Medical practitioners' use of the title 'surgeon' under the Health Practitioner Regulation National Law

Decision Regulation Impact Statement

Health Ministers' Meeting – December 2022

Health Ministers' Meeting

Contents

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.

Consultation RIS: If regulatory reform options are being considered by an intergovernmental decision-making body (such as the Health Ministers' Meeting (HMM)) then the regulatory options must be subject to Regulatory Impact Analysis through a two-stage process including the preparation of a draft Regulation Impact Statement for consultation (Consultation RIS) and final Regulation Impact Statement to inform the decision-making body (Decision RIS). The purpose of a Consultation RIS is to canvass the options under consideration, in order to elicit information from stakeholders to help analysis of the relative costs and benefits of those options.[1]

Consumer representative: An organisation or group that represents the views and interests of consumers.

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

Cosmetic injectables (or cosmetic injections): 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]

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[1] Commonwealth of Australia, Department of Prime Minister and Cabinet, Regulatory Impact Analysis Guide for Ministers' Meetings and national Standard Setting Bodies May 2021, p. 9, https://obpr.pmc.gov.au/resources/guidance-impact-analysis/regulatory-impact-analysis-guide-ministers-meetings-and-national.

[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.

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'.

Cosmetic surgeon: A registered medical practitioner who performs cosmetic surgical procedures and may be using the informal title 'cosmetic surgeon'. This practitioner may have further training in surgery and cosmetic procedures but does not necessarily hold accredited medical specialist qualifications. Training in cosmetic surgery is not recognised by the Royal Australasian College of Surgeons (RACS) or accredited by the AMC.[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.

Decision RIS: If regulatory reform options are being considered by an intergovernmental decision-making body (such as the Health Ministers' Meeting) then the regulatory options must be subject to Regulatory Impact Analysis through a two-stage process including the preparation of a draft Regulation Impact Statement for consultation (Consultation RIS) and final Regulation Impact Statement to inform the decision-making body (Decision RIS). The purpose of a Decision RIS is to inform the deliberations of the decision-making body, having drawn conclusions on whether regulation is necessary, and if so, on what the most efficient and effective regulatory approach might be, taking into account the outcomes of the consultation process.[9]

Fellows of the Royal Australasian College of Surgeons (FRACS): Fellows of the College (FRACS) have completed further training in one of the nine surgical specialties for which RACS provides accredited training.[10] Plastic and Reconstructive Surgery is one of the nine specialities, as

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[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.

[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] Commonwealth of Australia, Department of Prime Minister and Cabinet, Regulatory Impact Analysis Guide for Ministers' Meetings and national Standard Setting Bodies May 2021, p. 9, https://obpr.pmc.gov.au/resources/guidance-impact-analysis/regulatory-impact-analysis-guide-ministers-meetings-and-national.

[10] RACS does not provide training for the tenth recognised surgical field of practice, oral and maxillofacial surgery. Training for this field of practice is provided by the Royal Australasian College of Dental Surgeons.

is General Surgery. Ear, Nose and Throat surgeons may also perform procedures that are at least in part cosmetic.[11]

Health consumers (consumers): Health consumers are people who use health services, as well as their family and carers. It includes people who have used a health service in the past or who could potentially use the service in the future.[12]

Health Issues Centre (HIC): a health consumer organisation based in Victoria.[13]

Health literacy: There are three recognised levels of health literacy – functional, interactive and critical. Functional health literacy – basic reading and writing skills to be able to understand and use health information; interactive health literacy – more advanced cognitive and literacy skills to interact with health care providers and ability to interpret and apply information to changing circumstance; critical health literacy – more advanced cognitive skills to critically analyse information and exert greater control over one's life. For the purposes of this report, levels of low health literacy (reflecting functional health literacy) and medium-high health literacy (reflecting interactive and critical health literacy) have been used. There was not always sufficient information to distinguish between medium to high levels of health literacy.[14]

Health practitioner: An individual who practises a health profession.[15] This includes, but is not limited to, medical, nursing, midwifery, paramedicine, pharmacy and psychology.[16]

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).

Independent Review: the *Independent review of the regulation of medical practitioners who perform cosmetic surgery* commissioned by Ahpra and the Medical Board of Australia in November 2021, led by Mr Andrew Brown, former Queensland Health Ombudsman, supported by an expert panel. The final report of the Independent Review was published on 1 September 2022.[17]

Jurisdictional health departments: Government departments in each state and territory in Australia and the Commonwealth that have responsibility for their jurisdiction's health portfolio.

Medical Board of Australia (Medical Board): One of 15 National Boards in the National Registration and Accreditation Scheme, the Medical Board registers medical practitioners and medical students; develops standards, codes and guidelines for the profession; investigates notifications and complaints about medical practitioners; conducts panel hearings and refers serious health, performance and conduct matters to Tribunal hearings; assesses international medical

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

[12] Health Consumers NSW, 'Who is a health consumer?' retrieved 24 May 2022, <https://www.hcnsw.org.au/consumers-toolkit/who-is-a-health-consumer-and-other-definitions>.

[13] Health Issues Centre, 2022, https://hic.org.au/about-us/

[14] Nutbeam, D. 'Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', Health Promotion International, Volume 15, Issue 3, September 2000, p. 259-267, <https://academic.oup.com/heapro/article/15/3/259/551108?login=false>.

[15] *Health Practitioner Regulation National Law* s 5 (definition of 'health practitioner').

[16] See *Health Practitioner Regulation National Law* s 5 (definition of 'health profession'), which lists all 16 health professions under the National Registration and Accreditation Scheme.

[17] Brown, A (2022). Final report: independent review of the regulation of medical practitioners who perform cosmetic surgery, commissioned by Ahpra and the Medical Board. Available from <https://www.ahpra.gov.au/News/Cosmetic-surgery-independent-review-of-patient-safety.aspx>

graduates who wish to practice in Australia; approves accreditation standards and accredited courses of study.

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.

Medicare Benefits Scheme (MBS): A list of health professional services that the Australian Government subsidises.

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 Surgeons (FRACS). Plastic surgeons may specialise in cosmetic (aesthetic) surgery.[18]

Plastic surgery: A medical specialty accredited by the AMC that includes 'cosmetic' and 'reconstructive' surgery.[19]

Reconstructive surgery: Surgery that restores form and function as well as normality of appearance, which may incorporate aesthetic techniques to restore normal appearance.[20] 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.[21]

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

[19] 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.

[20] Ibid.

[21] Ibid, p. 5.

1. Executive summary

Purpose of this Decision Regulation Impact Statement

This Decision Regulation Impact Statement (Decision RIS) has been prepared to inform health ministers in making a decision on whether or not, and how, to restrict the use of the title 'surgeon' by medical practitioners under the Health Practitioner Regulation National Law (National Law) and to consider any alternative options.

The Decision RIS provides an analysis of the regulatory impacts of title restriction and alternative options, and recommends a preferred option. The Decision RIS follows a Consultation Regulation Impact Statement (Consultation RIS) on the use of the title 'surgeon' by medical practitioners in the National Law, which was prompted in particular by health ministers' concerns about the cosmetic surgery industry.

In late 2019, all health ministers agreed to consult the public on medical practitioners' use of the title 'surgeon', including 'cosmetic surgeon', under the National Law. In December 2021, health ministers released a Consultation RIS to explain the current regulatory framework and the potential issues that may be arising from it, and to seek feedback on a range of potential reform options, which included:

- **Option 1:** Maintaining the status quo and existing regulatory and other tools, and using other methods to address issues.
- **Option 2:** Increasing public awareness about the use of titles and provision of cosmetic procedures, and increasing opportunities for patient redress following adverse events.
- **Option 3:** Strengthening the existing regulatory framework, including existing mechanisms designed to protect the public from harm.
- **Option 4:** Amending the Health Practitioner Regulation National Law[22] (National Law) to restrict the use of the title 'surgeon' to certain registered medical practitioners.

This Decision RIS outlines the feedback received on the Consultation RIS, comprising direct submissions from 150 professional stakeholders and nearly 1,400 responses to a dedicated consumer survey.

This Decision RIS has been prepared in the context of other significant reforms relating to the regulation of cosmetic surgery. These include:

- the implementation of the recommendations contained in the *Independent review of the regulation of medical practitioners who perform cosmetic surgery* (Independent Review), which have been accepted by Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia (Medical Board), and endorsed by health ministers, and

[22] *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.

- other reforms committed to by health ministers on 2 September 2022, outlined in the Health Ministers' Meeting (HMM) statement on cosmetic surgery.[23]

The options considered in this Decision RIS have been refined since the release of the Consultation RIS to take into account these concurrent reforms.

The problem being considered

Currently, all registered medical practitioners in Australia can use the title 'surgeon', including 'cosmetic surgeon', even when they have completed different levels of training (which could include having no postgraduate training in surgery), or hold different qualifications.

This may be confusing for members of the public, who may not have knowledge of medical practitioner qualifications and training. This may lead members of the public to assume that the title 'surgeon' designates a level of training and specialisation and provides a degree of assurance of high quality and safety of services. In turn, this confusion may be contributing to avoidable and disproportionate risks and harms to the public. The problem is outlined in further detail in the 'Problem statement' section of the Consultation RIS and in section 3 of this Decision RIS.

Health ministers sought feedback through the Consultation RIS to verify these concerns, including to determine:

- if there is widespread belief that cosmetic surgery is regulated in the same way as other surgery
- if current regulation is sufficiently effective in helping the public to understand the differences between the regulation of cosmetic and other surgery, and
- if the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' is associated with risks and harm to the public.

As set out in this Decision RIS, health ministers' concerns have been broadly confirmed by consultation feedback received in response to the Consultation RIS, including through a consumer survey, as well as feedback on the Independent Review.

In particular, consultation confirmed there is widespread confusion about practitioners' titles and qualifications, that there is significant concern about risk and harm associated with the cosmetic surgery industry, and that the status quo considered in the Consultation RIS – maintaining the current regulatory framework – was overwhelmingly considered unacceptable by both consumers and professional stakeholders.

Preferred option

The findings and recommendations in the Decision RIS are informed by evidence from a range of sources, including:

- direct submissions to the Consultation RIS and the consumer survey undertaken by the Health Issues Centre (HIC)
- the Independent Review, commissioned by Ahpra and the Medical Board

[23] Available at <https://www.health.gov.au/resources/publications/hmm-statement-on-cosmetic-surgery-2-september-2022>.

- expert advice provided to the HMM by the Medical Board.

