obtain damages, within limitations, for non-economic loss[218] following personal injury resulting from negligent provision of services deemed not to have been provided with reasonable care[219] and where practitioners hold themselves out as having certain skills.[220] In the ACT, individuals may also obtain damages for non-economic loss for personal injury, such as pain and suffering and disfigurement[221] in cases of negligence, where a practitioner 'fails to exercise reasonable care and skill'.[222]

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[215] Australian Lawyers' Alliance, Testimony to NSW Parliament Committee, 1 August 2018, p. 28. Note, however, that much case law on quantifying and qualifying the nature of compensable non-economic loss has involved car crashes and infringements against the person such as false imprisonment. See the Judicial Commission of New South Wales, Civil Trials Bench Book at https://www.judcom.nsw.gov.au/publications/benchbks/civil/damages.html#p7-0040.

[216] Australian Lawyers' Alliance, Testimony to NSW Parliament Committee, 1 August 2018, p. 28.

[217] Ibid.

[218] *Wrongs Act 1958* (Vic) ss 28G, 28HA.

[219] Ibid s 43.

[220] Ibid s 58.

[221] *Civil Laws (Wrongs) Act 2002* (ACT) s 99.

[222] Ibid s 40.

Plaintiffs in Tasmania may also claim limited damages for non-economic loss[223] following a failure of a practitioner to meet a duty of care,[224] inclusive of a duty in tort.[225] However, a practitioner will not breach their required duty under statute if, at the time of conduct, their practice is deemed competent by peers.[226] Other jurisdictions have comparable legislative and common law systems.

Thus, effectively increasing the litigation power of consumers and patients in relation to negligent medical practitioners for surgical services would require changing several statutes across multiple jurisdictions, resulting in other drafting and implementation costs.

Option 3: Strengthening existing mechanisms in the National Scheme

A reform approach built around strengthening existing regulatory mechanisms would see little or no legislative change. Instead, administrative reforms could be devised and implemented. In general, administrative reforms are more likely to be moderate and incremental and can be introduced more speedily than legislative reforms, so it is reasonable to expect that such reforms might take effect before legislative reforms could.

Relevant existing mechanisms that can be updated administratively might include the Medical Board's Code of Conduct or other guidelines for medical practitioners, including any new guidelines the Board may deem necessary or advisable.

Medical practitioners would still be required to practise in accordance with the Medical Board Code of Conduct, and the title protection and health, conduct and performance provisions of the National Law. However, regulators may examine whether these existing mechanisms could be used in a different, or perhaps more expansive way, to make it easier for members of the public to:

- understand the titles that medical practitioners use
- rely on the title protection regulatory regime to effectively discipline and guide medical practitioners' use of titles
- understand regulations governing the use of Schedule 4 medicines and poisons used in many cosmetic surgical procedures
- understand regulations governing the licensing of facilities where cosmetic surgical procedures are performed
- understand how advertising provisions of the National Law are supposed to work.

Option 4: Restrict the title 'surgeon' in the National Law

Reforms restricting use of the title 'surgeon' by medical practitioners can be implemented by:

- **Option 4.1**: Restricting use of the title to the 10 surgical specialty fields of practice approved by the Ministerial Council.
- **Option 4.2**: Restricting use of the title to specialist medical practitioners with significant surgical training.

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[223] *Civil Liability Act 2002* (Tas) ss 27–28.

[224] Ibid s 11.

[225] Ibid s 3.

[226] Ibid s 22.

The National Law would need to be changed in order to introduce either of these options. This would involve preparation of a draft amendment bill and its passage first through the Queensland Parliament – the host jurisdiction of the National Law – and then in other jurisdictions. Reforms to the National Law are consulted on – in forms such as this consultation RIS – and are generally prefaced with an announcement by health ministers explaining the rationale/s for reform; this might take the form, for example, of a decision RIS. Legislative reform takes longer to develop and to introduce than administrative reform, so these options would not take effect immediately and their introduction would generally be supported by stakeholder information campaigns and administrative support by regulators.

The option to restrict the use of the title 'surgeon' will not prevent medical practitioners from performing surgery, as the right to perform surgical procedures is not restricted to those practitioners who hold a designated surgical specialty. However, if the title was further restricted, then practitioners not included in the final category of practitioners who may use the title 'surgeon' would be directly affected in the way they market their services and prohibited from using the title. This includes some practitioners who may currently use the title in their professional practice.

Approximately 100,000 medical practitioners in Australia may perform surgery of varying complexity as part of their usual scope of practice. They include both general practitioners and specialist practitioners (at 30 September 2021, over 34,000 registered specialist GPs; over 40,000 practitioners with 'general' registration; over 67,000 practitioners with 'general and specialist' registration).[227] Medical practitioners who hold specialist registration and may perform surgery include:

- specialist surgeons (at 30 September 2021, 6,558 registered)[228]
- dermatologists (at 30 September 2021, 632 registered)[229]
- obstetricians and gynaecologists (at September 2021, 2,291 registered)[230]
- ophthalmologists (1,104 registered).[231]

Medical practitioners that hold both general and specialist registration concurrently have a broader area of practice than those practitioners who hold only specialist registration. Medical practitioners with specialist registration only have a limited scope of practice, defined by the relevant medical specialist colleges in consultation with the Medical Board.[232]

Option 4.1

If option 4.1 were legislated, then only medical practitioners entitled to use one of the 11 specialist surgical titles (associated with the 10 surgical specialties) approved by the Ministerial Council would be permitted to refer to themselves as surgeons. Other medical practitioners who currently use the title 'surgeon', including those who have undertaken surgical training as part of

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[227] Medical Board of Australia (2021) 'Registrant Data, Reporting period: 01 July 2021 to 30 September 2021', p. 5, https://www.medicalboard.gov.au/News/Statistics.aspx.

[228] Ibid, p. 8.

[229] Ibid, p. 5.

[230] Ibid. Note that around 10% of obstetrics and gynaecology specialists practice in such areas as gynaecological oncology, maternal-foetal medicine, ultrasound, reproductive endocrinology and infertility, and urogynaecology where there may be limited or no surgical work.

[231] Medical Board of Australia (2021) 'Registrant Data, Reporting period: 01 July 2021 to 30 September 2021', p. 5, https://www.medicalboard.gov.au/News/Statistics.aspx.

[232] Medical Board, 'Registration Standard: Specialist Registration' (15 February 2018), https://www.medicalboard.gov.au/News/2018-02-15-specialist-standard.aspx.

a specialist qualification, would no longer be permitted to do so if they do not hold one of these surgical specialty qualifications.

Option 4.2

Option 4.2 would also permit specialist medical practitioners who have undertaken substantial surgical training – such as dermatologists, specialist GPs, obstetricians and ophthalmologists – to continue to use the title 'surgeon'. Stakeholder comment is sought on which specialties with which qualifications should fall within this category and be eligible to use the title.

Cost-benefit analyses

Option 1: Maintaining the status quo

Benefits of maintaining the status quo

Benefits of maintaining the status quo may include:

- consistent rise in total economic value of cosmetic surgical procedures market
- avoiding substantial business costs for providers, who will not have to retrain or undertake additional qualifications in order to comply with new regulations, which might, for example, restrict use of the title 'surgeon'
- avoiding substantial implementation costs, including:
  - development of legislative amendments
  - associated administrative costs (informing public and practitioners about changes, compliance monitoring)
  - compliance costs for medical practitioners
- lessened risk of inflating and passing on to consumers the inflated costs of cosmetic surgical procedures, which might be an outcome of additional regulation such as restricting use of the title 'surgeon'.

If the status quo is maintained, substantial costs associated with implementing changes to the National Law will not be incurred. There will be no additional regulatory burden or compliance costs for medical practitioners, such as retraining or additional study, or requirements to comply with new standards or guidelines. In addition, regulators will not incur costs from having to inform the public and practitioners about changes to operation of the National Scheme.

Further, if existing public knowledge campaigns about cosmetic surgery and cosmetic surgical providers' qualifications, and/or public access to these are deemed adequate, governments and regulators will not incur the financial costs of new or revised regulation or, for example, public information campaigns.

In addition, there is less risk that the costs of cosmetic surgical procedures might increase due to potential restrictions on the number of practitioners who could use the title 'surgeon' as outlined in Option 4. Some kinds of practitioners will also not incur additional training or compliance costs, which might otherwise be passed on to patients and clients.

Consumers can also pursue remedy for adverse cosmetic surgical outcomes under Australian Consumer Law. The *Australian Competition and Consumer Act 2010* (Cth) enables consumers to gain compensation or damages for injury or loss suffered as a result of unsafe goods obtained from a manufacturer that fall below the standard they are entitled to expect.[233]

This option would also have little effect on medical practitioners or individuals seeking out their services. The range of practitioners able to call themselves a 'surgeon' would remain the same as it currently is, and patients and consumers would continue to seek their services for the same reasons and in the same ways as they currently do.

The cosmetic surgical services market would likely continue to grow according to recent trends. A similar range of providers will continue to provide those services that are most in demand. It may be that the proportion of practitioners with entry-level or general medical qualifications providing cosmetic surgical services may rise, if the income and income growth associated with providing these services is seen by providers to be a reliable and promising line of business with little prospect of further regulation.

Costs of maintaining the status quo

Costs associated with maintaining the status quo may include:

- consumers may continue to access surgical procedures from under-qualified practitioners
- public confusion about medical practitioner and surgical qualifications and titles
- some identified issues in adverse surgical outcomes will not be addressed
- regulators – which have very limited budgets and expertise – will wear the costs of maintaining some public education campaigns
- practitioners practising outside of their scope of competence and qualifications without the discipline of tighter title restriction
- falling public confidence in the National Scheme and in medical practitioners
- economic and non-economic costs for consumers and public health systems from adverse cosmetic surgical outcomes.

While it is possible to address the problems created by public expectations about the meaning and import of medical practitioners' professional titles with current instruments and methods, it is likely that consumers and patients will continue to undergo surgical procedures without fully understanding the qualifications and capabilities of practitioners, and the full range of potential consequences of the procedures themselves. There is a perception that consumers are confused by the current regulatory framework as they anticipate that all medical practitioners who use the title 'surgeon', or perform surgical procedures, have undertaken comparable training and qualifications. As a result, members of the public are making decisions that they themselves have stated they would not have made if they had better understood the titles, qualifications and skills of medical practitioners they consulted.[234]

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[233] *Australian Competition and Consumer Act 2010* (Cth) sch 2, Australian Consumer Law pt 3–5).

[234] 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network) broadcast 20 September 2015.

This confusion may lead some consumers and patients to have procedures that they come to regret. They may also have had these procedures delivered by practitioners that they later realise they perhaps should not have engaged, and would not have engaged, if they had been more informed. This report has highlighted many cases where members of the public suffered considerable harm by making poor and ill-informed choices about surgical procedures and the proceduralists, who were operating outside of their capability and/or below expected standards. Their testimony, describing the mental, emotional, social and financial anguish they have suffered by undergoing complex cosmetic procedures at the hands of medical practitioners without advanced surgical training, is poignant and cautionary. They are also supported by peak health consumer bodies.

Further, if no additional education of consumers and patients were to occur, current problematic rates of proceduralist selection might continue or even grow, with growing normalisation and promotion of cosmetic surgical procedures.

In addition, the continuing incidence of poor surgical outcomes – particularly from cosmetic surgical procedures provided by practitioners who take advantage of ambiguous or general titles and work outside their capability – represents a major reputation threat to the medical profession, other practitioners involved in the provision of surgical procedures, and the entire National Scheme. If the public cannot have confidence that the National Scheme is prioritising public safety and public confidence in the scheme, then the scheme is not being managed as it should be. Health ministers believe there is ample evidence that the status quo has not addressed the public safety risks created by the relatively free use, by a diverse range of medical practitioners, of the title 'surgeon'.

The trend of exponential increase in cosmetic surgical provision in Australia will result in greater economic and non-economic costs for consumers. These costs include revision surgeries necessitated by adverse surgical outcomes. Many of these revising surgeries – such as elective cosmetic meloplasty,[235] mammaplasty and breast augmentation,[236] and contour reconstruction[237] – while classified as 'reconstructive', are not eligible for billing under Medicare.

While it is difficult to quantify the annual costs incurred by consumers who undergo these surgeries, it is highly probable that substantial economic and non-economic benefits will follow a move to restrict the title 'surgeon', even if this only modestly reduces the number of adverse patient outcomes. This is due, in part, to the substantial costs borne by the public health system from complications of cosmetic surgical procedures.[238] Stakeholders informed the NSWP Inquiry that these costs totalled approximately $10 million in surgical fees alone from 2000 – 2014. The paucity of data, particularly earlier this century, and continuous growth in the consumption of cosmetic surgical procedures makes it probable that this (likely underestimated) cost to the health system will inflate further if unchecked.[239] Ministers would like to better determine these costs and welcome the submission by stakeholders of any data that quantifies the cost to the

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[235] Australian Government, Department of Health, 'Medicare Benefits Schedule - Item 45588, *MBS Online: Medicare Benefits Schedule*, retrieved 4 March 2020, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=45588&qt=item&criteria=45587%2C45588.

[236] Australian Government, Department of Health, 'Medicare Benefits Schedule - Note TN.8.96', *MBS Online: Medicare Benefits Schedule*, retrieved 4 March 2020, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=TN.8.96.

[237] Australian Government, Department of Health, 'Medicare Benefits Schedule - Item 45051', *MBS Online: Medicare Benefits Schedule*, retrieved 4 March 2020, http://www9.health.gov.au/mbs/search.cfm?q=45051&sopt=I.

[238] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 87.

[239] Ibid.

public health system in performing revision surgeries for consumers who have suffered poor outcomes from cosmetic procedures.