Feedback on the Consultation RIS, including through the consumer survey, confirmed the key hypothesis that consumers experience significant confusion about the titles and qualifications of medical practitioners. Further, of the respondents to the consumer survey who had, or knew someone who had experiences of cosmetic surgery, a significant proportion – 28% (237 respondents) – reported experiencing harm as a result of cosmetic surgical procedures.

As set out in the section on 'Assessment of reform options', this Decision RIS recommends implementation of Option 3.2 (Option 4.2 in the Consultation RIS) – restricting the use of the title 'surgeon' to specialist medical practitioners with significant surgical training. As outlined in this Decision RIS, Option 3.2 is anticipated to have the greatest impact in addressing the problems set out in the 'Problem Statement'.

However, to maximise the benefits of Option 3.2, including addressing market failure and risks to consumers, this reform is proposed to be implemented concurrently with other complementary reforms already committed to by health ministers, Ahpra and the Medical Board, notably:

- a major public information campaign (Option 2.1 in the Consultation RIS), and
- other measures to strengthen regulation under the National Scheme (Option 3 in the Consultation RIS), including:
    1. establishment of an area of practice endorsement for cosmetic surgery
    2. establishment of a Cosmetic Surgery Enforcement Unit in Ahpra
    3. establishment of an Ahpra hotline for complaints about cosmetic surgery
    4. production by Ahpra and the Medical Board of educational material for members of the public who make a notification about a cosmetic surgery matter
    5. production by Ahpra and the Medical Board of educational material for practitioners about making mandatory and voluntary notifications about matters involving significant departures from accepted professional standards, that place the public at risk of harm
    6. reviewing Ahpra and the Medical Board's regulatory approach to advertising in the cosmetic surgery sector
    7. reviewing the Medical Board's *Guidelines for medical practitioners who perform cosmetic medical and surgical procedure*.[24]

These reforms will not restrict medical practitioners from performing surgery, including cosmetic surgery. They will, however, require practitioners not to use titles that they will not be lawfully entitled to use and this, in turn, will provide consumers with stronger guidance than has previously been available about the skills, training and qualifications of medical practitioners, including those performing cosmetic surgery.

The combined operation of title restriction and an area of practice endorsement for cosmetic surgery, in particular, is expected to achieve these objectives. Title restriction would prohibit certain

[24] See https://www.ahpra.gov.au/News/Cosmetic-surgery-independent-review-of-patient-safety/Medical-Board-and-Ahpra-response-to-the-cosmetic-surgery-review.aspx.

and the full report of the Independent review of the regulation of medical practitioners who perform cosmetic surgery, at https://www.ahpra.gov.au/News/Cosmetic-surgery-independent-review-of-patient-safety.aspx.

medical practitioners from using the title 'surgeon' in any capacity, whether with the word 'cosmetic' or with other descriptions. This will be supported by offences provisions with strict penalties and will therefore, be a powerful discipline on practitioner conduct in relation to how they describe themselves by title.

Establishment of an area of practice endorsement would mean only those practitioners holding the endorsement to be able to state that they hold an endorsement in cosmetic surgery. This information will be available in the public register published online by Ahpra. Strict penalties apply to practitioners who misrepresent their endorsements as recorded in the register. The right to use the title 'surgeon' will not guarantee that a practitioner can get the endorsement. Obtaining an endorsement will require a practitioner to have the requisite qualification approved by the Medical Board (noting the approved qualifications are yet to be determined).

These two reforms in combination will provide consumers with meaningful information to enable them to assess the qualifications of their prospective practitioner, including where consumers seek cosmetic surgery. Consumers will be able to assess whether a medical practitioner has significant surgical training (through use of the title 'surgeon') and whether the practitioner has qualifications relevant to cosmetic surgery (through holding an endorsement).

Other measures already committed to by health ministers to strengthen regulation under the National Scheme – and particularly a major public information campaign – are also expected to amplify the impact of both title restriction and an area of practice endorsement. The public education campaign is expected to provide consumers (particularly consumers seeking cosmetic procedures) with readily understandable information about titles and endorsements and what information these convey to a consumer about a practitioners' qualifications. It is expected the education campaign will also address avenues for complaint and other information sources such as the public register.

In aggregate, these reforms are expected to significantly address the concerns that have prompted health ministers to undertake this RIS process. The potential effects of these reform options are modelled in further detail in section 6 of this report.

2. Background

The National Registration and Accreditation Scheme for health professions

The National Registration and Accreditation Scheme for health professions (the 'National Scheme') was established under the National Law and has been in operation since 2010. It is delivered by the 15 National Boards and Ahpra.

The National Scheme was established under state and territory legislation using the 'adoption of laws' mechanism – except in Western Australia where complementary legislation has been enacted. Amendments to the National Law enacted by the host jurisdiction (Queensland) are automatically applied in all jurisdictions, except Western Australia where complementary legislation is required and New South Wales and South Australia where the amendments are made by regulation. The National Scheme is overseen by the HMM, which comprises health ministers from every state and territory and the Commonwealth.

The National Scheme currently regulates more than 800,000 health practitioners (of which over 130,000 are registered medical practitioners)[25] across 16 health professions and ensures that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. One in 16 people employed in Australia is a registered health practitioner and regulated under the National Scheme.[26]

Title protection under the National Law

The National Law generally functions by restricting the use by registered health practitioners of protected professional titles rather than by restricting types of practice.[27] This means that the National Law – with very few exceptions – is designed to regulate what practitioners may call themselves, rather than specifying what they can do.[28]

This is in part because practices evolve rapidly, in response, for example, to technological and disciplinary innovations. This makes prescribing practices in legislation impractical as the legislative process cannot keep pace with industry and practice advances.

Medical practitioners are instead advised, in general terms, by the Medical Board's Code of Conduct to:

- perform only those procedures for which they have appropriate training, expertise and experience, and

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[25] Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 4, https://www.medicalboard.gov.au/News/Statistics.aspx.

[26] Ahpra and National Boards Annual Report 2020-21, available at <https://www.ahpra.gov.au/Publications/Annual-reports.aspx>.

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

[28] There are three exceptions where restrictions on practice exist to mitigate public safety risks if the procedures are performed by unqualified practitioners: s.121: restricted dental acts; s.122: prescription of optical devices; s.123: spinal manipulation.

- not make misleading claims about their qualifications, experience or expertise.[29]

The Code of Conduct does not establish a blueprint for what a given medical practitioner should and should not do in their practice, but it "can be used to assist the Medical Board…in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor's professional conduct can be evaluated". If a practitioner's "professional conduct varies significantly" from these standards, a practitioner "should be prepared to explain and justify [their] decisions and actions". Serious and/or repeated failure to meet these standards can have consequences for the practitioner's medical registration.[30]

The title protection provisions of the National Law help to protect the public by ensuring that only health practitioners who are suitably trained and qualified are permitted to use designated professional titles.[31] 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.[32] The reckless or knowing misuse of a protected title (such as 'medical practitioner') carries heavy penalties for individuals and body corporates.[33]

Use of titles by medical practitioners

In the medical profession, the title 'medical practitioner' is protected under section 113 of the National Law.[34] A range of 'specialist' titles are also protected.[35] In the medical profession 86 specialist titles are associated with 23 specialties and 64 fields of specialty practice.[36] The entitlement to use specific medical specialist titles is gained through completion of accredited training courses. All practitioners are required to complete a foundational medical degree (formerly a Bachelor of Medicine and Bachelor of Science or MBBS degree but now more commonly a Doctor of Medicine or MD degree) and then can pursue specialist training programs through specialist colleges, such as the Royal Australasian College of Surgeons, the Australasian College for Emergency Medicine and the Royal Australasian College of Physicians.

Currently, all medical practitioners registered under the 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 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 speciality, such as 'specialist orthopaedic surgeon', 'specialist paediatric surgeon' or 'specialist plastic surgeon'.

Cosmetic surgery has not been assessed as a medical specialty by the Australian Medical Council (AMC), 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

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[29] Medical Board, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (March 2020), <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.

[30] Ibid, 3.

[31] National Law Schedule, Part 7, Division 10, Sub-Division 1.

[32] Ibid.

[33] Ibid s 113

[34] Ibid s 113(3).

[35] Ibid s 115.

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

'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, for example, neurosurgery, or plastic or cardio-thoracic surgery.

Surgical training of medical practitioners

During undergraduate medical training, all registered medical practitioners receive some surgical training. Denoting this, until recently, the basic (medical school) entry-level qualification for medical practitioners was the Bachelor of Medicine and Surgery (MBBS). More recently, Australian medical schools have progressively moved to confer a Doctorate of Medicine (MD) as the entry-level qualification.

The level of postgraduate training of different medical practitioners, training after qualification from medical school, varies greatly. Specialist surgeons seeking Fellowship of the Royal Australasian College of Surgeons (FRACS) undertake training through five stages of performance[37] across 10 competencies and are placed for training in hospital posts, undertake research as well as examinations and work-based assessments.[38] Plastic and reconstructive trainees, for example, are expected to complete at least five and no more than nine years' training.[39] 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 (FARGP) with Advanced Rural Skills Training (ARST).[40] Trainee fellows may also complete two years of advanced specialist training.[41] Cosmetic procedures do not form part of the formal training of GPs.

Overview of the cosmetic surgery industry

In 2017, stakeholders estimated that Australia surpassed the US in per capita expenditure on cosmetic procedures,[42] advising there is strong growth in demand for cosmetic plastic surgery.[43] This suggests that cosmetic procedures are becoming more commonly performed both in Australia and for Australians.

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

[38] 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.

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

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

[41] 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).

[42] 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.

[43] 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.

In 2018, the Australasian College of Cosmetic Surgery (ACCS) (now the Australasian College of Cosmetic Surgery and Medicine (ACCSM)) estimated that Australians spend about $1 billion annually on cosmetic procedures.[44]

While demand for cosmetic procedures across Australia is thought to be increasing rapidly, firm evidence is difficult to source.[45] The International Society of Aesthetic Plastic Surgery (ISAPS) conducts a periodic survey of business.[46] In 2018[47,] about 35,000 of an estimated 46,300 plastic surgeons were invited to participate, including Australian practitioners.[48] The survey found that in 2018, Australians underwent 202,642 surgical and medical cosmetic procedures.[49] This figure was actually less than reported for 2016, when ISAPS estimated that 225,002 cosmetic procedures were completed.[50] 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'.[51]

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.[52]

Surgical procedures comprised over half (102,404 of 202,642) of cosmetic procedures reported by respondents. These findings are generally consistent with those of the 2018 New South Wales Parliamentary *Inquiry into cosmetic health service complaints in New South Wales* (NSWP Inquiry), that 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.

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[44] 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.

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

[46] Cosmetic procedures undertaken by plastic surgeons are a subset of the total procedures – many of which is done by other medical practitioners who do not have specialist surgical titles but who can nevertheless perform cosmetic surgery under the national scheme.

[47] While survey data have been released for 2019 and 2022, 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.

[48] 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.

[49] International Society of Aesthetic Plastic Surgeons (ISAPS), 'ISAPS International Survey on Aesthetic/Cosmetic Procedures Performed in 2018', p. 23.

[50] ISAPS (2016) 'Countries by Total Number of Procedures - 2016', *ISAPS The International Study*

on Aesthetic/Cosmetic Procedures Performed in 2016, p. 39.

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

[52] Ibid, p. 23.

According to the ISAPS, Australia's total number of cosmetic surgical procedures performed in 2018 rose from 2016, which totalled 95,142.[53] 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%).[54] The Australian Medical Association (AMA) has noted that while some cosmetic surgical (and medical) procedures are reported, the number of procedures undertaken may be much greater.[55]

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.[56]

In 2013, the Queensland Health Quality and Complaints Commission (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'.[57]

In Australia, most cosmetic procedures are performed for female consumers aged 35-55.[58] Studies have found that women are about twice as likely to undergo a 'cosmetic surgical enhancement' than men[59] and that the popularity of cosmetic procedures continues to grow among younger women.[60]

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%.[61] The international survey these

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

[54] 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.

[55] Ibid, p. 5.

[56] 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.

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

[58] 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.

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

[60] 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.

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

figures are based on 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 about 7-8% of the total demographic of consumers undertaking procedures via its practice.[62]

The 2018 ISAPS survey found that Australian per capita demand for cosmetic surgical procedures is on par with comparable nations. In Australia, 4.2% underwent a procedure; this compares to similar figures of 4.5% in the US, 4.6% in Germany and 4.7% in Italy. 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 significantly lower in India (0.3%).[63]

The global market for cosmetic surgical and medical procedures c. 2005-2020 has grown significantly and has been estimated to generate hundreds of billions of dollars in economic activity each year.[64] 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.[65] The impact of the COVID-19 pandemic on this growth is not yet known.

Characteristics of the cosmetic surgery industry

As outlined in Table 1 below, a range of medical and industry characteristics of cosmetic surgery may heighten the association of the cosmetic surgery sector with risks and harm. Unlike many 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.[66]

Table 1: Characteristics of the cosmetic surgery industry

	Other surgery	Cosmetic surgery
Consumer need	Driven predominantly by medical / therapeutic necessity, some elective treatment.	All treatment is elective and non-medically indicated.
Burden of cost	Mostly borne by public health system through public hospitals and Medicare.	Solely borne by consumer.[67]

[62] 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.

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

[64] Wise Guy Reports, 'Global Non-Surgical Cosmetic Surgery Market 2017-2021', available at https://www.wiseguyreports.com/reports/1309356-global-non-surgical-cosmetic-surgery-market-2017-2021.

[65] Ibid.

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

[67] Recent media reports have highlighted concerns about Medicare billing for cosmetic surgery. See e.g., Adele Ferguson and Chris Gillett, 'Cosmetic surgery industry exploiting Medicare for services it is not entitled to claim', https://www.smh.com.au/politics/federal/cosmetic-surgery-industry-exploiting-medicare-for-services-it-is-not-entitled-to-claim-20221018-p5bqsb.html

Competition	Limited competition between providers in the public health care system which is financed by a single payer with standardised pricing.	Greater price competition between providers, often through advertising on social media platforms.
Clinical governance	Access usually controlled through referral by independent third-party medical expertise such as GPs. Specialist practitioners (including surgeons) required to complete annual continuing professional development (CPD).[68]	Consumers may seek surgery directly. Practitioners who are not specialist surgeons are not required to complete surgical specific CPD.
Setting / data	Data usually collected through established centralised datasets that operate across public and private hospitals.	Surgeries can be performed in private clinics with no data-reporting obligations.

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

As noted previously, generally, the National Law regulates what professional titles health practitioners may use but it does not, with few exceptions, restrict what procedures they can perform.

Members of the public seeking advice about whom to consult to perform a given procedure generally obtain this information from a GP. Many cosmetic surgery consumers, however, do not discuss getting a procedure with a GP and source a cosmetic surgeon through other channels. 50 per cent of respondents to the consumer survey (420 respondents out of 839 that answered this question) reported that they did not talk to a GP before undertaking a cosmetic surgical procedure.[69]

Health regulators are more reliant, therefore, on the title protection provisions of the National Law to help consumers to identify and consult appropriate practitioners. This reliance may exacerbate the 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

[68] Continuing professional development or CPD is a requirement for registration and annual recertification for all registered medical practitioners in Australia. CPD requirements for specialist surgeons have a significant surgical component, whereas CPD requirements for practitioners who are not specialist surgeons will focus less on surgical skills development.

[69] The report of the Independent Review (p. 80) also noted that more than a third of all respondents used an internet search to find a cosmetic surgical practitioner and a further 17% used social media. Of dissatisfied cosmetic surgery consumers, 42% sourced the practitioner through an online search, a further 30% through the practitioner's social media accounts, and a further 19% from the practitioner or clinic's online or print advertisements.

- without adequate pre, intra and post-surgery management

resulting in post-operative complications and un-aesthetic and/or adverse outcomes.[70]

Current regulatory framework for cosmetic surgery

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

- codes and guidelines issued by regulators[71] including for example the Medical Board's *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* (2016), Code of Conduct, advertising guidelines, and the Therapeutic Goods Administration guidance on advertising
- Ahpra's public register of health practitioners
- federal regulation of therapeutic goods and state and territory poisons laws and regulation
- state and territory private health facility licensing laws
- state and territory health care complaints entities
- other legal frameworks including consumer law and regulation, the law of negligence, civil liability legislation and criminal law.

Further information on these regulatory frameworks, instruments and agencies that collectively contribute to the provision of safe surgical care is provided at **Appendix A** (Other elements in the regulatory framework for the performance of surgical procedures).

Reform context

Since the release of the Consultation RIS, health ministers have continued to have concerns about the issues outlined in the Consultation RIS, and regulation of the cosmetic surgery industry more generally.

Concurrently with health ministers' public consultation on the Consultation RIS, Ahpra and the Medical Board commissioned an external Independent Review of patient safety issues in the cosmetic surgery industry, which included consideration of how to strengthen the regulation of practitioners in the industry. The review was led by Mr Andrew Brown, former Queensland Health Ombudsman, supported by an expert panel.

The final report of the Independent Review was published on 1 September 2022.[72] The report made 16 recommendations to tackle cosmetic surgery issues within the existing framework of the National

[70] See, for example, case study examples in Appendix D of this Decision RIS and in the Consultation RIS: 'Evidence of consumer harm: Case studies', pp 39-40.

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

[72] Brown, A (2022). Final report: independent review of the regulation of medical practitioners who perform cosmetic surgery, commissioned by Ahpra and the Medical Board. Available from <https://www.ahpra.gov.au/News/Cosmetic-surgery-independent-review-of-patient-safety.aspx>

Scheme. These have been accepted by Ahpra and the Medical Board.[73] Health ministers subsequently endorsed the decision to implement all recommendations of the review at the 2 September 2022 HMM.

In their joint response to the independent Review, Ahpra and the Medical Board stated that a new Cosmetic Surgery Enforcement Unit will be established to:

- **Set clear standards** – including through the creation of an area of practice endorsement in cosmetic surgery. The response notes, "[i]f Ministers change the Law to protect the title 'Surgeon', then only doctors with AMC-accredited qualifications could be called Cosmetic Surgeons in future."
- **Crackdown on advertising** – including by enforcing a ban on testimonials that mislead and deceive consumers and trivialise risk, cracking down on advertising and social media used to promote cosmetic surgery, and updating and enforcing advertising restrictions and using new technologies to audit social media, backed by tougher regulatory action.
- **Tackle under-reporting** – encouraging reporting of patient harm in the cosmetic surgery industry, and writing to every doctor in Australia about their reporting obligations.
- **Strengthen patients' voice** – by targeting the misuse of non-disclosure agreements (NDAs) and launching a campaign to remind consumers that honest disclosure to regulators is legal and their right when things go seriously wrong, including establishing a consumer hotline.
- **Reinforce and strengthen existing guidelines** – The Medical Board will strengthen its guidance for medical practitioners performing cosmetic procedures and surgery, and require practitioners to inform their cosmetic surgery patients of their registration type as part of the informed consent processes to ensure patients are aware if their doctor does not hold specialist registration.
- **Change the way they deal with complaints** – including by establishing a national team of regulatory experts to investigate complaints and make decisions about cosmetic complaints.
- **Work with others** – including working with state and territory health authorities to close current loopholes and address inconsistencies in areas such as facilities licensing and drugs and poisons rules.

On 2 September 2022, Health ministers agreed to take further urgent action to address concerns regarding cosmetic surgery, especially the risks to consumers.[74] Health ministers announced they would:

- protect the title of 'surgeon' through legislative amendment, to ensure doctors using this title have the requisite training
- task the Australian Commission on Safety and Quality in Health Care (ACSQHC) to immediately begin work to safeguard patients by leading a review of licensing standards and arrangements of private hospitals, day procedure centres and clinics where cosmetic

[73] Available at: <https://www.ahpra.gov.au/News/Cosmetic-surgery-independent-review-of-patient-safety/Medical-Board-and-Ahpra-response-to-the-cosmetic-surgery-review.aspx>

[74] Health Ministers' Meeting, 'Statement on Cosmetic Surgery', Communiqué 2 September 2022, available at https://www.health.gov.au/resources/publications/hmm-statement-on-cosmetic-surgery-2-september-2022.

procedures are performed and to develop national standards for the safe delivery of high-quality cosmetic procedures

- Endorse the decision of the Medical Board to implement all recommendations of the independent Review, including to:
    - commence work on credentialing providers of cosmetic procedures through an 'Area of Practice' endorsement on a doctor's medical registration
    - initiate a crackdown on misleading advertising including the use of testimonials and social media
    - strengthen guidance and deliver education to the medical profession about the requirements for doctors performing cosmetic procedures and surgery, and
    - establish a national team of regulatory experts to address existing complaints.
    - request the Health Chief Executives Forum (HCEF) to commission a national public education campaign, and request the HCEF to commission a national public education campaign, and
    - withdraw clauses regarding patient testimonials from the bill that was at the time in the Queensland Parliament to amend the Health Practitioner Regulation National Law.