The range of non-economic costs to the community flowing from unsuccessful surgical procedures, outlined earlier in this RIS, must also be considered when calculating the total cost of under-regulation of the use of professional title by medical practitioners.

The effectiveness of existing ancillary measures such as the advertising guidelines must also be considered when the overall effectiveness of the status quo is assessed. If important additional instruments such as the advertising guidelines are not effectively disciplining the behaviour of practitioners, other measures – such as title restriction – may need to be considered. If some practitioners are not deterred by the penalties attached to breaching the advertising guidelines or conclude that the chances of being pursued for breaching those guidelines are very low, an added threat of being found also to have breached the title restriction provisions of the National Law may give them greater cause for concern.

In this context, the effectiveness of the current advertising guidelines of the National Law have been questioned by stakeholders such as the ALA. In testimony provided to the NSWP Inquiry in 2018, the ALA stated that advertising guidelines on cosmetic surgery are 'rarely adhered to' and that any quick Internet search will confirm this.[240]

Consultation questions

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

Option 2: Alternatives to amending the National Law

Benefits to undertaking major public information campaigns: Option 2.1

Potential benefits of relying on public information campaigns rather than restricting the title 'surgeon' include:

- more educational information for the public to increase awareness about medical practitioner titles and their associated qualifications
- helping the public to navigate health care sectors, including who to contact following an adverse surgical outcome
- creation of a central portal to access information about surgical procedures and titles
- greater social media presence of regulators and governments to inform patients and consumers of surgical risks and future health initiatives, supporting prevention
- decreased adverse surgical outcomes
- greater public safety
- Minor or moderate impact on economic value of the cosmetic surgical services market and on cost of procedures, as most consumers may be expected to redirect their custom (to more highly credentialled practitioners) rather than withdrawing it altogether.

[240] Australian Lawyers' Alliance, Testimony to NSW Parliament Committee, 1 August 2018.

Patients and consumers state that education improves their capacity to interact with health care professionals on their own terms.[241] Therefore, information campaigns that increase public knowledge may help to promote better health and prevent harm. More public education may be an effective way to reduce confusion about the meaning and use of titles relating to surgery in the medical profession. This may help patients and consumers to make more informed and wiser health care and cosmetic service choices, including in their choice of proceduralist. This, in turn, may reduce instances of adverse consumer and patient outcomes.

Education activities will allow governments and regulators to inform the public about the risks associated with engaging services from practitioners without the requisite skill base to perform certain surgical procedures.

Well-designed campaigns that use appropriate media and distribution platforms would also create new or significantly enhance current information about surgical procedures and practitioners. The use of social media platforms and professionally designed campaign material will ensure that information is more likely to reach target audiences and enlarge the profile of government and regulators on these platforms; this could also help future public health initiatives. While engaging external suppliers comprises a cost, there are clear and often significant benefits in using the expertise they provide.

For businesses (cosmetic surgical providers) and consumers, the economic impact of major public education campaigns could be expected to be minor or moderate. As most consumers might be expected to redirect their cosmetic surgical spend to more highly credentialled practitioners rather than withdrawing it altogether, the overall market may not contract and any inflation in costs for consumers – charged by more highly credentialled practitioners – would be finite and met at the discretion of the individual consumer.

Costs of undertaking major public information campaigns: Option 2.1

Costs associated with relying on public information campaigns rather than restricting the title 'surgeon' may include:

- preparation and implementation of education campaigns, including contracting specialist content development and distribution specialists and developing hubs or platforms for consumer information
- time required to educate consumers (depends greatly on the quality of the message and its delivery)
- difficulty achieving and maintaining desired patient and consumer safety outcomes, i.e. costs of maintaining an education campaign for the period that will be required to bring demonstrable results
- continual review of public education to ensure messages and delivery remain contemporary in a rapidly evolving sector
- contraction in total economic value of cosmetic surgical services market, as consumption rates as a whole or of particular procedures diminish
- diminished custom for some providers of cosmetic surgical procedures, devaluing their businesses

[241] Horvat, L. (2019) 'Partnering in healthcare for better care and outcomes', Safer Care Victoria, State Government of Victoria, Melbourne, p. 18.

- inflating costs for some cosmetic surgical procedures as custom for less-credentialled and less expensive providers retreat from the market or experience diminished business.

If ministers decide to commission a public awareness campaign or several campaigns about medical practitioner titles, qualifications, and safe surgery, various costs would be associated with such initiatives. These could be expected to include direct costs associated with the preparation and delivery of educational campaign content for governments and/or regulators.

Usage data from some current campaigns suggests that public engagement would be better managed by external service providers. These entities could help governments and regulators to get their message to target recipients, particularly younger people and women in middle adulthood. Outsourcing to specialists in this area will likely ensure that higher quality content is developed and reaches audiences, through social media and other platforms. Governments would need to allocate funds for this purpose.

While public education campaigns such as transport safety and anti-smoking campaigns have been highly effective, their effectiveness was achieved with decades-long consistent, sustained messaging. In addition, the improvements to public health and safety that these campaigns have achieved are difficult to sustain. This is evident, for example, in the recent decision of the Transport Accident Commission in Victoria to revive a 30-year-old seat belt safety campaign, after a growing number of vehicle crash fatalities where failure to wear a seat belt was a relevant factor.[242]

Maintaining improved outcomes of patient safety will likely be difficult and involve additional future costs in an environment that is consistently evolving, and where practitioners who are performing outside the scope of their competency and qualifications develop new marketing strategies in order to retain and/or attract clientele.

Public health entities would also need to remember that new issues are likely to arise that will require public education messages to be revised. For example, the introduction of mobile phones has made necessary road transport safety campaigns that highlight the dangers of phone use for both drivers and pedestrians in traffic.[243] For the purposes of this inquiry, it is noted that effective public education campaigns would need to be regularly evaluated, to ensure they remain abreast of evolving surgical procedures and consumption patterns, particularly for cosmetic surgeries.[244] This will entail ongoing regulatory and administrative costs.

If a public information campaign did have the effect of reducing demand for the cosmetic surgical procedures market as a whole, or in relation to certain procedures, some economic costs would be incurred.

If demand for cosmetic surgical services fell, whether in total or in relation to particular procedures, then the declining (relative) value of the cosmetic surgical procedures market will affect providers of procedures and the products used in these procedures.

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[242] Transport Accident Commission, 'Iconic seatbelt campaign returns to tackle worrying trend', *Media Room*, retrieved 20 July 2020, https://www.tac.vic.gov.au/about-the-tac/media-and-events/news-and-events/2020/iconic-seatbelt-campaign-returns-to-tackle-worrying-trend.

[243] Transport Accident Commission, 'New campaign highlights the dangers of distracted driving', *Media Room*, retrieved 20 July 2020, https://www.tac.vic.gov.au/about-the-tac/media-room/news-and-events/2019/new-campaign-highlights-the-dangers-of-distracted.

[244] Medical Board (2015) Public consultation paper and RIS, p. 24.

Reduced demand for the custom of some providers of cosmetic surgical procedures, from whom some consumers turn away – whether because they no longer wish to have a procedure or would prefer to have it done by a more highly-credentialed practitioner – may result in the devaluing of their businesses, with loss of income and perhaps employment opportunities for support staff.

If custom for less credentialled and less expensive providers contracts then the costs of some cosmetic surgical procedures may inflate as these providers retreat from the market or experience diminished business, and proportionately more procedures are performed by more highly credentialled practitioners who may be able to or inclined to charge more for their services.

Benefits to increased provider liability for non-economic damages: Option 2.2

Potential benefits of increasing provider liability for non-economic damages include:

- deterring practitioners from practising beyond the scope of their competence and qualifications
- decreased adverse surgical outcomes
- decreased false or misleading advertising of surgical qualifications by providers
- greater public safety and confidence in the National Scheme and in medical practitioners
- no regulatory implications for cosmetic surgical providers
- no cost implications for individual consumers in the short-term.

If the range of non-economic damages for poor provision of surgical procedures is increased this may deter some practitioners from performing surgical procedures outside their qualifications or competence. Further, facility managers and/or owners may be less willing to allow these practitioners to operate in their facilities. They may therefore heighten consumer safety and confidence in the National Scheme. This measure is not expected to have any short-term implications for cosmetic surgical providers or the cost of procedures to individual consumers.

Costs of increased provider liability for non-economic damages: Option 2.2

Costs associated with increasing provider liability for non-economic damages include:

- preparation and implementation of legislative reform across jurisdictions to increase liability of surgical service providers for non-economic damages, and economic redress for patients and consumers
- potential increases to the cost of professional indemnity insurance for medical practitioners, which may influence some practitioners not to practise; a contraction of the workforce could increase the price for medical services that patients and consumers may have to pay
- varying consumer access to damages between jurisdictions if state and territory-based legislative change does not achieve national uniformity
- encouraging (albeit inadvertently) more risk aversion among all practitioners practising surgery with consequential adverse health outcomes for prospective patients.

While it may be worthwhile implementing consistent reforms across jurisdictions to remove limits on financial redress for consumers for non-economic loss, this may be difficult to achieve. Such reform would create costs for states and territories associated with the development of (presumably consistent) legislative reforms and related implementation and administrative costs.

Increasing provider liability for non-economic loss may also increase the cost of medical practitioners' professional indemnity insurance. If premiums increase, this may influence some practitioners not to practise or may reduce the number of practitioners practising, with consequent inflationary effects on the price of the services that practitioners perform.

In addition, this option may inadvertently encourage all practitioners practising surgery (and not just those practising cosmetic surgery) to become more risk averse. While in some instances this may, on balance, be a good outcome, there will likely be other cases where good outcomes that might be achieved with procedures with a medium or high degree of risk would not be attempted by practitioners, to the detriment of individual prospective patients and society at large.

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

Option 3: Strengthening existing mechanisms in the National Scheme

Benefits of strengthening existing mechanisms in the National Scheme

Benefits of strengthening existing mechanisms in the National Scheme may include:

- achieving better outcomes more quickly (administrative solutions are easier to devise and implement)
- increasing public protection by addressing information asymmetry and issues arising from low consumer health literacy
- improving the content and consistency of policies governing conduct requirements for medical practitioners and perhaps for other registered health professionals
- more rapid compliance by registered medical practitioners with moderate, incremental reforms
- lesser administrative burden for regulators, such as Ahpra and the National Boards
- flexibility for regulators to test and redesign public health and safety measures
- minor or moderate impact on economic value of the cosmetic surgical services market and on cost of procedures, as most consumers may be expected to redirect their custom (to more highly credentialled practitioners) rather than withdrawing it altogether.

Strengthening existing mechanisms in the National Scheme in response to any public misunderstanding of medical practitioners' titles and their relationship with actual medical practice may preclude the need for legislative change, which can bring advantages. Administrative reforms can be devised and implemented more speedily than legislative reform, and therefore be developed and introduced more quickly. Administrative changes can sometimes be simpler and less resource-intensive for entities to administer, and economic costs associated with development of legislative amendments will be avoided. Further, as administrative changes are perhaps more likely to be moderate and incremental, medical practitioners may find them easier to understand and to comply with.

Administrative components of the National Scheme, such as the Medical Board's Code of Conduct, are more flexible than legislative measures, which makes trialling, and revision simpler and quicker.

Updates to administrative instruments may also result in the development of new guidelines or improvements to existing guidelines by other National Boards if issues of concern for other health professions are identified. This may make practice requirements across regulated professions more consistent and easier to interpret, explain and apply, aiding regulators, practitioners and members of the public who may have clearer expectations about common requirements that practitioners are expected to meet.

In this way, administrative reforms may help to address any current information asymmetry between practitioners and patients/consumers and mitigate issues as a result of lower health literacy of some population cohorts in Australia.[245] Specifically, knowledge gaps among the general public about surgical procedures, and surgical and general qualifications of medical practitioners could potentially be reduced by administrative reforms.

Strengthening existing mechanisms can be expected to have only a minor or moderate economic impact on cosmetic surgical providers and consumers. While some current providers might be deterred from describing themselves, for example, as a 'cosmetic surgeon' if practice expectations in the Code of Conduct were changed or competency requirements were made more explicit, most consumers might still be expected to redirect their cosmetic surgical spend to more highly credentialled practitioners rather than withdrawing it altogether. Therefore, the overall cosmetic surgery market may not contract and any inflation in costs for consumers – that may be charged by more highly credentialled practitioners – would be finite and met at the discretion of the individual consumer.

Costs of strengthening existing mechanisms in the National Scheme

Costs of strengthening existing mechanisms in the National Scheme may include:

- insufficient action to address issues of consumer harm, i.e. the capacity of existing mechanisms such as guidelines may have been exhausted
- limited capacity to support increased public health literacy
- continued public reliance on medical practitioners to adhere to standards set by regulators regarding performance of surgical procedures
- additional burden placed on medical practitioners to ensure compliance
- additional burden for regulators to educate practitioners about new regulation

[245] Australian Institute of Health and Welfare, 'Health Literacy', retrieved 8 April 2021, https://www.aihw.gov.au/reports/australias-health/health-literacy.

- difficulty ensuring that isolated administrative reforms are sufficient to address issues
- minor or moderate inflation of costs of cosmetic surgery for consumers.

The extent to which administrative mechanisms can address issues relating to the general public's understanding of medical practitioners' training and qualifications may be limited. Regulators have updated the Medical Board's Code of Conduct[246] and have issued specific guidelines that medical practitioners should adhere to when performing cosmetic surgical procedures.[247] But it is possible that these administrative instruments cannot address issues relating to any public misunderstanding of surgical qualifications and practice to the best possible extent. The capacity of the Code of Conduct and the cosmetic surgery guidelines to influence medical practitioners' use of the title 'surgeon', for example, may have been exhausted. Ministers and regulators may decide that stronger rules governing use of title may be required to sufficiently improve public safety and public confidence in the medical profession, and the National Scheme.

While amended instruments may address specific issues occurring as a result of low public health literacy, they may have limited capacity to support better public education to address the underlying issue of the general public's knowledge gap, which is so important to making informed decisions about desired surgical procedures and the choice of a proceduralist. A reform effort relying only on strengthening existing measures may leave the public at risk of relying too much on practitioners being able and willing to explain their qualifications and competence to safely perform a given surgical procedure, in an appropriate facility.

Administrative reforms will also result in some additional compliance burden to medical practitioners, who will be required to interpret and comply with new requirements. The production of new communication material by regulators for practitioners, to aid compliance, may also create some regulatory burden.

Another potential problem with strengthening existing measures is the administrative complexity involved in trying to make substantial change. As there are many elements in the existing framework, strengthening one or two of these elements, and potentially at different times, may mean that harm reduction efforts are frustrated by a lack of coordinated targeting of issues. Put simply, reform of the Medical Board Code of Conduct, for example, may be insufficient to change outcomes while civil liability, criminal and consumer law remain unchanged. It may be, therefore, that a more substantial reform approach, such as those outlined in Option 4, would in the end be easier to define, explain and implement, as well as more effective.

Finally, it is possible that strengthening mechanisms such as the Medical Board's Code of Conduct may deter some practitioners from describing themselves, for example, as a cosmetic surgeon and if more custom for cosmetic surgical procedures was directed toward more highly credentialled medical practitioners as a result, then prices for some procedures may rise. This could create greater costs for individual consumers.

Consultation questions

[246] The Medical Board's Code of Conduct originally took effect following public consultation in 2012. The most recent Code of Conduct took effect from 1 October 2020. See https://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

[247] Medical Board (2016) 'Guidelines for Registered Medical Practitioners who Perform Cosmetic Medical and Surgical Procedures', https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

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

Option 4: Restrict the title 'surgeon' under the National Law

Potential effects on the existing medical practitioner workforce

There are many kinds of medical practitioners that use the title 'surgeon' or perform surgical procedures as part of their practice. Some of these practices are not categorised as medical specialities, while others are accredited by bodies other than the RACS.

If use of the title 'surgeon' by medical practitioners is to be restricted to just those practitioners with specialist surgical qualifications (Option 4.1) then this will significantly reduce the range of practitioners qualified to use the title under the National Law, as well as the range of authorities capable of certifying these practitioners' qualifications. As of 30 September 2021, there were 130,476 medical practitioners registered in Australia,[248] of which 6,558 are specialist surgeons.[249] Therefore, approximately only 5% of registered medical practitioners would be permitted to use the title 'surgeon' if option 4.1 is implemented.

Restricting the range of practitioners who may call themselves a 'surgeon', under either Option 4.1 or 4.2, will not necessarily reduce the gross number and types of practitioners – including those without specialist qualifications – that can perform various surgical procedures. However, restriction of the title 'surgeon' could deter some patients and consumers from consulting practitioners without specialist qualifications for surgical procedures. This may, in turn, contract the size of the supply side of the medical services 'market' in some fields, which could result in corresponding impacts on service provision, the cost of procedures to patients and consumers, and patient/consumer access to procedures. The proportionate market shares of different types of practitioners may also change. The potential flow of business to specialist practitioners might be particularly pronounced were Option 4.1. to proceed.

In relation to cosmetic surgical outcomes, it must particularly be considered whether restricting the title 'surgeon' could encourage consumers to consult with more highly qualified surgeons or practitioners with specialist surgical qualifications and/or expertise, and whether this would help to reduce the current number and range of adverse consumer outcomes following cosmetic surgical procedures.

Further, it is worth noting that specialist surgical qualifications are predominately obtained through RACS, except for oral and maxillofacial surgery. Therefore, implementation of this reform would result in one entity being predominately responsible for provision of medical practitioners' qualifications enabling them to use the title 'surgeon'.

Broadly, feedback is sought on whether more tightly restricting the title 'surgeon' may present new issues that are more multifaceted and difficult to resolve than those that regulators already grapple with. Further, it must be determined if this reform will in fact help to address any issues of public confusion and harm that have been identified.

[248] The Medical Board outlines in its registration data between 1 July – 30 September 2021 that this total figure encompasses 4,475 medical practitioners included on the 2020 and 2021 Pandemic response sub-register.

[249] Medical Board of Australia (2021) 'Registrant Data, Reporting period: 01 July 2021 to 30 September 2021', p. 8, https://www.medicalboard.gov.au/News/Statistics.aspx.

Regulatory burden

Restricting use of the title 'surgeon' under the National Law will theoretically impose some regulatory burden on those registered medical practitioners who would wish to qualify under the new rules for the right to use the title. This burden would comprise the costs of training and the time it would take practitioners to acquire new qualifications, i.e. time that would otherwise be spent either earning income or pursuing other activity.

Training costs would vary depending on the individual practitioner's prior qualifications and ambitions, as well as the nature of the restriction placed on use of the title surgeon. If Option 4.1 were favoured, then a practitioner might opt to become a general surgeon or plastic and reconstructive surgeon. If Option 4.2 were favoured, they might opt to undertake the additional training required to become a specialist GP. The length and expense of training for various specialities obviously varies.

It is not possible or desirable to enumerate the training costs for the full range of medical specialities. Rather, some indicative costs are provided, and stakeholders are invited to submit data and information to help health ministers to subsequently estimate these costs with more precision, should that be necessary.

It is important to remember that a practitioner would only need to incur these costs if they wanted to be entitled to call themselves a 'surgeon'. So, if the right to use the title 'surgeon' was more tightly restricted, it is possible that only a small number of medical practitioners would seek to acquire advanced surgical qualifications in order to be able to use the title.

Estimated regulatory burden: example

This example of regulatory burden is based on the costs of qualifying as a plastic and reconstructive surgeon.

It is assumed the training will take six years' study. At the time of writing, the annual fees for training in this field in Australia are $6,242.[250] The examination fees are $3,175.[251] In 2020, the examination fees were $3,115, showing that they inflated by 1.9% from 2020 – 2021.[252] Assuming this inflation rate for both costs, the estimated total training cost to qualify as a plastic and reconstructive surgeon over six years will be $39,275 in training fees and $19,977 in examination fees, totalling $59,252 at an annual average cost of $9875.

The calculation of opportunity cost is more complex. It must be remembered that these costs are not directly imposed by the regulation but arise when an individual decides to undertake training and forego other professional opportunities.

A December 2020 RIS issued by the Commonwealth Department of Health assessed the value of a doctor's time to be $84.26 per hour.[253]

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[250] RACS, 2021 SET Training Fees, retrieved 23 November 2021, https://www.surgeons.org/en/Trainees/the-set-program.

[251] RACS, '2021 fees', *Examination fees*, retrieved 23 November 2021, https://www.surgeons.org/examinations/examination-fees.

[252] Ibid

[253] Commonwealth Department of Health, Proposal to prevent the uptake of nicotine containing e-cigarettes by ever users (adolescents and young adults), to support smoking cessation and to reduce nicotine poisonings of children (Regulation Impact Statement, ID number 26377), December 2020.

The time spent qualifying to use the title 'surgeon' would be considerable. Assuming that a trainee surgeon works on average for 50 hours a week, for 45 weeks each year,[254] this hourly figure can be used to estimate the opportunity cost at around $189,585 p.a. If this sum is inflated by 1.9% over the next five years, the total opportunity cost to qualify as a plastic and reconstructive surgeon is $1,192,930.

The combined training and opportunity costs in total in this example are $1,252,182, at an average annual cost of $208,697.

These (considerable) costs are a more useful gauge of the expense of qualifying as a medical specialist rather than the regulatory burden that would be imposed by Option 4. It is not known how many individual practitioners would embark on such lengthy and expensive studies solely in order to be entitled a 'surgeon'. Stakeholder feedback is sought on this contention and on the example of regulatory burden provided (see consultation question 6.8).

International Medical Graduates

Stakeholders are also asked to consider whether restricting the title 'surgeon' may affect practitioners who have obtained surgical qualifications in jurisdictions other than Australia and New Zealand. Stakeholder feedback is sought as to whether changes to the National Law could necessitate changes to the assessment requirements and accreditation standards set by specialist colleges. This RIS welcomes feedback more broadly about potential impacts of reform options 4.1 and 4.2 on the assessment of International Medical Graduates' (IMG) qualifications, if applicable.

Effects of restricting the title 'surgeon' on outbound cosmetic medical tourism

A key question relating to cosmetic medical tourism for this RIS is whether restricting the title 'surgeon' will encourage more Australians to travel abroad for cosmetic procedures and the domestic industry will contract. Without pre-empting stakeholders' responses to this issue, it is noted that:

- Australia is already a net exporter of medical tourists who undergo cosmetic procedures, even without restricting the title 'surgeon'
- Australian practitioners already cannot compete on cost with practitioners and facilities in many other nations, and this is the primary reason that Australians tour for cosmetic procedures
- heightened consumer awareness of disease risks – particularly in the wake of COVID-19 – may make cost a less influential consideration when purchasing cosmetic procedures
- the public health consequences of medical tourism include unwanted contact between different disease ecosystems, as returning consumers may bring into Australia pathogenic microorganisms and emerging infectious diseases (see Appendix 4).[255]

Even if restricting the title 'surgeon' were to make Australian surgeons and facilities less cost-competitive, relative to international competitors, this consideration must be measured against the potential health and economic benefits of restricting title. A related question is whether and to

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[254] A RACS workforce census found that on average Fellows of the College worked 50 hours per week. The College recommends minimum periods of 4 weeks' recreational leave, 2 weeks' study leave and sundry leave 'not less than appropriate award leave entitlements'. See RACS, 'Royal Australasian College of Surgeons Guide for Safe Working Hours and Conditions' (2018).

[255] Leggat, Peter. 'Medical tourism', p. 17; OECD, *Medical tourism*, p. 26.

what extent Australian lawmakers should consider factors such as patient access to cosmetic surgical procedures through the international market and whether this attempt to design regulation is beneficial for the public and professions.

Benefits of restricting the title 'surgeon': Option 4.1

Potential benefits of restricting use of the title 'surgeon' to the 10 surgical specialty fields of practice approved by the Ministerial Council may include:

- increased consumer knowledge and understanding of practitioner qualifications
- more consumers making more informed choices when selecting practitioners to undergo surgical procedures
- greater consumer confidence in the National Scheme
- fewer consumers accessing services from practitioners who practise outside of their scope of competence or qualifications
- increased consumer satisfaction with surgical outcomes
- fewer patients/consumers vs practitioner disputes and litigation
- lower instances of adverse events to patients
- greater practitioner uptake of additional specialist training
- no impact on existing scope of practice for practitioners practising competently and within the scope of their qualifications and skills.

The proposed restriction of the title 'surgeon' may help to ensure that only those medical practitioners that have qualified to practise a recognised surgical specialty will be legally permitted to describe themselves as 'surgeon'. The use of the title 'cosmetic surgeon' by registered practitioners would, by extension, be more tightly regulated than is currently the case.

Restricting the title 'surgeon' to those practitioners who have obtained qualifications in one of the 10 surgical specialty fields of practice approved by the Ministerial Council may help members of the public to better understand what qualifications their prospective surgical practitioner has obtained. This option may simplify for the public the complexities of medical practitioner training, resulting in a greater distinction between medical practitioners who have surgical qualifications and those who do not and increased understanding of the range of medical practitioners who perform surgical procedures that may have a cosmetic aspect. Members of the public should, therefore, be able to select practitioners to undertake their desired surgical procedures with greater care and confidence. The provision of this information may also result in fewer sub-optimal outcomes following cosmetic surgical procedures due to greater exercise of informed choice by consumers.

The reform might encourage more practitioners to consider obtaining specialist surgical qualifications and give the public greater confidence that services accessed from practitioners who use the title 'surgeon' are provided by medical practitioners that have undertaken surgical training accredited by the AMC (noting that each year there are many more applicants for specialist training posts than there are available positions).[256] Greater restriction on the use of the title 'surgeon' is not expected to result in greater restrictions on the scope of practice of any

[256] Royal Australasian College of Surgeons (2021) 'Guide to SET: An Overview of Selection and Training 2021', p. 11. https://www.surgeons.org/Trainees/the-set-program.

medical practitioner who practises in line with the requirements of the Medical Board's Code of Conduct.[257] That is, any medical practitioner might still perform surgical procedures if they consider it within their scope of competency and training, regardless of whether they are a surgical, or other type of medical specialist. The only difference is that these medical practitioners will not be able call themselves a 'surgeon'.

The reform may also increase patient protection and safety, satisfaction with operative outcomes and, arguably, public confidence in the medical profession and the National Scheme. While practitioners' scope of practice will not be limited by the reform, patients may be less inclined to purchase surgical services from medical practitioners who are unable, by law, to call themselves a 'surgeon'. This may reduce current levels of:

- patient and consumer dissatisfaction with surgical outcomes, especially cosmetic surgical outcomes[258]
- surgical procedures required to revise or follow up first procedures
- disputes between practitioners and patients/consumers.[259]

Further, some medical practitioners may decide to obtain more advanced qualifications which may raise the overall standard of surgical performance. Practitioners may also alter their scope of practice in response to title restriction, which may lead to changes in the public's cosmetic surgery consumption patterns; that is, proportionately more people will purchase cosmetic procedures from more qualified practitioners. More stringent title restriction may also discourage practitioners such as those in case studies mentioned in this RIS from performing procedures they are not competent to perform.