Further, a suite of National Law amendments was passed by the Queensland Parliament on 13 October 2022. Among these reforms are the introduction of the paramount principle of public protection and public confidence in the National Scheme, and increased penalties for advertising offences. Both of these reforms came into effect on 21 October 2022 and are expected to support improved outcomes for consumers, including cosmetic surgery consumers.

It is noted that many of the commitments recently announced by health ministers, Ahpra and the Medical Board substantially overlap with options canvassed in the Consultation RIS. These options are now considered part of the forward-looking status quo and excluded from analysis in this Decision RIS. This is further discussed in the section below on options for government to address the problem.

To the extent possible this Decision RIS therefore seeks to:

- have regard to the broader reform context in assessing the options in the Decision RIS and making recommendations, noting that aspects of other reforms – such as the approved qualifications for the proposed area of practice endorsement – are not known at the time of writing
- consider how these reforms recommended by this Decision RIS will operate in a complementary manner to other reforms, and
- provide information to inform health ministers' final decision on reforms that are the subject of this Decision RIS.

3. Problem statement

Overview of the problem

All medical practitioners registered under the National Scheme may use the title 'surgeon' in their practice regardless of whether or not they have obtained postgraduate level accredited surgical training. The 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'.

As outlined in the Consultation RIS, Health ministers are concerned that use of the title 'surgeon' by medical practitioners:

- may be confusing for the public, who may expect and/or believe that all medical practitioners who use the title have obtained comparable qualifications and training, and
- that this expectation or belief may be creating risks and harm to members of the public.

Health 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.

In turn, this may lead to diminished public confidence that the National Scheme is effective and medical practitioners are well-regulated. This is particularly significant in light of recent amendments to the National Law making clear that protection of the public and public confidence in the safety of services provided by health practitioners is the paramount principle guiding the application of the National Law.

Cosmetic surgery, if not properly performed by an appropriately qualified, trained, and experienced medical practitioner, has the potential to result in significant and permanent avoidable harm to individuals, including loss of function, disfigurement and death.[75]

Risks such as harm and ongoing complications are inherent in any surgery and regulation cannot eliminate all risk of harm. However, reports of risk and harm to consumers of cosmetic surgery have been consistent over an extended period,[76] are likely occurring at greater rates than for other forms of surgery[77] and may increase as demand for cosmetic surgery increases.[78]

It is important that consumers seeking to undergo surgery, including cosmetic surgery, are empowered to make informed choices about the medical practitioner that they choose and trust to

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[75] See for example, case studies in **Appendix D**. See also the Consultation RIS, 'Evidence of consumer harm: Case studies' at pp 39-40, available at <https://engage.vic.gov.au/medical-practitioners-use-title-surgeon-under-national-law>.

[76] See for example QHQCC (2013) 'Great expectations'; 'Knife's edge: cosmetic surgery has become a billion-dollar industry in Australia', *7.30* (ABC), broadcast 20 August 2015; 'Cosmetic cowboys: cosmetic surgery is a billion-dollar industry in Australia', 60 Minutes (Nine Network) broadcast 20 September 2015; 'Beauty's new normal', *Four Corners* (ABC), posted 13 August 2018 https://www.abc.net.au/4corners/beautys-new-normal/10115838; NSW Parliament Committee on the Health Care Complaints Commission, 2018.

[77] International studies have placed the rate of postoperative complications at around 20% – see Ludbrook, G.L. The Hidden Pandemic: the Cost of Postoperative Complications. *Current Anesthesiology Reports* 12, 1–9 (2022). https://doi.org/10.1007/s40140-021-00493-y and the 'Risk and harm associated with cosmetic surgery – consumer survey responses' section of this report.

[78] Arna Richardson, *Industry Report OD4199 Plastic Surgeons in Australia Market Research Report: Waiting List: Travel restrictions due to COVID-19 boost industry demand in the current year* (Ibis World, October 2021).

perform their cosmetic surgery. As previously outlined, there is significant information and power asymmetry between healthcare consumers and practitioners that may contribute to the risk of harm to consumers.

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.[79] However, it can be difficult for the public to obtain information from neutral and informed sources, particularly as most cosmetic surgery consumers obtain information about prospective procedures directly 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.[80]

As set out in this Decision RIS (see section 7), health ministers' concerns have been broadly confirmed by consultation feedback received in response to the Consultation RIS and the consumer survey responses.

These issues were also raised in the Independent Review, which noted that consumers emphasised that practitioners' training and qualifications are important matters to them and that they rely heavily upon what they are told by their doctors about their training, qualifications and experience.

The Independent Review further remarked:

> *"Consumers are largely left on their own when it comes to selecting a practitioner to perform cosmetic surgery. Often they are required to sift through a plethora of advertising and marketing material, seek to understand various titles and try to make sense of numerous qualifications, all in an attempt to identify a qualified and competent practitioner. This is an unacceptable situation."*[81]

This information asymmetry inhibits consumers from being able to make fully informed decisions when seeking a practitioner to perform surgery, particularly cosmetic surgery. There are significant concerns that this may be contributing to risks of harm, particularly in relation to cosmetic surgery. This can be viewed as a market or regulatory failure that warrants government action. Options for responding to the problem are outlined and assessed in this Decision RIS. These issues also contribute to a risk of diminished public confidence in the National Scheme and its ability to effectively regulate medical practitioners and protect consumers.

Affected stakeholders

Consumers

Consumers seeking to undergo surgery, particularly cosmetic surgery, are the group impacted by these problems. As previously noted, existing regulation, which allows any medical practitioner to use the title 'surgeon', may be confusing for consumers, who may assume that practitioners using the title have advanced surgical qualifications.

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

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

[81] *Independent review of the regulation of medical practitioners who perform cosmetic surgery*, 5.

In relation to cosmetic surgery specifically, 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. The Consultation RIS[82], as well as **Appendix D** of this Decision RIS, include evidence 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
- inadequate provision of local anaesthetic and/or anaesthesia medication
- excruciating pain
- haemorrhage
- excessive tissue trauma
- scarring
- local anaesthetic toxicity
- sepsis
- pneumothorax (collapsed lung)
- central nervous depression
- cardiac arrest
- death.

Reports of harm (also documented in the Consultation RIS) have continued to be reported, including through major media outlets, and include:

- lacerated liver (caused by incompetent liposuction)
- numbness and loss of sensation
- disfigurement
- bleeding ears
- chronic headache[83]

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[82] Available at https://engage.vic.gov.au/medical-practitioners-use-title-surgeon-under-national-law.

[83] Adele Ferguson, 'Cosmos Clinics faces two class action investigations', *The Age* (Cosmetic surgery: Cosmos Clinics faces two class action investigations (theage.com.au), 25 June 2022.

- humiliation (caused by practitioners laughing while filming and working on unconscious patients)
- shooting pains and nerve damage
- anxiety and depression
- inadequate provision of local anaesthetic and/or anaesthesia medication.[84]

Consumers reported significant levels of harm in responses to the consumer survey, with 28% of respondents who had, or knew someone who had, undergone cosmetic surgery reporting an experience of harm (n. 237). This is discussed further in the Consultation section.

More broadly, consumers and the community are impacted by:

- confusion about which medical practitioners consumers should consult for safer cosmetic surgery
- impacts on public confidence in the medical and other professions (such as nurses who work in cosmetic surgery facilities)[85]
- impacts on public confidence in the regulation of health services and the regulators[86]
- potential increased costs of regulating cosmetic surgery, which may be passed on to practitioners (in higher registration fees) and consumers (in higher consultation and operating fees).

Additional downstream community costs may also include a growing increase in rates of other important avoidable harm, if members of the public delay seeking care for other health problems due to reduced confidence in the profession and the health system.

Despite these alarming reports of harm, quantifying the prevalence of cosmetic surgery and the impacts of avoidable harms from cosmetic surgery on individuals and the community is difficult.[87] While information to support quantitative estimates was sought through the Consultation RIS, complete and reliable quantitative data to estimate these impacts is scarce or not available, and this was acknowledged and confirmed in many submissions to the Consultation RIS. However, those respondents that did respond to questions about the volume of cosmetic surgery undertaken in Australia strongly hold the view that the volume of cosmetic surgery performed in Australia is increasing. The problem of the paucity of cosmetic surgery data in Australia has been recognised by Health ministers who are developing a national plan for improving collection of data on cosmetic surgery.

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[84] Adele Ferguson and Joel Tozer, ''Please help me, I can't die': how social media lured Keisha to the dark side of cosmetic surgery', *The Age* Joseph Ajaka's Cosmos Clinics exposed: Inside Australia's cosmetic surgery underbelly (theage.com.au), 9 June 2022.

[85] The Independent review comments in its final report: "it appears that there is a weak reporting and safety culture in many areas of cosmetic surgery and patient safety concerns are not being notified in a timely way as required by doctors, nurses or other health professionals who become aware of these practices", pp. 117-118. See also Dana Daniel, Doctors opposed to push to name and shame doctors under investigation for misconduct (theage.com.au), *The Age*, 8 June 2022.

[86] See Consultation, Views on regulation and advertising of cosmetic surgery, Consumer survey responses section of this RIS.

[87] For further information, see **Appendix B** – Challenges with estimating the cost of consumer harm from cosmetic surgery.

Health professionals

Poor cosmetic surgery outcomes harm the medical profession and the National Scheme at large. The principal impact of poor outcomes on the profession and the National Scheme are loss of reputation and trust. This risk has been identified by practitioners themselves. One respondent to the Consultation RIS, for example, stated that 'a small number of practitioners' are tainting 'all cosmetic surgeons'.

The final report of the Independent Review found a 'significant underreporting of safety issues by registered health practitioners and employers in the cosmetic surgery sector'. Health practitioners are required to make mandatory notifications when there is a concern about a practitioner's impairment, intoxication while practising, significant departure from accepted professional standards, and sexual misconduct and there is a risk of harm to the public.[88] The Independent Review noted that while mandatory notifications comprised 12.5% of all notifications received by Ahpra during the 2021-22 financial year, it appears that not a single mandatory notification by other registered practitioners was received by Ahpra in relation to cosmetic surgery between July 2018 and December 2021.[89] The Review also notes that 'if the ratio of mandatory to voluntary notifications for cosmetic surgery matters was similar to the average in all matters' across the National Scheme, then 'approximately 22 mandatory notifications relating to cosmetic surgery' would be expected, rather than 'zero'.[90]

Health ministers are also aware of reporting by medical indemnity insurers noting a high incidence of complaints about surgical outcomes, practitioner behaviours, and consent issues.[91] While these complaints must not be treated as proven in every case or even in many cases, it is reasonable to infer that a significant number of cosmetic surgery consumers have reasonable grounds to be dissatisfied with the care (pre-operative, intra-operative and post-operative) they receive and that in total, poorly performed cosmetic surgery may be damaging the reputation of the medical profession in general and the health system more broadly. This may lead to a reduction in consumer confidence and trust in the industry.