Although advanced surgical qualifications may not protect cosmetic surgery consumers from disappointment,[260] or guarantee optimal performance and outcomes, they may protect against potential physical harm that may arise from such surgery. There is evidence that consumers have:

- been harmed by practitioners whom the consumer thought was more qualified than they were, and in many cases possessed no specialist or specialist surgical qualifications and skills[261]
- realised after their procedure that they did not understand the different qualifications of medical practitioners who might state that they are a 'surgeon'[262]
- stated that they would not know how to obtain information that would explain these different qualifications[263]
- stated that they would not have undergone procedures with a practitioner if they had better understood their qualifications (particularly medical practitioners calling themselves

[257] Medical Board, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (March 2020).

[258] QHQCC (2013) 'Great expectations', p. 10.

[259] Ibid.

[260] Ibid, pp. 21-23.

[261] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 10.

[262] Ibid, p. 52.

[263] Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', *60 Minutes* (Nine Network) broadcast 20 September 2015.

'cosmetic surgeons', who do not have specialist surgical or other relevant qualifications).[264]

Greater provision of cosmetic surgical procedures, for example, by more highly qualified medical practitioners may reduce the overall incidence of severe complications and side effects of such procedures. This may lead to increased satisfaction with surgical outcomes, fewer corrective procedures and fewer patient disputes with practitioners.

Finally, if restricting the title 'surgeon' were to have any impact on the total cosmetic surgery market, it would be moderate or minor, as such restrictions would not prevent any practitioner from actually performing a surgical procedure, and any prospective consumers that may be deterred from asking a practitioner who cannot call themselves a surgeon to perform a cosmetic surgical procedure will likely find another, more highly credentialled practitioner to perform the procedure.

In addition, it is unlikely that any other branch of medical practice may be significantly affected by this change, as this RIS is not aware of significant areas of practice or trends where medical practitioners would be deprived of business that they currently enjoy if they were restricted from describing themselves as a 'surgeon', as the scope of their practice will not change.

Costs of restricting the title 'surgeon': Option 4.1

Potential costs of restricting use of the title 'surgeon' to the 10 surgical specialty fields of practice approved by the Ministerial Council may include:

- increased patient confusion about whether non-surgical specialists and general practitioners can perform surgical procedures
- increased costs of procedures and flow-on inflated costs to patients/consumers as fewer practitioners perform certain procedures
- decreased business for practitioners without designated specialist surgical qualifications (if members of the public recognise that certain practitioners are not 'surgeons' and direct their custom elsewhere)
- undesirable clinical implications may arise, if the vibrancy of professional medical debate and the impact of this clinical-scholarly debate on training and accreditation suffers from a narrowing of the range of training and accreditation authorities
- more cosmetic surgery consumers choosing cheaper options (i.e. fewer choosing services from specialist practitioners)
- increased cosmetic medical tourism by Australians, with corresponding risk of importing the costs of treating poor health outcomes from overseas
- training costs incurred by practitioners who wish to acquire qualifications that will entitle them to use the title 'surgeon'
- additional strain on available accredited surgical training posts and barriers for practitioners applying for surgical training
- compliance costs for practitioners who will need to change the way they advertise their services
- compliance and monitoring costs for Ahpra

[264] 'Ibid.

- implementation costs including education of the public and medical practitioners
- no significant change in consumption patterns of cosmetic surgical procedures if there is limited public reaction (i.e. the public may continue to use the same medical practitioners at similar rates, regardless if these practitioners can use the title 'surgeon')
- continuing incidence of poor surgical outcomes even when operations are performed by specialist surgeons.

There are limits to the effectiveness of title protection as a public protection tool. If this proposed option is implemented, public confusion about medical practitioner qualifications and the relevance of these to competency to perform surgical procedures may not be significantly reduced. This option may indeed result in public confusion about whether medical practitioners who cannot use the title 'surgeon' are qualified to and capable of performing surgical procedures. This reform option may, therefore, decrease the business of practitioners who do not have a specialist surgical qualification but who may nevertheless have regularly performed a range of surgical procedures competently.

Advanced surgical qualifications do not in themselves guarantee optimal performance and outcomes. Less-than-optimal cosmetic surgical procedures have been provided by practitioners with advanced surgical qualifications. In cases such as that highlighted by the QHQCC, restriction of title would likely have no bearing on the conduct of or investigation findings in relation to the surgeon in question or of the consumer, and it would also have no bearing on the end result of the consumer's procedures. The proposed reform to restrict the title of 'surgeon' may not, therefore, address this issue to the desired extent.

This reform option may also adversely affect consumers and the cosmetic surgical procedures market in general. If fewer medical practitioners can use the title 'surgeon' this may influence more members of the public to access procedures from a smaller cohort of practitioners, and costs for consumers may consequently increase. This may, in turn, encourage more consumers to consider cosmetic medical tourism or still cheaper options that would generally be provided by less qualified practitioners. This may result in the Australian healthcare system bearing the cost of proportionately more reparative surgeries for adverse surgical outcomes, over time. Additional costs may arise for medical practitioners who would not meet the determined criteria to use the title of 'surgeon', including expenses associated with (a) having to change the way they market the services that they wish to continue to provide; and (b) complying with new legislative requirements. Some practitioners may incur significant expenses if they wish to undertake additional training in order to be entitled to use the title 'surgeon'. In addition, each year there are fewer accredited surgical training posts available than there are interested applicants.[265] In 2020 for example, there were 693 applicants for surgical specialty training through the SET program but only approximately 220 training posts were available.[266] The limited number of available accredited training positions means that legislated title restriction changes may create demand for accredited surgical training that exceeds the available supply of training posts, on a continual basis.

The potential of this option to reduce the market share of practitioners without a specialist surgical qualification may be problematic for both those many thousands of practitioners who would lose the right to call themselves a 'surgeon' (such as specialist GPs) and for the general

[265] Royal Australasian College of Surgeons (2021) 'Guide to SET: An Overview of Selection and Training 2021', p. 11. https://www.surgeons.org/Trainees/the-set-program.

[266] Ibid, p. 4.

public. If members of the public become more reluctant to undergo some forms of surgery with practitioners that are not surgical specialists, this may lead to adverse public health outcomes. Prospective patients may neglect to proceed with necessary surgery if they cannot access the services of a surgical specialist – due to time, distance or cost prohibitions – and have lost confidence in practitioners who cannot call themselves a 'surgeon'. Some relatively routine surgeries may also become more expensive if members of the public become unwilling to consult with practitioners who cannot take the title 'surgeon'.

It is possible, also, that implementation of this reform would result in one entity (RACS) being predominately responsible for provision of medical practitioners' qualifications enabling them to use the title 'surgeon'. Undesirable clinical implications may arise, if the vibrancy of professional medical debate and the impact of this clinical-scholarly debate on training and accreditation suffers from a narrowing of the range of training and accreditation authorities.

Further, direct costs associated with preparing and implementing legislative reforms and managing compliance with them would also be incurred, principally by Ahpra and the National Boards; ultimately the professions and the public will have to meet these costs. These costs would also include any related administrative costs as well as potential costs associated with educating the professions and the public about the reforms and their impacts.

Finally, it is possible, if unlikely, that reducing the number of medical practitioners that may use the title 'surgeon' may depress the total value of the cosmetic surgery or wider medical services market.

Benefits of restricting the title 'surgeon': Option 4.2

Potential benefits of permitting specialist medical practitioners who have undertaken substantial surgical training to continue to use the title 'surgeon' may include:

- increased public understanding of practitioner qualifications (but perhaps to a lesser extent than with option 4.1)
- more patients and consumers will make more informed choices when selecting practitioners to undergo surgical procedures (but perhaps to a lesser extent than with option 4.1)
- increased overall standard of surgical performance
- greater practitioner uptake of additional specialist training
- greater public safety or reduced public harm
- fewer patients and consumers accessing services from practitioners who practise outside of their scope of competence or qualifications
- lesser impact on practitioners (relative to Option 4.1) in terms of how they may describe themselves and their practices professionally
- increased consumer satisfaction with surgical outcomes
- fewer patients/consumers vs practitioner disputes and litigation
- no impact on existing scope of practice for practitioners practising competently and within the scope of their qualifications and skills
- greater consumer confidence in the National Scheme.

Under this option, eligibility parameters for use of the title 'surgeon' will be much wider, as tens of thousands of specialist medical practitioners that currently use the title 'surgeon' would continue to do so. Therefore, many more medical practitioners will not need to engage in specialist surgical training in order to call themselves a 'surgeon' and fewer practitioners would need to change how they trade and market their services, in comparison with Option 4.1. This may also be of significant benefit to the wider public, as a broader range of practitioners being entitled to use the title 'surgeon' may help to contain inflation of costs of surgical procedures more than might occur with Option 4.1. It might also give the general public greater confidence in consulting a broader range of practitioners for a diverse range of surgical procedures, some of which can and have been competently performed by practitioners with advanced but not specialist surgical training.

Many other potential benefits of Option 4.1 carry over into Option 4.2. Restricting use of the title 'surgeon' in this way will still encourage greater public understanding of practitioner qualifications than currently occurs, as more patients and consumers may learn that only practitioners with advanced specialist training will be entitled to call themselves a 'surgeon'.

It is likely, also, that this option would see more patients and consumers making more informed choices when selecting which medical practitioners they will engage when undergoing surgical procedures, in comparison with current experience.

Over time, this option could be expected to direct most surgeries towards medical practitioners with some form of advanced surgical training – a specialist GP or a surgical specialist, for example – and this, in turn, might increase the overall standard of surgical performance across different medical fields.

Restricting title in this way may also encourage greater uptake by medical practitioners of additional surgical training and this could also be expected to increase the standard of surgical performance across different medical fields. This, in turn, could reduce public harm and increase public safety.

As with option 4.1, option 4.2 will not restrict medical practitioners' existing scope of practice, allowing practitioners to practise competently and within the scope of their qualifications and skills. This option may also discourage members of the public from accessing services from practitioners who practise outside of their scope of competence or qualifications, including in the field of cosmetic surgery. Increased satisfaction with surgical outcomes, fewer corrective procedures and fewer patient disputes with practitioners are all outcomes that might be reasonably anticipated.

This Option will have a lesser impact on practitioners (relative to Option 4.1) in terms of imposing title restrictions on far (tens of thousands) fewer practitioners.

In common with option 4.1, this option could be expected to increase public confidence in the National Scheme.

Costs of restricting the title 'surgeon': Option 4.2

Potential costs of permitting only specialist medical practitioners who have undertaken substantial surgical training or specialist surgeons to continue to use the title 'surgeon' may include:

- increased costs of procedures and flow-on inflated costs to patients/consumers as fewer practitioners perform certain procedures

- decreased business for some practitioners without designated specialist qualifications (if members of the public recognise that certain practitioners are not 'surgeons' and direct their custom elsewhere)
- more cosmetic surgery consumers choosing cheaper options (i.e. fewer choosing services from specialist practitioners)
- increased cosmetic medical tourism by Australians, with corresponding risk of importing the costs of treating poor health outcomes from overseas
- increased training costs for those practitioners who wish to acquire qualifications that will entitle them to use the title 'surgeon'
- compliance costs for practitioners who will need to change the way they advertise their services
- compliance and monitoring costs for Ahpra
- no significant change in consumption patterns of cosmetic surgical procedures if there is limited public reaction (i.e. the public may continue to use the same medical practitioners at similar rates, regardless if these practitioners can use the title 'surgeon')
- implementation costs including education of the public and medical practitioners.

Many costs associated with Option 4.1 may also be attributed to Option 4.2. As the eligibility to use the title 'surgeon' would be narrower in scope than is currently allowed, the public may prefer to direct custom toward medical practitioners that would be deemed eligible to use the title. This may result in a loss of business for practitioners who can no longer call themselves a 'surgeon' but who otherwise currently perform surgical procedures competently and without issues to patient safety. These remaining practitioners who would be restricted from using the title would be required to undertake specialist surgical (or other) training, resulting in additional out of pocket expenses.

This option may also result in increased costs to patients and consumers if fewer practitioners are consulted by the public for surgeries and the practitioners who are entitled to call themselves a 'surgeon' are able to inflate their fees in a market where there is diminished supply of providers. While this problem would arguably be less likely with this option than it would be with Option 4.1, it is possible that increased consultancy and operating fees may result in patients opting to access low-cost services from practitioners who may not be qualified to use the title or from foreign service providers through uptake of cheaper surgical procedures available via medical tourism, with increased risks of patient harm and Australian hospitals managing costs for reparative surgeries. A proportion of prospective patients may also be deterred by rising costs from undergoing necessary surgery, resulting in public harm.

Practitioners who would not be deemed eligible to use the title will need to adapt their advertising and marketing strategies to comply with legislative requirements.

Further, while some practitioners with significant surgical training may be able to use the title surgeon, no restrictions would be imposed on these practitioners in terms of performing surgical procedures outside their field. Consumers may continue to access cosmetic surgical procedures through these medical practitioners with the understanding that they have undertaken aspects of surgical training. However, this in itself does not guarantee that each of these practitioners have the requisite surgical skills to perform particular cosmetic surgical procedures.

It should be noted that practitioners who would be restricted from using the title 'surgeon' and who currently perform surgical procedures outside of their competence or training may continue to perform these procedures using a different title. The use of titles evolves over time and some

practitioners without the requisite skill base may choose to perform surgical procedures and market themselves as experts in areas of surgery by using titles other than ‘surgeon’. They might, for example, start to refer to themselves as a ‘cosmetic doctor’ or ‘cosmetic surgical proceduralist’.

As with Option 4.1, this option may result in costs required for legislative amendments, as well as compliance costs for regulators, particularly Ahpra and the Medical Board. Governments and/or regulators would be required to incur out of pocket expenses to advise the public of legislative amendments and provide education about the impacts of the reform.

Title restriction may also only have a regulatory impact for a limited time as registered medical practitioners adapt their titles and marketing, particularly for cosmetic surgical procedures. Given the current lack of understanding of practitioner qualifications, consumers and patients may continue to access procedures offered by practitioners who perform outside their competence and training and use attractive and/or persuasive alternate titles. This limited understanding may result in restrictions on the use of title having limited impact in deterring prospective patients from accessing medical practitioners that perform cosmetic surgical procedures and consumption patterns of these practitioners remain relatively stable.

As with Option 4.1, it is possible, if unlikely, that reducing the number of medical practitioners that may use the title ‘surgeon’ may depress the total value of the cosmetic surgery or wider medical services market.

The last two ‘costs’ might perhaps be considered lesser benefits rather than costs, in comparison with option 4.1. First, it is possible that the greater understanding the public might be expected gain about the relationship between title, qualifications and skills might still occur with option 4.2, but perhaps to a lesser extent than with option 4.1, by virtue of the greater variety of practitioners that could use the title. Similarly, although the public may expectedly choose a surgical practitioner with greater knowledge and confidence if option 4.2 were to proceed, the greater number of practitioners that would be able to use the title ‘surgeon’ with option 4.2 would necessarily make understanding the relationship between title, qualifications and skills more complex than would be the case with option 4.1.

Consultation questions

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

Question 6.5: Will restricting the title 'surgeon' prevent medical practitioners who cannot use that title from using other titles that imply they are expert providers of cosmetic surgical services?

Question 6.6: What other impacts will restricting the title 'surgeon' have on surgical specialists and other medical practitioners, including those who obtained their qualifications overseas?

Question 6.7: Is it likely that cosmetic surgery consumption patterns will change because of title restriction (whether option 4.1 or 4.2)? In what way? Will they be changed by options 2 and 3? In what way?

Question 6.8: Is the regulatory burden estimate provided in this RIS realistic? How likely is it that medical practitioners would embark on advanced studies solely in order to call themselves a 'surgeon'? Do you expect option 4.1 or 4.2 to heighten demand for advanced surgical qualifications? If so by what number? What evidence do you have to support this view?

Question 6.9: Should any options be implemented alongside other options, as a package? If so, please explain why this would be ideal and how any potential impediments might be overcome?

Question 6.10: Should Australian lawmakers be mindful of the potential for regulatory change in Australia to shift cosmetic surgery consumption to other jurisdictions abroad? What would the impacts be?

Question 6.11: Are you concerned that a particular option might have serious, adverse and possibly unanticipated effects? Please state which option/s and why?

Bibliography

Monographs

McLuhan, Marshall (1964), *Understanding Media: The Extensions of Man* (Routledge: London)

Journal articles

Arab, K. et al. (2019) 'Influence of Social Media on the Decision to Undergo a Cosmetic Procedure', *Plastic and Reconstructive Surgery - Global Open*, 7(8): e2333, https://doi.org/10.1097/GOX.0000000000002333

Cárdenas-Camarena, Lázaro; Bayter, Jorge Enrique; Aguirre-Serrano, Herley; Cuenca-Pardo, Jesús, 'Deaths Caused by Gluteal Lipoinjection: What Are We Doing Wrong?', *Plastic and Reconstructive Surgery*, July 2015, 58-66

Franzblau, L. E. and Chung, K. C. (2013) 'Impact of Medical Tourism on Cosmetic Surgery in the United States', *Plastic and Reconstructive Surgery Global Open*, 1(7)

Gogos, A. J., Clark, R.B., Bismark, M. M., Gruen, R. L. & Studdert, D. M (2011) 'When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints', *Medical Journal of Australia*, 195(6), pp. 340–344

Horvat, L. (2019) 'Partnering in healthcare for better care and outcomes', Safer Care Victoria, State Government of Victoria, Melbourne

Leggat, Peter 'Medical tourism', *Australian Family Physician* (Vol. 44, No. 1–2, January–February 2015)

Nahai, F. (2009). 'Minimising risk in aesthetic surgery', *Clinical Risk*, 15(6), 232–236

Penna, A., Chan, Q. and Marucci, D. D. (2019) 'Compliance of plastic surgeons with advertising guidelines', *Australian Journal of Plastic Surgery*, 2(1), 37–43

Tranter, B. and Hanson, D (2015) 'The social bases of cosmetic surgery in Australia', *Journal of Sociology*, 51(2), 189–206

Legislation, regulation and government protocols

Charitable and Non-Profit Gaming Act 1999 (Qld)

Civil Laws (Wrongs) Act 2002 (ACT)

Civil Liability Act 2002 (NSW)

Civil Liability Act 2002 (Tas)

Council of Australian Governments, Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (2008)

Criminal Code 1899 (Qld)

Criminal Code 1924 (Tas)

Criminal Code 1913 (WA)

Drugs, Poisons and Controlled Substances Act 1981 (Vic)

Gaming and Wagering Commission Regulations 1988 (WA)

Health and Community Services Complaints Act 2004 and Health and Community Services Complaints Regulations 2005 (SA)

Health and Disability Services (Complaints) Act 1995 (WA)

Health Care Complaints Act 1993 (NSW)

Health Complaints Act 2016 (Vic)

Health Ombudsman Act 2013 and Health Ombudsman Regulation 2014 (Qld)

Health Practitioner Regulation National Law Act 2009 (Qld) *and*

- *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT)
- *Health Practitioner Regulation National Law (NSW)* No 86a (NSW)
- *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT)
- *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA)
- *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas)
- *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic)
- *Health Practitioner Regulation National Law (WA) Act 2010* (WA)

Health Care Regulations 2008 (SA)

Health Services (Health Service Establishments) Regulations 2013 (Vic)

Lotteries and Art Unions Act 1901 (NSW)

Lottery and Gaming Act 1936 (SA) and Lottery and Gaming Regulations 2008 (SA)

Medical Board of Australia (Medical Board):

- 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (March 2020)
- 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures' (2016)
- 'List of specialities, fields of specialty practice and related specialist titles' (1 June 2018)
- 'Medical Practice in 2018/19'

Medicines, Poisons and Therapeutic Goods Act 1966 (ACT)

Medicines, Poisons and Therapeutic Goods Act 2012 (NT)

Poisons Act 1971 (Tas)

Poisons Act 1964 (WA)

Poisons and Therapeutic Goods Act 1966 (NSW)

Private Health Facilities Regulation 2017 (NSW)

Private Health Facilities Regulation 2016 (Qld)

Public Health Act 2010 and Public Health Regulations 2012 (NSW)

Public Health Act 2005 (Qld)

Public Health Act 2011 (SA)

Wrongs Act 1958 (Vic)

Training material

Australasian College of Dermatologists, Training Program Handbook: Dermatology 2020

Australian College of Rural and Remote Medicine, 'Fellowship Training: Handbook' (March 2020)

Royal Australian College of General Practitioners:

- 'The Fellowship in Advanced Rural General Practice (FARGP) Advanced Rural Skills Training – Curriculum for GP surgery'
- 'About this committee'. *Joint Consultative Committee for GP Procedural Surgery JCC-GPSP*

Royal Australian College of Surgeons:

- 'Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies' (2012).
- 'A Guide to Surgical Education and Training' (2019)
- 'Guide to SET: An Overview of Selection and Training 2021' (2021)

Royal Australia New Zealand College of Obstetricians and Gynaecologists (2019) 'Fellowship of RANZCOG Training Handbook'

Royal Australia New Zealand College of Ophthalmologists:

- 'Cataract surgery online patient advisory' (2019)
- 'Glaucoma surgery online patient advisory' (2019)
- 'Ocular Surgery Guidelines for Ensuring Correct Patient, Correct Eye, Correct Site and Correct Procedure' (2019)
- 'Refractive surgery online patient advisory' (2019)
- Strabismus surgery online patient advisory' (2019)
- 'Training Network Information (2020)'
- 'Vocational Training Program Selection'.

Inquiry, periodical and special reports

Australian Breast Device Registry, Annual Report 2018 (December 2019), Department of Epidemiology and Preventive Medicine, Monash University

Australian Health Ministers' Advisory Council's Inter-Jurisdictional Cosmetic Surgery Working Group (AHMAC) (2011) 'Cosmetic Medical and Surgical Procedures: A National Framework'

Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards (2019) '2018-19 Annual Report'

Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards (2020) '2019-20 Annual Report'

Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards (2021) '2020-21 Annual Report'

Chartered Accountants of Australia and New Zealand, *The future of trust: New technology meets old-fashioned values* (March 2019)

Economic and Social Research Council, University of Leeds (ESRC) (2014) 'Sun, Sea, Sand and Silicone: Mapping Cosmetic Surgery Tourism'

Health Complaints Commissioner (Victoria), Annual Report 2018-19

Health Complaints Commissioner (Victoria), Annual Report 2019-20

International Society of Plastic Surgery (2016) '2016 Gender Distribution for Cosmetic Procedures', *ISAPS The International Study on Aesthetic/Cosmetic Procedures Performed in 2016*

Medical Board (2015) 'Public consultation paper and Regulation Impact Statement'

Medical Board (2021) 'Registrant data, Reporting period: 01 July 2021 to 30 September 2021'

NSW Health, 'Report on the Review of the Regulation of Cosmetic Procedures', April 2018

Australian Institute of Health and Welfare (2018) 'Australia's health 2018: in brief', Cat. no. AUS 222. Canberra: AIHW

Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56

Testimony to NSW Committee on the Health Care Complaints Commission, Inquiry into Cosmetic Health Service Complaints in NSW, 1 August 2018

Queensland Health Quality and Complaints Commission (QHQCC) (2013) 'Great expectations: a spotlight report on complaints about cosmetic surgical and medical procedures in Queensland'

Websites and webpages

Australasian College of Cosmetic Surgery and Medicine, https://www.accsm.org.au /

Australasian Academy of Facial Plastic Surgery, https://www.aafps.com.au

Australasian Society of Cosmetic Dermatologists, https://ascd.org.au

Australian College of Podiatric Surgery, https://www.acps.edu.au

Australian College of Rural and Remote Medicine, ACRRM Position Statement: Defining the Specialty of General Practice' (January 2013), https://www.acrrm.org.au/about-us/the-college/about-the-college

Australian Commission on Safety and Quality in Health Care, https://www.safetyandquality.gov.au

Australian Health Practitioner Regulation Agency (Ahpra) & National Boards, https://www.ahpra.gov.au

Australian Medical Council, 'Specialist medical colleges', *Accreditation and Recognition*, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/specialist-medical-colleges

Australian Radiation and Protection and Nuclear Safety Agency (ARPANSA), https://www.arpansa.gov.au

Australasian Society of Aesthetic Plastic Surgeons, https://aestheticplasticsurgeons.org.au

Australian Society of Plastic Surgeons, https://plasticsurgery.org.au

Better Health Channel (Vic), https://www.betterhealth.vic.gov.au

COAG Health Council Communiqué 31 October - 1 November 2019, https://www.coaghealthcouncil.gov.au/Announcements/Meeting-Communiques1

CosMediTour Australia, https://www.cosmeditouraustralia.com.au

Cosmetic Physicians College of Australasia, https://cpca.net.au/

Dental Board of Australia, specialist registration https://www.dentalboard.gov.au/Registration/Specialist-Registration.aspx

International Society of Plastic Surgery, https://www.isaps.org

McCann advertising ('Dumb Ways to Die'), https://mccann.com.au/work/dumb-ways-to-die/

Medical Board, 2019/20 annual summary https://www.medicalboard.gov.au/News/Annual-report.aspx

Medical Council of NSW, https://www.mcnsw.org.au

NSW Health Care Complaints Commission, https://www.hccc.nsw.gov.au

Podiatry Board of Australia, 'Ministerial Council Directions and Approvals' (accessed 25 June 2020) https://www.podiatryboard.gov.au/news/ministerial-council-directions-and-approvals.aspx

Queensland Health, www.health.qld.gov.au

Royal Australian College of Surgeons:

- https://www.surgeons.org/become-a-surgeon/about-specialist-surgeons
- https://www.surgeons.org/trainees/surgical-specialties

Royal Australian and New Zealand College of Obstetricians and Gynaecologists, https://ranzcog.edu.au/training/specialist-training/curriculum-handbook

Skintech Medical Cosmetic Laser Clinic https://skintech.com.au

Transport Accident Commission (Vic), https://www.tac.vic.gov.au

Trusted Surgeons, https://trustedsurgeons.com.au

Western Australia Health and Disability Services Complaints Office https://www.hadsco.wa.gov.au/complaints/cosmetic.cfm

Media reports

'Body modifier urged mother, 30, against hospital visit despite pain, court told', *The Sydney Morning Herald*, 14 August 2018 https://www.smh.com.au/national/nsw/body-modifier-urged-mother-30-against-hospital-visit-despite-pain-court-told-20180814-p4zxfw.html

'Beauty's new normal', *Four Corners* (ABC), posted 13 August 2018 https://www.abc.net.au/4corners/beautys-new-normal/10115838

Canstar, Medical tourism, https://www.canstar.com.au/health-insurance/medical-tourism-yes-or-no/

‘Chinese doctor charged over fatal breast surgery gets bail’, *The Sydney Morning Herald*, 22 February 2018, https://www.smh.com.au/national/nsw/chinese-doctor-charged-over-fatal-breast-surgery-gets-bail-20180222-p4z19m.html

‘Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia’, *60 Minutes* (Nine Network) broadcast 20 September 2015

‘Knife’s edge: cosmetic surgery has become a billion-dollar industry in Australia’, *7.30* (ABC), broadcast 20 August 2015

SBS News https://www.sbs.com.au/news/why-is-medical-tourism-from-australia-booming

Appendix 1: Identifying and remedying poor cosmetic surgical practice

It is difficult for regulators to identify adverse practitioner performance resulting from a cosmetic procedure from collected data. This is because the data that Ahpra and the National Boards routinely collect do not relate to the specific procedure being undertaken that gave rise to a notification. Ahpra and the National Boards organise mandatory notifications data into four broad categories of:

- impairment
- intoxication while practising
- significant departure from accepted professional standards
- sexual misconduct.[267]

As there is no recognised specialty category for the provision of cosmetic surgical procedures it is necessary to examine notifications across several professions and specialties to identify notifications that have been made in relation to cosmetic procedures. Even then, the reliability of the data would be questionable.