Governments and regulators

The harms caused to governments and regulators by poor cosmetic surgery outcomes are similar to the harms caused to the community at large and outlined above. They include:

- impacts on public confidence in the ability of the National Scheme to protect the public[92]
- impacts on public confidence in the performance of regulators and government

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[88] Treating practitioners in Western Australia are exempt from these reporting requirements but may still be obliged to make a notification as a non-treating practitioner. See Ahpra and National Boards, 'Guidelines: Mandatory notifications about registered health practitioners' (March 2020), p. 2.

[89] *Independent review of the regulation of medical practitioners who perform cosmetic surgery* pp. 8, 51. The Independent Review final report noted that of the 177 notifications received about cosmetic surgery matters between 1 July 2018 to 31 December 2021 and finalised by 31 December 2021, none were mandatory notifications. However, it was possible that a mandatory notification or notifications may have been made but not finalised in the review period.

[90] Ibid., p. 51.

[91] Avant, 'Claims and Complaints Insights: Plastic, Reconstructive and Cosmetic Surgeons' (Avant - Claims and complaints insights plastic, reconstructive and cosmetic surgeons).

[92] Mark Ashton, "Worse than Wild West: Cosmetic Cowboys Must be Reined in" Cosmetic surgery scandal: cowboys must be reined in (theage.com.au), *The Age*, 13 June 2022.

- increased regulatory costs associated with the management of cosmetic surgery notifications if harms continue or increase over time
- increased public health system costs associated with repairing cosmetic surgery harms to consumers and delayed care for other conditions.

Government and regulators are charged with ensuring that regulation protects the public. This obligation has recently been strengthened by legislation through the recent suite of changes to the National Law including the introduction of the paramount principle of public protection and public confidence in the National Scheme, and the increased penalties for advertising offences, which commenced on 21 October 2022 and are expected to support improved outcomes for cosmetic surgery consumers.

The public in turn expects governments and regulators to help to ensure that they are able to access quality information to help them make safer health care choices. Failure to do so may diminish consumers' confidence in the regulatory scheme. Respondents to health ministers' consumer survey who had, for example, accessed the Ahpra register of practitioners frequently commented that improvements are needed.

Some members of the public also indicated that they expected government would not allow medical staff who do not hold specialist medical qualifications to call themselves surgeons, attesting to the importance of professional titles to consumers. For example, when discussing why they did not deem it necessary to consult a GP before undertaking a cosmetic surgical procedure, one respondent stated:

> *'I assumed the Government wouldn't allow non-qualified medical staff [to] call themselves Surgeons unless they had the same level of training as Plastic Surgeons!'*

4. Why is government action needed?

The feedback from consumers and professional stakeholders on the Consultation RIS have substantiated Health ministers' concern that there is significant public confusion about medical practitioners' titles and qualifications associated with the use of the title 'surgeon'. Feedback has also confirmed there are significant concerns about risk and harm associated with the cosmetic surgery industry. These consultation outcomes are set out in more detail in the section of the Decision RIS titled 'Consultation'.

The consultation outcomes suggest there is a substantial gap between how consumers may understand the title 'surgeon' and how some practitioners use the title, particularly in relation to cosmetic surgery. This information asymmetry provides an unfair advantage in the marketplace for practitioners who may leverage the credibility and prestige conveyed by the title to attract customers. This market failure may be contributing to serious and unacceptable risks and harm to consumers who agree to undergo cosmetic surgery, as evidenced by numerous patient testimonies, case studies and media reports.

As such, some instances of consumer harm from cosmetic surgery may be preventable and stem from market and regulatory failure. Without government action, existing levels of consumer confusion about practitioners' use of titles and qualifications, risk and harm to cosmetic surgery patients, and erosion of confidence in the National Scheme are likely to continue.

Health Ministers are obligated by their governing responsibilities of the National Scheme to take meaningful action to address these information asymmetries and the continuing incidence or the

risk of continuing incidence of such harm. Although protecting the public by assuring the training and competency and 'ethical manner' of registered practitioners has been a cardinal objective of the National Scheme since its inception, Health ministers in 2022 approved the insertion of a new 'guiding principle' into the National Law stating that protection of the public, and public confidence in the safety of services provided by registered health practitioners and students, are 'paramount'. This strongly suggests that any competition between the interests of practitioners and public safety and confidence in the health system should be resolved in favour of the latter.

Consumers' confusion around titles undermines the ability of the National Scheme to safeguard public confidence in the quality and safety of services provided by accredited health practitioners. Consistent with the paramount principle, government action is necessary to address this. Failure to ensure this public confidence may lead to loss of repute and trust for not only the National Scheme, but also for wider health care regulation and the wider health care profession.

Finally, government has an interest in ensuring that its regulatory frameworks achieve their stated outcomes. This is important not only so that government can deliver benefits to the public, but also to avoid unnecessary regulatory costs involved in implementing and ensuring compliance to ineffective regulation.

The need for government action has also been separately confirmed by Ahpra, the Medical Board and Health ministers, particularly in relation to cosmetic surgery, including through the implementation of the recommendations of the Independent Review and related reforms. These concurrent reforms have been taken into account in developing this Decision RIS.

Options for government to take action to address the identified concerns are outlined below in section 5.

5. Options for government to address the problem

Option 1 – Base case (maintaining the status quo)

The Consultation RIS (which was released in December 2021), at the time identified a 'status quo' option that would see no legislative reform or implementation of other options considered in the Consultation RIS.

Since that time (as noted under 'Reform Context') there have been a number of significant commitments made – by Health ministers, Ahpra and the Medical Board – that substantially overlap with options in the Consultation RIS and that therefore affect the base case for this Decision RIS.

Following consultation with the Office of Best Practice Regulation (OBPR), it has been determined that the base case should be revised to take account of reforms that have already been committed to and are likely to be implemented. These are summarised in the table below.

Table 2 - Announced reforms (base case)

Announced reforms	Options covered in Consultation RIS
Implementation of all recommendations of the Independent Review by Ahpra and the Medical Board, including: • establishment of an area of practice endorsement for cosmetic surgery, and accompanying public education campaign • establishment of a Cosmetic Surgery Enforcement Unit in Ahpra • establishment of an Ahpra hotline for complaints about cosmetic surgery • production by Ahpra and the Medical Board of educational material for members of the public who make a notification about a cosmetic surgery matter • production by Ahpra and the Medical Board of educational material for practitioners about making mandatory and voluntary notifications about matters involving significant departures from accepted professional standards, that place the public at risk of harm • reviewing Ahpra and the Medical Board's regulatory approach to advertising in the cosmetic surgery sector • reviewing the Medical Board's Guidelines for medical practitioners who perform cosmetic medical and surgical procedures.	Consultation RIS options 2.1 and 3
Health Chief Executives Forum to commission a national public education campaign	Consultation RIS option 2.1

In addition, the ACSQHC has also been tasked by health ministers with:

- leading a review of licensing standards and arrangements for private facilities where cosmetic procedures are performed, and
- developing national standards for the safe delivery of high-quality cosmetic procedures.

Additional background on the proposed area of practice endorsement is also set out below.

These announced reforms have led to changes to the forward outlook of the base case, which, as per the Australian Government's guidance on cost-benefit analysis,[93] should recognise the world in which the regulation will be implemented as opposed to the current situation. The base case in this Decision RIS therefore reflects a scenario where these reforms will be implemented.

Under the revised base case, medical practitioners could continue to use the title 'surgeon' as they do currently, regardless of whether they have obtained a specialist qualification. Medical practitioners will still be required to practise in accordance with code of conduct requirements set out by the Medical Board,[94] and those performing cosmetic surgical procedures must continue to abide by the Board's guidelines for performing cosmetic procedures.[95] 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.[96]

Background on area of practice endorsement

An area of practice endorsement is another mechanism by which information can be communicated to consumers about a practitioners' qualifications. Under section 15 of the National Law, the Ministerial Council, on the recommendation of a National Board (such as the Medical Board) may approve an area of practice for which the registration of a health practitioner may be endorsed. This mechanism under the National Law already exists, is separate from title protection and can be introduced without legislative amendment.

Health ministers have endorsed the decision of the Medical Board to establish an area of practice endorsement for cosmetic surgery. Subject to health ministers formally approving that an area of practice endorsement operate for cosmetic surgery, and approving a registration standard for the area of practice endorsement as recommended by the Medical Board, a practitioner could apply for the endorsement.

To obtain an endorsement, a practitioner would be required to meet the requirements of the registration standard and demonstrate that they hold a qualification approved by the Medical Board for the purposes of that area of practice or another qualification that, in the Board's opinion, is substantially equivalent to or based on similar competencies to, an approved qualification. Critical to the establishment of an area of practice endorsement is the development of an accreditation standard by the relevant accreditation authority (in this case, the AMC) for approval by the Medical Board. The accreditation standard for the endorsement will be used to assess whether a program of

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[93] Available at <https://obpr.pmc.gov.au/sites/default/files/2021-09/cost-benefit-analysis.pdf>

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

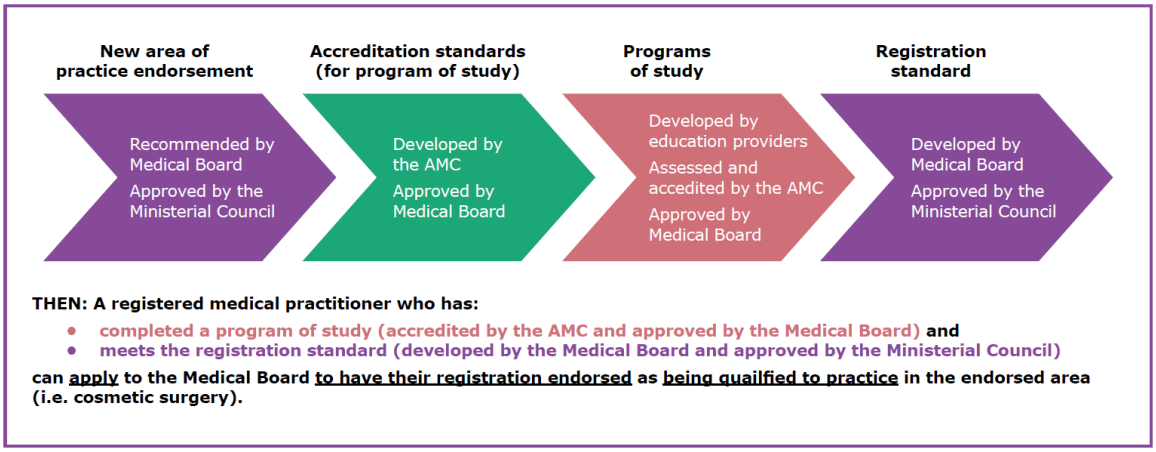
[95] Medical Board (2016) 'Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures'.