Ahpra has acted where a procedure was undertaken by someone who did not appear to have the appropriate skill and training to undertake a specific procedure. It has also acted against persons who held themselves out to be registered health practitioners when they may not have undertaken any required training or were no longer registered to practice.

In recent years, proceedings have been conducted against persons:

- holding out as a registered nurse and administering Schedule 4 medicines, providing false information to the regulator and/or performing various cosmetic medical procedures
- whose limited registration as a medical practitioner was suspended through immediate action after performing cosmetic surgery resulting in adverse patient outcomes, and performance of further cosmetic surgeries while unregistered
- holding out as a registered medical practitioner and administering medical and cosmetic treatments for patients on various occasions
- holding out as a registered medical practitioner and performing various cosmetic procedures including numerous instances of administering Schedule 4 medicines.

Over the years, regulators have continued to improve data sharing relating to notifications and continually refine data reporting and collation.[268] Ongoing analysis of notifications relating to the provision of cosmetic procedures will inform the development of more effective regulation for these practices.

[267] Ahpra and the National Boards (2019) '2018-19 Annual Report', p. 67; Ahpra and the National Boards (2020) '2019-20 Annual Report', p. 74; Ahpra and the National Boards (2021) '2020-21 Annual Report', p. 73.

[268] Ahpra and the National Boards (2019) '2018-19 Annual Report', p. 61; Ahpra and the National Boards (2021) '2020-21 Annual Report', p. 1.

Appendix 2: Previous inquiries

NSW Committee of Inquiry into Cosmetic Surgery, 1998

In 1998, the New South Wales Committee of Inquiry into Cosmetic Surgery investigated the quality and safety of cosmetic surgery procedures. The inquiry found lack of information on clinical standards and adverse outcomes. It recommended changes to regulations governing the training of practitioners, licensing of facilities, information for consumers, aftercare, and promotion of cosmetic surgery.[269]

AHMAC Inter-jurisdictional Cosmetic Surgery Working Group, 2010-11

The Inter-jurisdictional Cosmetic Surgery Working Group (Working Group), established by a Principal Committee of the Australian Health Ministers' Conference, examined the appropriateness of consumer safeguards in relation to cosmetic surgery with a focus on advertising, training, restrictions on provision to children, informed consent and health facility standards. The Working Group expressed concerns regarding the inconsistent nature of regulation of cosmetic surgical and medical procedures, and associated substances across Australian jurisdictions in what was identified as a continuously evolving area. The final report noted that rapid growth of the industry had fostered potentially unethical promotion of services, which may contribute to issues faced by consumers with linkages to access to procedures due to inadequate safeguards in place. The Working Group recommended that a National Framework be developed outlining consistent standards for cosmetic surgical procedures with five pillars of focus, including procedures, promotion of procedures, practitioners, patients and the place of procedure.[270] The recommendations of the final report informed the development of supplementary guidelines to the code of conduct for medical practitioners by the Medical Board, outlining expectations of medical practitioners performing cosmetic surgical and medical procedures.

Medical Board Draft supplementary guidelines on cosmetic medical and surgical procedures for code of conduct, 2012

In response to the AHMAC Inter-jurisdictional Cosmetic Surgery Working Group findings, the Medical Board consulted on draft supplementary guidelines for cosmetic medical and surgical procedures for code of conduct in 2012. These draft guidelines provided definitions of cosmetic medical and surgical procedures and outlined aspects of 'good patient care', including accounting for the patient's clinical history, physical and psychological states, and socio-cultural profile. Supplementary guidelines for cosmetic medical or surgical procedures proposed for adults and children; provision of a suitable patient management plan; working with patients; professional behaviour. These guidelines informed the development of the Medical Board's

[269] Medical Board (2015) Public consultation paper and RIS, p. 10.

[270] AHMAC (2011) 'Cosmetic Medical and Surgical Procedures: A National Framework, final report'.

'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures', issued in 2016.[271]

Queensland Health Quality and Complaints Commission, 2013

The HQCC[272] issued a report, 'Great expectations: A spotlight report on complaints about cosmetic surgical and medical procedures in Queensland' in April 2013. The report was premised on notions that the general public underestimates risks associated with cosmetic procedures and that the industry has fewer patient safeguards and less regulation than other areas of medicine. The commission analysed 245 complaints about procedures performed by registered practitioners between 2006-2012. Key findings of the report include that: the roles of patient and customer are blurred by practitioners' vested interest in providing a commercial service; out-of-pocket payments have a uniquely distorting (inflationary) effect of on consumer expectations of procedure outcomes; both the cosmetic medical and surgical procedure complaints examined resulted (respectively) in high levels of major temporary and permanent harm; a majority of procedures giving rise to complaints were performed in private sole practitioner or group rooms and clinics; technical skill and high-level qualifications afford little protection against poor perceived outcomes; a high proportion of complaints were found to involve insufficient disclosure of risk to the consumer by the practitioner.[273]

Medical Board public consultation and RIS – Registered medical practitioners who provide cosmetic medical and surgical procedures, 2015

In March 2015, the Medical Board of Australia released a consultation RIS which sought stakeholder feedback relating to issues surrounding medical practitioners performing cosmetic medical and surgical procedures. The paper intended to gather information from stakeholders about the extent of perceived issues in the cosmetic services sector, including adverse outcomes to consumers. Stakeholders were requested to advise whether regulation in place was effective for practitioners and whether it was believed additional safeguards were required in terms of provision of these procedures.

The Medical Board of Australia proposed a number of options to address key issues identified in the cosmetic services sector, including an option to implement national guidelines to assist in monitoring and compliance of practitioners performing cosmetic procedures. Responses to this consultation also informed the Medical Board's 2016 *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures*.

[271] Medical Board (2016) 'Guidelines for Registered Medical Practitioners who Perform Cosmetic Medical and Surgical Procedures', https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx.

[272] In 2014 the Commission was replaced by the OHOQ.

[273] QHQCC (2013) 'Great expectations'.

NSW Parliament Committee on the Health Care Complaints Commission, 2018

Most recently, the Parliament of New South Wales' Committee on the Health Care Complaints Commission released a report titled 'Cosmetic Health Service Complaints in New South Wales' in 2018. The report highlighted the risks associated with and adverse patient outcomes as a result of cosmetic surgery in Australia and was the result of an inquiry by the Joint Committee on the Health Care Complaints Commission following instances of consumer deaths as a result of cosmetic procedures.

The Committee made 16 recommendations to address a number of issues identified within the cosmetic services sector, including underreporting to health complaints entities. These recommendations also sought to strengthen existing legislative and regulatory frameworks, ensure relevant information about the cosmetic services sector was accessible to consumers and ensure the HCCC's capability to manage complaints and undertake action where required.

Appendix 3: Further information about medical practitioners that perform surgical procedures

Specialist surgeons

There are three pathways for admission to Fellowship of the RACS:

- examination (Surgical Trainees)
- examination (International Medical Graduates or IMGs)
- assessment (International Medical Graduates or IMGs).[274]

Specialty training boards allocate Trainees to accredited training posts for clinical placements. The specialty boards monitor the quality and outcomes of training in each post through hospital accreditation processes and by reviewing Trainees' logbooks. Supervisors in hospitals monitor Trainee progress. Surgical training involves a progression in levels of competency from being a doctor with at least three years of postgraduate experience to becoming a practising specialist.[275]

Trainees move through five stages of performance – described as 'pre-vocational', 'novice', 'intermediate', 'competent' and 'proficient' – in competency areas of:

1. *Medical expertise* – 'the acquisition, integrating and application of medical knowledge, clinical skills and professional attitudes in the provision of patient care'
2. *Judgement: clinical decision-making* – 'making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance and promotion'
3. *Technical expertise* – 'safely and effectively performing surgical procedures conducted in the unit in which they are training'
4. *Professionalism and ethics* – 'demonstrating commitment to patients, the community, and the profession through the ethical practice of surgery'
5. *Health advocacy* – 'responding appropriately to the health needs and expectations of individual patients, families, carers and communities'
6. *Communication* – 'communicating effectively with patients, families, carers, colleagues and other staff'
7. *Collaboration and teamwork* – 'developing a high-level ability to work in a cooperative context to ensure that the surgical team has a shared understanding of the clinical situation and can complete tasks effectively'
8. *Management and leadership* – 'leading [a] team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members'
9. *Scholar and teacher* – 'demonstrate a lifelong commitment to reflective learning, and the translation, application, dissemination and creation of medical knowledge'.[276]

The main components of accredited surgical training are:

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[274] RACS, 'Pathways for admission to Fellowship', retrieved 23 November 2021, https://www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/admission-to-fellowship/overview.

[275] RACS, 'The SET program', retrieved 23 November 2021, https://www.surgeons.org/trainees/the-set-program.

[276] Royal Australasian College of Surgeons (2012) 'Becoming a competent and proficient surgeon: Training Standards for the Nine RACS Competencies'.

- placements (or rotations) in hospital posts
- short courses – RACS run skills courses and specialty-specific courses
- research – each specialty has research requirements
- assessments – including work-based assessments and generic and specialty-specific examinations.[277]

Plastic and reconstructive trainees are expected to complete at least five and no more than nine years of training, though the program can be taken part-time.

General practice

Registrars undertaking a fellowship are also required to complete multiple online courses, including dermatology and skin surgery. Trainee fellows may also complete two years of advanced specialist training. Available modules include obstetrics and gynaecology (which has surgical components) and surgery. Advanced surgery trainee Fellows gain experience in regional secondary or tertiary referral hospitals and complete placements in orthopaedic trauma, obstetrics and gynaecology, burns, and vascular and plastic surgery.[278]

Aspiring Fellows of the College who opt to complete a vocational training pathway, for example, are expected to successfully complete at least one year of hospital rotations to give them 'adequate exposure' to various disciplines, including surgery. The Royal Australian College of General Practitioners (RACGP) also offers a Fellowship in Advanced Rural General Practice (FARGP).

The FARGP has pathways for both general practice registrars and practising GPs. Aspiring FARGP must spend at least one year both in a rural general practice setting and pursuing Advanced Rural Skills Training (ARST) in an accredited procedural or non-procedural training post.[279]

Training is intended to equip graduates to perform surgical services to rural communities through a local hospital operating theatre or other appropriate medical facility, without the need for referral. The 'end point' of the program 'must be recognition of a described capability to deliver safe, unsupervised, high-quality surgical services'.[280]

GPs can obtain a Fellowship from either RACGP or Australian College of Rural and Remote Medicine. The Curriculum for GP Surgery in the FARGP: ARST requires the candidate to complete 12 months' (full-time equivalent) supervised surgical training in an accredited training post, approved by the RACS and the regional training provider for general practice registrars, or the RACGP Rural Censor for practising GPs. This training period includes:

- a six-month general surgery rotation
- a three-month orthopaedics rotation
- three months in another relevant surgical rotation or additional general surgery or orthopaedic rotations

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[277] Royal Australasian College of Surgeons (2019) 'A Guide to Surgical Education and Training', p. 10.

[278] ACRRM, *Fellowship Training: Handbook* (March 2020) pp. 9, 19, 23 and 26 (available at https://www.acrrm.org.au/fellowship/discover-fellowship/core-training, accessed 23 March 2020).

[279] RACGP, 'The Fellowship in Advanced Rural General Practice (FARGP) Advanced Rural Skills Training – Curriculum for GP surgery', 2014, p. 1.

[280] RACGP, 'FARGP Curriculum for GP surgery', 2014, p. 2.

- direct supervision by a Fellow of the RACS throughout the training period.[281]

The ARST qualification prepares GPs to perform a broad range of strictly therapeutic procedures for communities with limited access to specialist surgeons. Strictly cosmetic procedures, with no demonstrable therapeutic benefit, do not form part of the formal training of GPs serving rural and regional areas. It may be that most GPs working in these areas do not perform many or any cosmetic procedures and that citizens of these areas usually source their cosmetic procedures from city-based or foreign proceduralists.

In urban areas, the scope of general practice is usually narrower than in regional and rural areas. Decades-long trends toward ever greater specialisation and the referral of complex care to specialists have encouraged city-and-suburban-based general practitioners to relinquish 'procedural, obstetric, hospital, public health and medically complex care for a scope of office-based community practice characterised by management of minor ailments, counselling, preventive activities, shared-care for chronic conditions, advocacy and referral-orientated medicine'.[282] Nevertheless, many GPs in urban areas continue to perform minor surgeries.

Dermatology

The ACD is also accredited by the Tertiary Education Quality Standards Agency (TEQSA) as a higher education provider in addition to the AMC.

Trainee Fellows study essential and advanced surgical procedures, covering essential skills such as biopsies, curettage, electrosurgery, excisional and phototherapy, as well as advanced procedures including:

- radiotherapy
- injectable fillers and relaxants
- ablative laser resurfacing (used to treat sun damage, acne scarring, traumatic and surgical scars, benign skin tumours, warts, rhinophyma and rosacea, and cholesterol deposits)
- chemical peels
- Mohs surgery
- complex flap surgery
- scar revision
- sclerotherapy (vein surgery)
- composite skin cartilaginous grafts.[283]

Fellows sit vivae (exams) including 'Repairs, Laser, General Surgery, Topicals/Injectables, and Phototherapy' (the latter for disorders of the skin such as psoriasis, acne vulgaris, eczema and neonatal jaundice).[284]

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[281] RACGP (2014) 'FARGP Curriculum for GP surgery', p. 2.

[282] ACRRM, 'ACRRM Position Statement: Defining the Specialty of General Practice' (January 2013), p. 1 (extracted from https://www.acrrm.org.au/about-us/the-college/about-the-college 23 March 2020).

[283] Australasian College of Dermatologists (ACD), *Training Program Handbook: Dermatology 2020*, pp. 6, 15, 19-20.

[284] ACD, *Dermatology 2020*, 26; Daniel N. Sauder, 'Light-emitting diodes: their role in skin rejuvenation', *International Journal of Dermatology*, Vol. 49, Issue 1 (January 2010), pp. 12-16; for laser resurfacing see https://www.dermcoll.edu.au/atoz/laser-resurfacing-fully-ablative/ (accessed 7 April 2020).

Obstetrics and gynaecology

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is accredited by the AMC to provide specialist obstetrics and gynaecology training for medical practitioners,[285] via rotations in hospitals accredited by RANZCOG.[286]

The first four years of basic training requires participants to undertake a range of surgical procedures throughout their rotations[287] while advanced training in participants' final two years involves expanding expertise of basic training and increased confidence in performance of surgical procedures.[288]

Ophthalmology

RANZCO delivers a Vocational Training Program for medical practitioners wishing to become specialist ophthalmologists. Eligibility is contingent on:

- possession of a medical degree with full registration to practice medicine in either Australia or New Zealand
- a minimum of two years full-time postgraduate pre-vocational experience at the commencement of ophthalmology training including a minimum of 18 months of broad experience in non-ophthalmic medical, clinical and surgical settings.[289]

Training occurs for the first four years in a network of hospitals and ophthalmic settings in regional and rural locations. Settings for the final year of training are negotiated by the trainee and approved individually in advance.[290]

RANZCO issues 'Ocular Surgery Guidelines for Ensuring Correct Patient, Correct Eye, Correct Site and Correct Procedure'.[291]

Common ophthalmological surgery includes cataract, glaucoma, refractive and strabismus surgery. These surgeries variously require small incisions, laser pulses and other laser techniques, large incisions (for example, to muscles that move the eye), implants, and the use of local and general anaesthetic.[292]

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[285] Australian Medical Council, 'Specialist medical colleges', *Accreditation and Recognition*, retrieved 26 June 2020, https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/specialist-medical-colleges.

[286] RANZCOG (2019) 'Fellowship of RANZCOG Training Handbook', p. 15.

[287] Ibid, pp. 15–16, 19–20.

[288] Ibid, p. 23.

[289] https://ranzco.edu/home/future-ophthalmologists/vocational-training-program/selection/ (accessed 17 April 2020).

[290] RANZCO, 'Training Network Information (2020)', https://ranzco.edu/wp-content/uploads/2020/01/2020-Training-Network-Information-03012020.pdf.

[291] RANZCO issues 'Ocular Surgery Guidelines for Ensuring Correct Patient, Correct Eye, Correct Site and Correct Procedure' (2019), https://ranzco.edu/wp-content/uploads/2018/11/RANZCO_Ocular_surgery_guidelines_correct_patien_eye_site.pdf.

[292] RANZCO, 'Cataract surgery online patient advisory' (2019) accessed at https://ranzco.edu/home/policies-and-guidelines/ (17 April 2020); 'Glaucoma surgery online patient advisory' (2019) accessed at https://ranzco.edu/home/policies-and-guidelines/; 'Refractive surgery online patient advisory' (2019) accessed at https://ranzco.edu/home/policies-and-guidelines/; 'Strabismus surgery online patient advisory' (2019) accessed at https://ranzco.edu/home/policies-and-guidelines/ (all accessed 17 April 2020).

Appendix 4: Further information about demand for cosmetic procedures and cosmetic medical tourism

What Australians spend each year on 'cosmetic surgery'

More than $350 million (over a third) of the $1 billion spent in 2018 on cosmetic procedures in Australia was thought to be spent on prescription-only cosmetic injectables. The ACCS (now the ACCSM) estimated that approximately 20,000 breast augmentation surgeries and 30,000 liposuction procedures were being performed by medical practitioners each year.[293]

In 2013, the QHQCC reported that reliable statistics on demand for cosmetic surgery are not available but noted that AHMAC had accepted that demand for cosmetic surgical and medical procedures had increased by 40-50% in the five years to 2011.[294]

More recently, the Australian Breast Device Registry (ABDR) reported that from 2012 – 2018, more than 37,000 women underwent a surgical procedure involving a breast device, in a procedure performed either by a plastic/reconstructive, 'general/breast' or 'cosmetic' surgeon. Three quarters of surveyed recipients had undergone a cosmetic augmentation rather than a reconstructive or other form of procedure. Demand for these cosmetic procedures grew exponentially, from 2,045 in 2015; to 7,037 in 2016; to 10,019 in 2017; and remaining high (9,337) in 2018.[295]

The QHQCC noted that advances in technology might be reducing the proportion of surgical procedures being performed, as laser resurfacing, Botox and dermal fillers grow in popularity.[296] These changes have not depressed the total number of cosmetic procedures being performed but may have reduced the proportion of surgical procedures.

Demand for cosmetic procedures in Australia

In 2013, the QHQCC reported that 85-90% of procedures were performed on women, most commonly comprising breast enhancements. Other common procedures also included 'breast reduction, liposuction, tummy tucks, eyelid surgery, and facelifts'.[297]

International data suggests that this gender imbalance in several procedures has fallen, in some cases quite significantly. Nevertheless, the proportion of females undergoing any given surgical procedure has not been reported at less than around two thirds of all consumers, and medical procedures are typically requested by females at rates of 85-90%.[298] The international survey on which these figures are based receives data from Australian plastic surgeons and there is little reason to believe that the gender imbalance in procuring cosmetic procedures differs significantly

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[293] Australasian College of Cosmetic Surgery and Medicine, 'Patients Need to Be Protected Against Rogue Medical Practitioners Calling Themselves 'Cosmetic Surgeons'', *Media Release*, 12 May 2018,https://www.accsm.org.au/media/press.

[294] QHQCC (2013) 'Great expectations', p. 6.

[295] ABDR (Annual Report) 2018, pp. 13, 37.

[296] QHQCC (2013) 'Great expectations', p. 6.

[297] Ibid.

[298] ISAPS (2018) 'Australia', *ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018*, pp. 41- 42.

in Australia relative to comparable nations. In addition, the Cosmetic Physicians College of Australasia reported in 2018 that cosmetic procedures in Australia are growing in popularity among men who represented approximately 7-8% of the total demographic of consumers undertaking procedures via its practice.[299]

Popular surgical procedures

Respondents to the 2018 ISAPS survey identified the five most common cosmetic surgical procedures performed on Australians as:

1. Breast augmentation
2. Eyelid surgery
3. Liposuction
4. Abdominoplasty
5. Breast reduction.[300]

Surgical procedures comprised over 50% (102,404 of 202,642) of cosmetic procedures reported by respondents.[301] These findings are generally consistent with that of the 2018 NSWP Inquiry, which found that the most performed surgical procedures are breast enhancements, while other common procedures included breast reduction, liposuction, abdominoplasty (tummy tuck), eyelid surgery and facelifts.[302]

According to the ISAPS, Australia's total number of cosmetic surgical procedures performed in 2018 rose from 2016, which totalled 95,142.303. The RACS also advised the NSWP Inquiry that in 2017 one in ten Australians would seek to have plastic surgery in the next three years; the main procedures to be undertaken would be facial contouring (37%); other facial (31%); and breast/chest enhancement (27%).[304] The AMA has noted that while some cosmetic surgical (and medical) procedures are reported, the number of procedures undertaken may be much greater.[305]

International comparisons

The 2018 ISAPS survey found that Australian per capita demand for cosmetic surgical procedures is on par with comparable nations. In the US 4.5% of the population underwent a cosmetic surgical procedure. In Germany and Italy 4.6% and 4.7% respectively had a procedure. In Australia, 4.2% had a procedure. The proportions of consumers per capita in some Latin

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[299] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 7.

[300] ISAPS (2018) 'Australia', *ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018*, p. 23.

[301] Ibid.

[302] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4.

[303] ISAPS (2016) 'Procedures by Country', *ISAPS The International Study on Aesthetic/Cosmetic Procedures Performed in 2016*, p. 8.

[304] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 4.

[305] Ibid, p. 5.

American countries are considerably higher (7.1% in Brazil; 6.3% in Argentina cf. only 4% in Mexico) and dramatically lower in India (0.3%).[306]

The global market for cosmetic surgical and medical procedures c. 2005-2020 has grown exponentially and has been widely estimated to generate hundreds of billions of dollars in economic activity each year. Much of this growth is experienced in non-surgical procedures. Commercial research published in 2017 forecast the global non-surgical cosmetic surgery market to grow at a compound annual growth rate of 7.87% from 2017-2021.[307] The impact of the COVID-19 global pandemic on this growth is not yet known.

Factors governing choice of proceduralist

Several factors influence consumers' choice of cosmetic surgical proceduralist and procedures, including cost, service quality, advertising and marketing, and the availability of proceduralists to perform a desired procedure.

Cost

As cosmetic procedures predominately occur in the private sector and are not covered by Medicare rebate,[308] pricing strongly influences consumers' choice of proceduralist as well as the location in which they choose to have a procedure performed. As demand for cosmetic procedures continues to grow, services are increasingly provided by corporate entities, some of which operate as franchises or have multiple branches.[309] These organisations are said to provide lower cost cosmetic procedures to entice consumers.

Service quality

Service quality influences consumer selections of a cosmetic service provider and procedures. While various forms of information are available to consumers to help them choose a provider and their desired procedures, consumers often source information from commercial or social media rather than more impartial sources, such as a government health website,[310] or websites and blogs comparing practitioners and organisations.[311] Many of these sources are affiliated with cosmetic industry bodies and are likely to promote services provided by members of these entities.

Australian cosmetic industry bodies use the concept of 'service quality' to encourage consumers to select their members to perform desired procedures, for example, by highlighting eligibility requirements for membership of their association or organisation. These may emphasise previous training, including training that is offered by those associations/organisations, as well as practice experience. Consumers undertaking their own research to select practitioners and

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[306] ISAPS (2018) 'Australia', *ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018*, p. 25.

[307] https://www.wiseguyreports.com/reports/1309356-global-non-surgical-cosmetic-surgery-market-2017-2021.

[308] QHQCC (2013) 'Great expectations', p. 6.

[309] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 5.

[310] Medical Board (2015) 'Public consultation paper and RIS', p. 15.

[311] See example Plastic Surgery Hub, retrieved 18 May 2020, https://www.plasticsurgeryhub.com.au.

procedures must balance service quality – or the appearance of – with price; but higher prices do not necessarily guarantee high or higher-quality procedures.[312]

Advertising and marketing

To help grow the cosmetic service industry, providers use various direct advertising methods to entice consumers.[313] Advertising can glamorise certain procedures or target specific client groups, such as consumers from lower socio-economic backgrounds and non-English speaking communities.[314]

Social media is used to market services, where high-profile consumers with large fanbases or followers are alleged to market cosmetic procedures they have received in exchange for discounted or free services.[315] Social media marketing is more likely to target younger consumers into undergoing cosmetic procedures.[316] Some practitioners use websites or other platforms to offer discounted services or gifts to consumers,[317] and encourage consumers to undergo cosmetic surgeries to assist with feelings of self-improvement.[318]

Availability

Along with evolved marketing strategies, the cosmetic services industry is making procedures more readily available for consumers. This includes virtual (or telehealth) consultations. At the time of writing, additional entities have provided options for virtual consultations due to the COVID-19 pandemic.

The increase in cosmetic corporate franchises means that consumers have easier access to cosmetic procedures as large organisations operate across jurisdictions.[319] Further, as cosmetic procedures are provided by both registered and unregistered practitioners,[320] these procedures are widely available, and far more so than many other categories of 'care'.

Cosmetic medical tourism: Destinations, favoured procedures and participation rates continued

Many outbound, prospective consumers of cosmetic medical tourism embark on package tours with little knowledge about the medical practitioners who will perform their desired procedure and the location – both the destination country and the medical facility – in which they are to take place.[321] Although one empirical study finds that Australian medical tourists are more likely than

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[312] Medical Board (2015) 'Public consultation paper and RIS', p. 14.

[313] Ibid.

[314] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 68.

[315] 'Beauty's new normal', *Four Corners* (ABC), posted 13 August 2018, 5:00, https://www.abc.net.au/4corners/beautys-new-normal/10115838.

[316] Penna, A., Chan, Q. and Marucci, D. D. (2019) 'Compliance of plastic surgeons with advertising guidelines', *Australian Journal of Plastic Surgery*, 2(1), pp. 37–43, 38, https://doi.org/10.34239/ajops.v2i1.103.

[317] Ibid, pp. 37–43, 41.

[318] Ibid, pp. 37–43, 42.

[319] Parliament of New South Wales, Committee on the Health Care Complaints Commission (2018) 'Cosmetic Health Service Complaints in New South Wales', Report 4/56, p. 5.

[320] Medical Board (2015) 'Public consultation paper and RIS', p. 8.