[96] See example Australian College of Cosmetic Surgery and Medicine, 'ACCSM Policies and Codes', retrieved 22 November 2021, 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.

study and the education provider that provides the program of study, provides an approved qualification for the endorsement.

Figure 1 below, reproduced from the final report of the Independent Review, sets out the process for an endorsement.

Figure 1 – Endorsement process (from Independent Review report) [97]



It is an offence under section 119 of the National Law for a practitioner to hold themselves out as holding, or being qualified to hold, an endorsement they do not hold or are not qualified to hold.

Further, as stated in the report of the Independent Review:

> *"if an endorsement for cosmetic surgery was approved, it would be easy for consumers to identify practitioners who have an endorsement as the endorsement would be listed on the public register. Practitioners would be permitted to advertise themselves as having an endorsement for cosmetic surgery and those without an endorsement would be prohibited from claiming to hold one."*[98]

It is noted the consumer survey responses indicate there is limited use of the public register by consumers. The ease with which potential consumers and patients could access and interpret information such as an area of practice endorsement could therefore be improved by targeted public information campaigns such as that endorsed recently by health ministers (as noted in the 'Preferred option' section of this Decision RIS).

Option 2 – Strengthening guidance on use of the title 'surgeon' using existing mechanisms in the National Scheme

This option would involve the use of existing mechanisms in the National Scheme to provide strengthened guidance to medical practitioners on use of the title 'surgeon', and potentially to improve consumers' understanding of practitioners' qualifications and titles.

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[97] Independent Review, Final Report, p. 34.

[98] Independent Review, Final Report, p. 6.

This would partially implement Option 3 in the Consultation RIS, which noted (among other matters) that existing mechanisms in the National Scheme could be strengthened to make it easier for members of the public to:

- understand the titles that medical practitioners use, and
- rely on the title protection regime to effectively discipline and guide medical practitioners' use of titles.[99]

While a range of non-legislative actions relating to strengthening existing mechanisms under the National Scheme have already been committed to by Ahpra and the Medical Board (and hence considered part of Option 1 in this RIS), this option only considers specific actions relating to the use of the title 'surgeon'. Matters relating to protection of the title 'surgeon' were noted in the Independent Review as being outside the scope of that review, due to the issue being considered by health ministers.[100]

Such actions would include using codes and guidelines to provide additional advice or direction to medical practitioners on the use of the title 'surgeon' by medical practitioners (rather than amending legislation to restrict its use). For example, existing mechanisms that could be updated administratively include, for example:

- the Medical Board's Code of Conduct[101]
- the *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*[102]
- other guidelines for medical practitioners, including any new guidelines the Board may deem necessary or advisable.

Codes and guidelines are admissible in proceedings under the National Law or a law of a co-regulatory jurisdiction against a health practitioner as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Current codes and guidelines do not include specific guidance on use of the title 'surgeon' and include only high-level advice in relation to qualifications and titles. For example, clause 9.1 of the *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures* states that:

> *'A medical practitioner must not make claims about their qualifications, experience or expertise that could mislead patients by implying the practitioner is more skilled or more experienced than is the case. To do so is a breach of the National Law (sections 117 – 119).'*

The guidelines state that they 'aim to inform registered medical practitioners and the community about the Board's expectations of medical practitioners who perform cosmetic medical and surgical procedures in Australia'. The guidelines or other instruments could potentially be strengthened to set out clearer expectations about when it might not be appropriate for a medical practitioner to use the title 'surgeon' (or 'cosmetic surgeon'). For example, guidelines could be amended to suggest

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[99] Consultation RIS, p. 63.

[100] Independent Review, Final Report, p. 6.

[101] *Good Medical Practice: a code of conduct for doctors in Australia*. Available at: https://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

[102] *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*. Available at: https://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

practitioners avoid using the title 'surgeon' if the practitioner has not completed significant postgraduate surgical training.

However, the extent to which these instruments could regulate the use of titles or make similar claims is limited by the nature of the instruments. While they could provide guidance or set clear expectations, they could not, for example, prohibit the use of the title 'surgeon' by any medical practitioners as this is a matter that is regulated by the National Law itself rather than the instruments made under it.

Option 3 – Restrict the title 'surgeon' in the National Law

This option would involve amendments to the National Law to protect the title 'surgeon' and restrict its use to certain medical practitioners.

There are two sub-options for Option 3, corresponding to Options 4.1 and 4.2 in the Consultation RIS. The sub-options set out different criteria for the medical practitioners that would be permitted to use the title 'surgeon':

- Option 3.1 would limit the use of the title to the 10 surgical specialty fields of practice approved by the Ministerial Council. These are:
    1. Cardio-thoracic surgery
    2. General surgery
    3. Neurosurgery
    4. Orthopaedic surgery
    5. Otolaryngology – head and neck surgery
    6. Oral and maxillofacial surgery
    7. Paediatric surgery
    8. Plastic surgery
    9. Urology
    10. Vascular surgery.
- Option 3.2 would limit the use of the title to specialist medical practitioners with significant surgical training.

Restricting the title 'surgeon' within the medical profession under either option 3.1 or 3.2 would require amendments to the title protection provisions in Part 7, Division 10 of the National Law.

Subdivision 1 of this Division contains an existing title protection scheme which sets out powers to prosecute or take disciplinary action against persons who:

- unlawfully take or use a protected title
- unlawfully hold themselves or another person out as a registered health practitioner
- claim that they or another person hold a type of registration or endorsement that they do not.

Either of options 3.1 or 3.2 would require amendments to the National Law to restrict use of the title 'surgeon' by medical practitioners to an authorised cohort of practitioners. As noted previously, this will change the current law which permits any medical practitioner to call themselves a 'surgeon'.

New offences would also be created for medical practitioners and other persons for unauthorised use of the new protected title. If the penalties for this offence were set at the same level as existing title protection offences, unauthorised use of the title 'surgeon' would carry a maximum penalty of $60,000 or 3 years' imprisonment or both for an individual, and $120,000 for a body corporate. Breaches of the title restriction provisions would also constitute grounds for health, performance and conduct action against a practitioner by the Medical Board.

It is important to note that restricting use of the title 'surgeon' would 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 or other medical specialty. However, if the title was restricted, practitioners who were restricted from using the title (which may include some practitioners who currently use the title in their professional practice) would be directly affected in the way they market their services and prohibited from using the title 'surgeon'.

Option 3.1 – Restricting the title 'surgeon' to the 10 surgical specialty fields of practice

If Option 3.1 were legislated, then only medical practitioners entitled to use one of the 11 specialist surgical titles (associated with the 10 fields of surgical specialty practice) approved by the Ministerial Council would be permitted to refer to themselves as a 'surgeon'. Other medical practitioners who currently use the title 'surgeon', including those who have undertaken surgical training as part of a specialist qualification, would no longer be permitted to do so if they are not registered in a field of specialist surgical practice.

As of 30 June 2022, there were 131,953 medical practitioners registered in Australia (including 1,367 on the 2020 and 2021 Pandemic response sub-registers). Of these 6,441 (5%) are specialist surgeons and would be permitted to use the title 'surgeon' if this option were implemented.

Option 3.2 – Restricting the title 'surgeon' to medical practitioners with significant surgical training

If Option 3.2 were legislated, a significant cohort of specialist medical practitioners who have undertaken substantial surgical training and who practice sophisticated surgery as part of their normal scope of practice would be added to those practitioners within the scope of Option 3.1 who would also be permitted to continue to use the title 'surgeon'.

The precise scope of this option would depend on what is determined to constitute 'significant' or 'substantial' surgical training. To ensure appropriate flexibility, if this option were implemented the classes of practitioners authorised to use the title 'surgeon' could be specified in an administrative instrument that could be updated by health ministers from time to time on the recommendation of the Medical Board.

As the primary regulator of medical training, accreditation and registration standards in Australia, the Medical Board is considered an appropriate body to advise health ministers on this matter. The Board is responsible for registering medical practitioners and medical students. It develops standards, codes and guidelines for the profession, investigates notifications and complaints about medical practitioners, and conducts panel hearings and refers serious health, performance and conduct matters to Tribunals. The Board also assesses international medical graduates who wish to practice in Australia and approves accreditation standards and accredited courses of medical training, in partnership with the AMC, the independent national standards body for medical education and training (see also Glossary).

As outlined below, the Medical Board provided advice to health ministers in relation to this option. The impact analysis of this option outlined in the RIS is based on the scope of the title restriction if the Medical Board's advice were to be adopted by health ministers.

Advice from the Medical Board of Australia

Following the 2 September 2022 HMM, in which ministers confirmed their intention to progress reforms to restrict the use of the title 'surgeon', health ministers requested advice from the Medical Board on which medical practitioners, in the Board's view, should be permitted to use the title 'surgeon'.

In response to the request from HMM, the Medical Board recommended that the title 'surgeon' only be used by medical practitioners who have successfully undertaken significant, AMC specialist surgical training (or equivalent in the case of international medical graduates with specialist registration).

The Medical Board has advised that these are:

- Individuals with specialist registration in surgery. This includes the following fields of specialty practice:
    1. Cardio-thoracic surgery
    2. General surgery
    3. Neurosurgery
    4. Orthopaedic surgery
    5. Otolaryngology – head and neck surgery
    6. Oral and maxillofacial surgery
    7. Paediatric surgery
    8. Plastic surgery
    9. Urology
    10. Vascular surgery
- Individuals with specialist registration in Ophthalmology – commonly referred to as 'eye surgeons'
- Individuals with specialist registration in Obstetrics and gynaecology – commonly referred to as 'gynaecological surgeons'.

The Medical Board considered whether to recommend to health ministers that specialist general practitioners (GPs) be allowed to use the title 'surgeon' but did not do so as they have not completed AMC accredited specialist surgical training.

The Medical Board also considered whether individuals who have an endorsement on their registration for cosmetic surgery should be able to use the title. The Board agreed that endorsed individuals should only be able to use the title 'surgeon' if they also have successfully completed AMC-accredited specialist surgical training and have specialist registration in the relevant area. That is, someone with an endorsement who does not have AMC-accredited specialist surgical training should not be permitted to call themselves 'surgeon'.