[321] AHMAC (2011) 'Cosmetic Procedures: A National Framework', 38 citing Nahai, F. (2009). 'Minimising risk in aesthetic surgery', *Clinical Risk*, 15(6), pp. 232–236, https://doi.org/10.1258/cr.2009.090048.

medical tourists from China and the UK to consider the qualifications of surgeons prior to embarking on an international package tour,[322] cosmetic medical tourism more often than not excludes any involvement by a GP or disinterested medical professional in either the referral process or post-procedural care.[323] In common with most domestic consumption of cosmetic surgical procedures, the process curtails waiting times for treatment, so consumers have less time to reflect or to reconsider undertaking procedures.[324] In addition, the availability of a global market heightens the commodification of medical procedures, as 'patients' become 'consumers' and 'economic forces, including supply, demand, and competition for market share' shape the global cosmetic surgery industry.[325]

The cosmetic surgery tourism industry could not survive without the Internet, where consumers generally find information on surgeries, destinations, surgeons' qualifications and patient testimonies (which are prohibited in Australia by the National Law). Websites compare prices and emphasise quality of care and hygiene, while social networking sites 'facilitate mutual support and group travel' for consumers. Hospitals, clinics and agents advertise online, with direct price comparisons (also prohibited by the National Law), emphasising international accreditation and hygiene. Surgeons also discuss techniques in social media (prohibited by the National Law). The Internet is also where consumers access support, including where to find help in the case of complications.[326]

Cultural preferences play a large role determining who becomes a cosmetic surgery tourist, what procedures the tourist undergoes and where they travel for procedures. The Economic and Social Research Council found that Australian consumers mostly have breast augmentation procedures; two thirds of surveyed Australian consumers sought this procedure, which costs roughly one third as much in Thailand as it does in Australia ($4,000 in 2014, as opposed to $12,000). Australian consumers were more likely than British or Chinese consumers to have considered the surgical qualifications of their proceduralist, but the surgeon's reputation as reported in social media was important to consumers from all three countries.[327]

Even academic medical journal articles routinely state that medical tourism continues to grow, but many do not quantify these claims with precise or even general figures;[328] the OECD has previously commented that while 'an increasing amount [is] written on the subject of medical tourism, such material is hardly ever evidence-based'.[329]

Cosmetic medical tourism: Risks

The risks inherent in cosmetic medical tourism are considerable and varied. While these risks occur in cosmetic surgical and medical procedures undertaken in Australia, but the level of risk

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[322] Economic and Social Research Council, University of Leeds (ESRC) (2014) 'Sun, Sea, Sand and Silicone: Mapping Cosmetic Surgery Tourism' ('Sun, Sea, Sand and Silicone'), p. 9.

[323] Leggat, Peter 'Medical tourism', p. 18. Leggat states 'only about 40% of Australians seek health advice from a qualified source before travelling abroad'. It is inferred that the proportion of cosmetic medical tourists would quite probably be considerably lower, as the figure Leggat cites includes prospective patients for serious health-related procedures.

[324] Franzblau, L. E. and Chung, K. C. (2013) 'Impact of Medical Tourism on Cosmetic Surgery in the United States', *Plastic and Reconstructive Surgery Global Open*, 1(7), p. 2.

[325] Ibid, p. 6.

[326] ESRC (2014) 'Sun, Sea, Sand and Silicone', pp. 10, 12.

[327] Ibid, p. 7-9.

[328] See for example Franzblau, L. E. and Chung, K. C. (2013) 'Impact of Medical Tourism on Cosmetic Surgery', p. 1.

[329] OECD, *Medical Tourism*, p. 2.

can be exaggerated by numerous medico-legal issues that can complicate the receipt of necessary reparative surgery or other treatment in Australia. Further, returning consumers with complications can expose Australia to acquired pathogens. The significance of this latter point has acquired greater significance since the emergence of COVID-19.

Regulation of medical professionals across international borders is also uneven. As the OECD notes, the 'ethical and legal issues' involved in 'all forms of medical care – informed consent, liability and legislating for clinical malpractice … are intensified for medical tourism'. The seeking of redress or pursuit of a breach of contract or a matter of clinical negligence are complicated by legal disclaimers that consumers may be encouraged to sign, which restrict Australian jurisdiction over any subsequent legal matters.[330] In addition, medical complications may be insured for only 12 months, preventing any claims for issues that require revision after this time.[331] These complications can impose significant costs on the Australian public healthcare system.[332] Researchers also report that practitioners in the Australian public healthcare system resent having to perform and sometimes even refuse to perform reparative work; corrective procedures such as seromas cannot be treated in an outpatient facility and surgeons may not want to risk transfer of liability.[333]

Cosmetic medical tourism can result in very serious health consequences for individual consumers and the broader community, including fatalities. The procedure known colloquially as the 'Brazilian Butt Lift' (the intramuscular gluteal lipoinjection) is particularly lethal.[334] Questions relating to liability in cases where the consumer contracts a serious blood-borne disease in an overseas hospital are also difficult to resolve.[335] The public health consequences of medical tourism generally also include 'the potential for the spread of pathogenic microorganisms via the [consumer] from the overseas provider to medical services at home, as well as the spread of resistant strains of microorganisms and, occasionally, the spread of emerging infectious diseases'.[336] Thus the process of medical tourism brings unwanted contact between different 'disease ecosystems'.[337]

The cosmetic surgery workforce in Australia

Statistics from the National Health Workforce Data Set may support a hypothesis that many cosmetic surgical procedures are being performed by proceduralists who are not specialist plastic surgeons. Data from 2018 indicate that the supply of plastic surgeons has only just kept pace with population growth. Forward projections of demand in the hospital system for plastic surgeons and of the proportion of plastic surgeons who are expected to retire over the next 10 years suggest that almost 60 new surgeons would be required to replace expected attrition and

[330] Ibid, pp. 27, 37.

[331] ESRC (2014) 'Sun, Sea, Sand and Silicone', p. 15.

[332] Leggat, Peter. 'Medical tourism', pp. 17-18.

[333] ESRC (2014) 'Sun, Sea, Sand and Silicone', p. 16.

[334] Cárdenas-Camarena, Lázaro; Bayter, Jorge Enrique; Aguirre-Serrano, Herley; Cuenca-Pardo, Jesús, 'Deaths Caused by Gluteal Lipoinjection: What Are We Doing Wrong?', *Plastic and Reconstructive Surgery*, July 2015, pp. 58-66.

[335] OECD, *Medical tourism*, p. 38.

[336] Leggat, Peter. 'Medical tourism', p. 17.

[337] OECD, *Medical tourism*, p. 26.

another 55 would be required to cater for additional demand. This is around a quarter of the current registered workforce of plastic surgeons.[338]

As the gross size of the cosmetic surgical procedures industry in Australia has continued to increase in recent years, the proportion of procedures being performed by persons without specialist plastic surgical training has likely risen.

It is difficult to determine the number of 'cosmetic surgeons' in Australia as practitioners who call themselves 'cosmetic surgeons' are not registered under this title. Profiling the cosmetic surgery workforce in Australia can be attempted by taking a census of the professional groups and bodies that represent practitioners performing cosmetic procedures.[339] Many practitioners are members of several such bodies, including specialist medical colleges, societies and other non-accredited entities. These representative bodies have a range of eligibility requirements and prerequisites for membership or fellowship, and some consider themselves multidisciplinary. As membership is potentially open to a range of practitioners, it is difficult to form an accurate representation of the workforce.

[338] In February 2015, the Medical Board had registered 433 medical practitioners as plastic surgeon specialists. The number of plastic surgeons with RACS-recognised qualifications was put at around 520, with around 105 in training. These practitioners were members either of the Australian Society of Plastic Surgeons or the Australasian Society of Aesthetic Plastic Surgery (see Medical Board (2015) 'Public consultation and RIS', p. 8).

[339] At the end of December 2018, the ABDR reported that it was receiving clinical data from 605 eligible surgeons currently performing procedures and was aware of 80 additional surgeons not currently performing the work but having future capacity. Most of these practitioners (360 / 60%) were plastic surgeons. Around 30% (181) were 'general/breast surgeons' and the remaining 10% (64) described themselves as 'cosmetic surgeons'. See ABDR Annual Report (2018), pp. 10–12.

Appendix 5: Stakeholder views on title restriction

The question whether the professional titles 'surgeon' and 'cosmetic surgeon' should be protected was put to the public by the COAG Health Council in a consultation paper issued in August 2018, *Regulation of Australia's health professions: Keeping the National Law up to date and fit for purpose*.

A little less than 50 organisations and individuals across Australia submitted formal comments on the issue of professional titles for surgeons and cosmetic surgeons. Support among these organisations and individuals for protecting both titles is high, at about 85% of respondents.

The issue of protecting the titles 'surgeon' and particularly 'cosmetic surgeon' have also been examined in other public fora, including, most recently, the NSWP Inquiry, which released its report *Cosmetic Health Service Complaints in New South Wales* in November 2018.

Stakeholder support for restricting the titles 'surgeon' and 'cosmetic surgeon'

A proposal to protect the title 'cosmetic surgeon' first advanced by health ministers in 2018 had strong and broad stakeholder support. Supporters included the Ahpra Community Reference Group (Ahpra CRG), legal firms and associations (such as the Australian Lawyers' Alliance or ALA, which also provided testimony to the NSWP Inquiry),[340] the Medical Services Committee of NSW, medical indemnity insurers, and medical professional associations, including the AMA, the Australian Dental Association, the Australian Society of Plastic Surgeons and the Australian Society of Aesthetic Plastic Surgeons.

These organisations supported the proposal on public safety grounds. They share a view that there is currently too little regulation of professional title and that the general public is not qualified to safely navigate the industry as it is currently constructed and marketed. In support of these concerns, these organisations stated:

- research shows that most prospective patients (or consumers) do not check a surgeon's qualifications before they undergo an operation
- more than 90% of people surveyed in some studies expect that any doctor performing a surgery is 'fully qualified' to do so
- there are 'repeat offender' practitioners who are not removed from circulation quickly, or quickly enough, through existing means[341]
- health service providers and their insurers are not required to disclose to health care complaint commissions settlement payments for failure to secure appropriate consent or for adverse clinical outcomes.[342]

The common view, stated for example by the Ahpra CRG, is that the use of the title 'surgeon' should be restricted to practitioners with specialist qualifications.

[340] Australian Lawyers' Alliance, Testimony to NSWP Inquiry, 1 August 2018.

[341] See also, for example, Australian Lawyers' Alliance, Testimony to NSWP Inquiry, 1 August 2018.

[342] Australian Lawyers' Alliance, Testimony to NSWP Inquiry, 1 August 2018.

Most respondents to the COAG Health Council consultation paper understand and sympathise with the principle driving the proposal to amend the law to protect the title 'surgeon'.

Stakeholders who argue the right to use the term 'surgeon' should be restricted to practitioners with requisite, AMC-accredited surgical training include the Medical Services Committee NSW, practitioners, several health professions associations, Maurice Blackburn Lawyers, the SA Health and Community Services Complaints Commissioner and several medical colleges, including RACS.[343]

The need for restriction is summarised by the Australasian College of Dermatologists, which stated in response to the COAG Health Council consultation paper, that the 'ubiquity' and 'growing popularity' of cosmetic surgical and medical procedures is creating an urgent demand for the development of 'definitions … not only for the stratification of procedures … but also for the practitioners performing them'.[344]

Reservations about/opposition to restriction of the title 'surgeon'

Many respondents to the COAG Health Council consultation paper are sceptical about the practicability of legislating to protect the title 'surgeon' and equally sceptical that this would achieve the desired objective of preventing unqualified persons from attracting custom.

The ACRRM argues that protecting the title 'surgeon' is not a practical way to educate the public about risky practices and risks in practice. It also notes that the title 'surgeon' is widely used in society and that the expense, time and effort required to change use of the term and the public's understanding of the implications of this change are unknown and probably would not justify committing the necessary resources.

The medical insurer MIPS argues that there is significant risk of creating unintended consequences by restricting the title 'surgeon'.

Ahpra and the National Boards note that most medical practitioners hold the Bachelor of Medicine Bachelor of Science (MBBS) qualification and are entitled to use the term 'surgeon'. Changing this right, therefore, will affect the great majority of registered medical practitioners. It may be that a sizeable proportion of them will have to relinquish the right to refer to themselves as 'surgeons'; or, suitable alternative titles will need to be developed and agreed.

Another ground for scepticism about the effectiveness of title protection as a measure to protect consumers emerged in testimony provided to the NSWP Inquiry. This ground concerns the corporatisation of the cosmetic service industry. In testimony provided in 2016, Professor Saxon Smith, Chair of NSW Faculty, Australasian College of Dermatologists, argued against measures that could place too much emphasis on practitioners rather than corporate entities. The specific concern articulated by Professor Smith is that in the current regulatory environment, too often corporate entities escape culpability for misleading and harming consumers by filing for bankruptcy and establishing phoenix operations.[345]

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[343] Note that references to organisational and private individuals' comments on the COAG Health Council consultation paper are drawn from those organisations' and individuals' submissions to COAG, unless otherwise indicated.

[344] https://www.coaghealthcouncil.gov.au/Projects/Progressing-reforms-to-the-Health-Practitioner-Regulation-National-Law/Stage-2-submissions.

[345] Saxon Smith, Testimony to NSW Committee on the Health Care Complaints Commission, Inquiry into Cosmetic Health Service Complaints in NSW, 1 August 2018.

Though Professor Smith did not necessarily cite this concern in relation to any proposal to protect the title ‘surgeon’, it is reasonable to surmise that the prevalence of this corporate activity will not be affected, or not swiftly affected, by any action to protect the title ‘surgeon’. On the other hand, it may be that protecting title might, over time, deprive poor corporate entities of the staff they require to operate.