It is also noted that approved qualifications for an area of practice endorsement for cosmetic surgery have not yet been determined. This will be undertaken as part of the work to establish the area of practice endorsement.

6. Assessment of reform options

Cost–benefit analysis (CBA) is used to assess regulatory proposals in order to encourage better decision making. As set out in the Australian Government's CBA guidance material,[103] CBA involves a systematic evaluation of the impacts of a regulatory proposal, accounting for all the effects on the community and economy, not just the immediate or direct effects, financial effects or effects on one group. It emphasises, to the extent possible, valuing the gains and losses from a regulatory proposal in monetary terms.

However, as noted in the Australian Government's CBA guidance, it can often be difficult to identify and measure the effects of a proposed regulation. The principal challenge for this RIS is that while cosmetic surgery procedures are evidently a traded commodity within a market, the magnitude of the incremental impact of policy options is uncertain due to limitations in available quantitative data and evidence on a range of metrics including:

- the number of cosmetic surgery procedures that occur in Australia per year
- the proportion of procedures that result in adverse outcomes and harm to patients
- the cost of harm for consumers and others (such as public health systems where treatment is required after a harmful procedure)
- the cost of regulating cosmetic surgeons and cosmetic surgery.

These limitations have been well documented in previous attempts to understand and ameliorate harm arising from cosmetic surgery,[104] and have also been noted in the Consultation RIS and subsequently confirmed by stakeholder responses.

Further discussion of these data limitations, including attempts to provide estimates to unknown variables can be found in **Appendix B**. Give the paucity of extant data, it is not feasible to develop an accurate baseline estimate of the level of harm currently experienced by consumers of cosmetic surgery procedures. In turn, it is not possible to quantify the effect of different policy options under consideration on reducing levels of harm.

Additionally, it was not feasible to quantify or monetise the benefits achieved by the different options in terms of correcting market and regulatory failure. While many stakeholders through consultation have made clear that the current state of information asymmetry is unacceptable, there is limited information available to quantify this impact.

Another challenge in conducting a CBA for this Decision RIS is the rapidly evolving reform environment around cosmetic surgery procedures which reflects the urgency for government action to prevent further consumer harm. As noted under 'Reform Context', since the commencement of this RIS process, Ahpra, Medical Board, and health ministers have committed to implementing a suite of reforms within the scope of options raised in the Consultation RIS.

These forthcoming reforms have led to changes to the forward outlook of the base case, which, as per the Australian Government's CBA guidance, should recognise the world in which the regulation will be implemented as opposed to the current situation. Accordingly, Option 1 of this decision RIS has been modelled on a status quo scenario where these reforms are assumed to be implemented.

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[103] Available at https://obpr.pmc.gov.au/sites/default/files/2021-09/cost-benefit-analysis.pdf.

[104] Independent Review, 2022; NSW Parliament Committee on the Health Care Complaints Commission, 2018.

In turn, the analysis of Options 2 and 3 consider the incremental impacts of additional reforms in relation to use of the title 'surgeon'.

Given the challenges noted, where impacts are not able to be quantified, this Decision RIS has followed Australian Government's CBA guidance which indicates that the impact assessment should be qualitative, supported by quantitative information where possible.

Assessment methodology

The reform options outlined in this Decision RIS have been assessed using the following analyses:

- a qualitative assessment of the costs and benefits of each option
- a quantitative assessment of the regulatory burden associated with each option
- a comparative assessment of the extent to which each option is likely to address the identified problem.

The cost-benefit analysis assesses these impacts in relation to the following categories of impacted stakeholders:

- consumers
- medical practitioners
- government and regulators, and
- the broader health sector.

The regulatory burden analysis has been undertaken in accordance with the Australian Government's Regulatory Burden Measurement Framework.

Where quantitative assessment has been undertaken, this has been developed using available sources including:

- research undertaken to inform the development of the Consultation RIS
- information published in the Consultation RIS
- information provided in stakeholder submissions
- other publicly available information.

Further information on the methodology and assumptions underpinning the quantitative assessment is at **Appendix C**.

The comparative assessment of the extent to which each option is likely to address the identified problem is an alternative means of understanding the overall benefits of the options in the Decision RIS. Each option has been assessed against the following criteria, reflecting the problem statement in this Decision RIS:

- **addressing information asymmetry –** to what extent would the option address consumers' confusion about medical practitioners' titles and qualifications?
- **improving public protection –** to what extent would the option reduce consumers' exposure to unacceptable risks and harm associated with poorly performed cosmetic surgery?

- **promoting confidence in the National Scheme –** to what extent would the option increase the public's confidence that the National Scheme is effective and medical practitioners are well-regulated?

Option 1 – Base case (maintaining the status quo)

Impact analysis of Option 1

Benefits and costs

As previously outlined, for the purposes of this Decision RIS the status quo includes a range of reforms already committed to by health ministers (as well as Ahpra and the Medical Board) and that are in the process of being implemented.

Although they now form the status quo, it is important to recognise that the suite of impending reforms, once implemented, is anticipated to yield a range of benefits including:

- improving consumer knowledge on medical practitioners' qualifications and titles, the cosmetic surgery industry, and service obligations and consumers' legal rights
- deterring practitioners from operating beyond their competence and qualifications, and from using false or misleading advertising
- encouraging practitioners to provide services responsibly, including by obtaining the area of practice endorsement in cosmetic surgery.

As such, the status quo is already associated with incremental improvements on a range of key problems identified in this RIS (and when compared to the status quo outlined in the Consultation RIS), including:

- greater public confidence in the National Scheme
- more informed decision making for consumers seeking to undergo surgery (including cosmetic surgery)
- reduced risk of harm to cosmetic surgery consumers
- reduced harms leading to reduced impact on tertiary and public health systems.

For the purpose of this Decision RIS, this state of affairs is taken as the baseline. The analysis of options 2 and 3 below will outline the anticipated incremental benefits and costs against this baseline.

The table below outlines the range of costs and benefits associated with the base case (maintaining the status quo).

Table 3 - Cost-benefit analysis: Option 1

	Benefits	Costs
Consumers	• No additional impact on cosmetic surgery market (including pricing and supply).	• Consumer confusion about practitioners' titles and qualifications in relation to use of the title 'surgeon' will not be addressed. • Consumers may continue to experience difficulty assessing

		suitably qualified practitioners and may continue to be exposed to risk and harm. • Unclear if base case reforms alone are sufficient to improve consumers' confidence in the cosmetic surgery industry.
Medical practitioners	• No additional compliance costs for practitioners.[105] • All practitioners who use the title 'surgeon' may continue to do so.	• Unclear if base case reforms alone are sufficient to improve in the cosmetic surgery industry.
Government and regulators	• No additional implementation costs for regulators. • No additional costs associated with developing policy or legislation.	• Unclear if base case reforms alone are sufficient to improve confidence in the regulatory system. • Expectations of government action to address an issue of public concern will not be met.
Broader health sector		• Costs to public health system associated with revision surgery for consumers who have suffered poor outcomes may continue.

There are a range of costs associated with maintaining the status quo.

Critically, under the existing title protection scheme, all medical practitioners will still be able to use the title 'surgeon' in how they promote their services, regardless of their level of advanced surgical training. This includes use of the informal title 'cosmetic surgeon', which will continue to have no restrictions on its use by medical practitioners (unlike specialist titles such as 'specialist plastic surgeon'). In turn, information asymmetry marketplace will persist and consumers will likely remain confused about the qualifications of those who use the title 'surgeon'.

This may contribute to consumers of cosmetic surgery continuing to be exposed to unacceptable risk and harm. Consumers' confidence in the regulatory system, as well as the cosmetic surgery industry, may continue to be negatively impacted.

This will also attenuate the benefits of forthcoming reforms, including most notably:

- **Area of practice endorsement** – without title protection, those who do not have advanced surgical qualifications may continue to use the title 'surgeon'. Compared to pursuing an area of practice endorsement, the use of the title 'surgeon' is free, does not require time investment, and may afford a comparable level of credibility with consumers. As such, the value of an area of practice endorsement would be enhanced if practitioners without

[105] It is expected that some practitioners will be influenced by the reforms in the base case to change how they currently use titles in advertising or to pursue the practice of area endorsement. These entail additional costs compared to the status quo considered in the Consultation RIS, however for the purposes of this RIS has been assumed to be the new baseline cost of doing business.

advanced surgical qualifications are not able to continue using the title 'surgeon'. At worst, the introduction of area of practice endorsement without title protection may exacerbate existing consumer confusion around titles and qualifications.

- **Public education campaign** – the ability for campaigns to provide clarity to consumers on matters relating to medical practitioner use of titles and qualifications will be limited if there remains uncertainty and variation in the experience and qualifications of those who are able to use the title 'surgeon.'

Regulatory burden estimate

While there may be a regulatory burden associated with implementation of the reforms within this option, these reforms are considered part of the base case and so for the purposes of this Decision RIS the regulatory burden associated with Option 1 is assumed to be zero.

Option 2 – Strengthening guidance on use of the title 'surgeon' using existing mechanisms in the National Scheme

Impact analysis of Option 2

Benefits and costs

Strengthening existing mechanisms in the National Scheme (such as creating new or updating existing codes and guidelines) to provide specific guidance on the use of the title 'surgeon' may have incremental benefits on the problem by making the Medical Board's expectations about the appropriate use of the title 'surgeon' clearer to medical practitioners and consumers. Given that this option proposes administrative reform through existing mechanisms it is considered to have relatively lower cost impacts on all stakeholder groups than Option 3.

Providing specific guidance on the use of the title 'surgeon' would clarify the Medical Board's expectations around the use of the title. Medical practitioners and cosmetic surgery providers who currently use the title 'surgeon' may consider whether as a result of the guidance they should adjust their use of the title 'surgeon'.

The table below summarises the anticipated benefits and costs associated with Option 2.

Table 4 - Cost-benefit analysis – Option 2

	Benefits	Costs
Consumers	• Minimal impact on cosmetic surgery market (including supply and prices). • Some limited potential to improve consumers' understanding of practitioners' titles and qualifications.	• Consumer confusion about practitioners' title and qualifications in relation to the use of the title 'surgeon' is likely to persist. Risk that guidance may be confusing to consumers if there is no actual restriction on use of the title. • Limited ability to limit consumers' exposure to risk and harm as a result of confusion about practitioners' titles and qualifications.

		• Unclear if this would be sufficient to improve consumers' confidence in the cosmetic surgery industry.
Medical practitioners	• Greater clarity as to the regulator's expectations on appropriate use of the title 'surgeon'. • Practitioners who wish to use the title 'surgeon' would not be prohibited from doing so. • Lower risk (compared to Option 3) of impacts on supply and prices in the cosmetic surgery market.	• Some practitioners may decide to seek additional specialist training. • Some practitioners may decide to revise advertising and marketing materials. • Compliance expectations for practitioners may be unclear if there is no actual restriction on use of the title 'surgeon'.
Government and regulators	• Some limited potential to reduce consumer confusion and increase public confidence in the National Scheme.	• Negligible / minimal costs to regulators to develop guidance and perform monitoring and enforcement activities as current infrastructure and resources can be used. • Unclear if this would be sufficient to improve confidence in the regulatory system. • Unclear if this would meet expectations on government to address an issue of public concern.
Broader health sector		• Costs to public health system associated with revision surgery for consumers who have suffered poor outcomes may continue.

The benefits of this option include that it will be clearer to medical practitioners, cosmetic surgery providers, and consumers when the use of the title 'surgeon' is appropriate in light of the assumptions that some consumers have about the meaning of the term. This may include guidance on the use of the informal title 'cosmetic surgeon', but the use of this title would otherwise continue to be unrestricted (unlike specialist titles).

However, the option may have limited impact on addressing the information asymmetry experienced by some consumers as the option would rely on a consumer's awareness and understanding of the National Scheme's administrative mechanisms which are primarily targeted at health practitioners not consumers, and this option may be relatively difficult to communicate clearly and effectively via a public education campaign.

In addition, it is also anticipated that the impact on changing practitioner and provider behaviour may be limited given that the reform option doesn't involve restrictions on who may use the title 'surgeon'. It is anticipated that only a very small number of medical practitioners would undertake further education or training activities just to retain the ability to use the title 'surgeon' given that the reforms do not impose any restrictions on practice.

Generally, administrative reforms can be devised, implemented, and updated more speedily than legislative reform. However, it is noted that health ministers have agreed that actions to address concerns regarding cosmetic surgery and risks to consumers should be taken urgently.[106] Therefore, the benefits of the relative speed that administrative mechanisms can usually be implemented compared to legislative reform may be diminished in this case if health ministers prioritise and expedite legislative reform if agreed.

On balance, while this option would provide some incremental benefits in addressing information asymmetry and improving public protection it may not go far enough in addressing the problems identified. The nature of any such guidance through administrative mechanisms would mean it would likely remain open for practitioners without advanced surgical qualifications who wish to use the title 'surgeon' to continue to do so. Information asymmetries and associated problems including risks of harm will likely continue to persist.

Regulatory burden estimate

An estimate of the regulatory costs imposed by Option 2 is provided in the table below, averaged over a 10-year default duration.

Similar to Option 3, the key regulatory burdens associated with Option 2 arise from costs associated with medical practitioners pursuing additional specialist training and registration and revising advertising and marketing material that uses the title 'surgeon'.

Unlike Option 3, Option 2 would not actually involve practitioners being prohibited from using the title 'surgeon'. Instead, guidance (in the form of amendments to codes or guidelines) would be provided to practitioners to encourage appropriate use of the title. While it is expected some practitioners would modify their behaviour as a result of this guidance (by no longer using the title 'surgeon'), it is expected that the effect would be significantly reduced compared to Option 3, which would prohibit the use of the title. Accordingly, it has been assumed that 30% of practitioners impacted by Option 3.2 might also be impacted under Option 2 and therefore the regulatory burden has been calculated by discounting the regulatory burden imposed by Option 3.2 by 70%.

Consistent with the methodology and limitations outlined earlier, it is challenging to accurately estimate the quantifiable cost impacts of this reform option given the lack of complete and reliable data. The calculations of the regulatory burden estimate and assumptions underpinning these calculations are set out further in **Appendix C**. The table below sets out the expected annual regulatory cost, averaged over a 10-year duration.

Table 5 - Regulatory burden estimate – Option 2

Impacted group	Cost item	Annual regulatory cost (averaged over 10 years)
Medical practitioners	Additional training and application for specialist registration	$0.10m – $0.51m
Medical practitioners	Revising advertising and marketing material	$0.095m
Total annual regulatory cost (averaged over 10 years)		**$0.20m – $0.60m**

[106] HMM statement on cosmetic surgery 2 September 2022, available at https://www.health.gov.au/resources/publications/hmm-statement-on-cosmetic-surgery-2-september-2022

Option 3 – Restrict the title 'surgeon' in the National Law

Impact analysis of Option 3

Benefits and costs

The key benefits and costs associated with Option 3 are set out in the table below. Most impacts are applicable to both sub-options. The table further identifies some additional benefits of Option 3.2 compared to Option 3.1.

Under these options, use of the title 'surgeon' by medical practitioners would be restricted to a defined cohort of practitioners. This would include use of the informal title 'cosmetic surgeon'. Cosmetic surgery would therefore be regulated more similarly to other types of surgery. Were the title 'surgeon' protected through legislation, this will likely increase consumers' confidence that any practitioner using the title has appropriate training and qualifications to do so. If the title 'surgeon' were restricted, consumers would be better positioned to select appropriately qualified surgeons to perform the procedure(s) sought. This may also reduce the risk and costs of harm from cosmetic surgery performed by practitioners who do not have the required competencies.

Under both option 3.1 and 3.2, a significant number of medical practitioners would be prevented from using the title 'surgeon'. However, only a small proportion of these practitioners would be likely to experience a regulatory burden, as not all practitioners currently use, or would conceivably want to use, the title 'surgeon'. It is likely that the vast majority do not use this title, though it is difficult to obtain precise estimates.

Significantly, implementation of Options 3.1 or 3.2 will not restrict medical practitioners' practice. This means that all medical practitioners, regardless of whether they have obtained qualifications in an 'approved' medical specialty, can continue to perform surgical procedures within their scope of competence. Medical practitioners must continue to adhere to the Medical Board's requisite codes and guidelines, such as the Code of Conduct[107] and associated guidelines where medical practitioners are performing cosmetic surgical procedures.[108]

Medical practitioners who are excluded from being eligible to use the title will be required to undertake further AMC-accredited training to obtain requisite specialist medical qualifications in an approved specialty if they wish to use the title 'surgeon'. Where medical practitioners choose to undertake this training in order to use the title, this will likely result in costs to medical practitioners through:

- specialist medical college registration and other fees
- annual training and examination fees
- time dedicated to completion of additional studies and requisite clinical practice placements
- registration fees with Ahpra and the Medical Board
- ongoing continuing professional development requirements and costs.

However, the number of medical practitioners who would pursue additional training to regain the use of the title 'surgeon' is expected to be very low given that obtaining an area of practice in

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

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

cosmetic surgery will likely involve much lower costs and similar benefits in terms of experience, qualification, and credibility to consumers.

This was confirmed through consultation where several professional stakeholder submissions indicated that it is highly unlikely many medical practitioners will embark in an additional 5-6 years of training for the sole purpose of gaining eligibility to use the title of 'surgeon'.

Table 6 - Cost-benefit analysis – Option 3

	Benefits	Costs
Consumers	• Improved ability to make informed choices about appropriately qualified practitioners. • Addresses information asymmetry by aligning use of the title 'surgeon' with consumers' understanding of the term. • Improved understanding of practitioner qualifications and titles (particularly if supported by education campaign). • Potential reduced exposure to risks and harm in relation to cosmetic surgery. • Likely increased satisfaction with surgical outcomes and potential for fewer disputes and/or litigation. • Increased confidence in the regulatory system. • Increased confidence in the cosmetic surgery industry, potentially leading to increased demand. • **Option 3.2** (compared to 3.1): potentially simpler to communicate that 'surgeons' have 'significant advanced surgical training' rather than explain specialist qualifications.	• Consumers may seek services from a smaller pool of cosmetic proceduralists eligible to use the title, possibly increasing costs of procedures, which may in turn be passed onto consumers. • Possible contraction in the market for cosmetic surgery (may be offset or mitigated by increased demand if consumers have greater confidence in the industry). • Possible risk of consumers seeking cheaper services overseas, possibly in jurisdictions where procedures may be less safe. • Possible confusion as to whether practitioners who cannot use the title 'surgeon' are able to perform surgery.
Medical practitioners	• Practitioners who would be eligible to continue using the title 'surgeon' may benefit from shifts in business revenue towards practitioners that can use the title.	• Practitioners who are not eligible to use the title 'surgeon' will be required to undertake additional specialist training if they wish to use the title. • For practitioners no longer eligible to use the title 'surgeon',

	• Practitioners may benefit from increased consumer confidence in the regulation of the industry. • Practitioners who do undergo additional training in order to use the title 'surgeon' will be better qualified. • **Option 3.2** (compared to 3.1): higher number of practitioners permitted to use the title 'surgeon'.[109]	costs of revising advertising and marketing material to ensure compliance. • Potential shifts in business revenue within the cosmetic surgery industry from practitioners who can no longer use the title of 'surgeon' to practitioners who can use the title 'surgeon'. The scale of this cost would be dependent on the resulting change in consumer behaviour.
Government and regulators	• Reduced consumer confusion about use of title is likely to increase public confidence in the National Scheme. • Regulators will be more able to monitor and enforce compliance, and take action when needed, supporting public confidence and public protection in the National Scheme. • Expectations of government action in response to an issue of major public concern will be met. • Title protection is an existing mechanism – regulators have existing approaches that can be used to monitor compliance in an efficient manner. • **Option 3.2** (compared to 3.1): greater flexibility to adjust the categories of practitioners able to use the title 'surgeon' in future to adapt to changes in surgical training and practice.	• There are likely to be some implementation costs for regulators associated with monitoring and enforcing title protection provisions. These costs are expected to be small.[110] • Potential to incur additional costs for government to support specialist training places, though it is anticipated very few practitioners who would be ineligible to use the title 'surgeon' would pursue additional specialist training. • Costs related to policy development and legislation drafting, and subsequent evaluation.
Broader health sector	• Potentially lower costs to the public health system of revision surgeries for consumers who have suffered	• Where practitioners undertake accredited specialist surgical training, strain will be placed on

[109] See section on 'Impacted practitioners' below. Under Option 3.1, 6,441 practitioners would be eligible to use the title 'surgeon'. Under Option 3.2 (if the Medical Board's advice is adopted), 9,793 practitioners would be eligible to use the title.

[110] Ahpra has advised that additional compliance activity will be supported through existing resourcing, including the new $4.5m investment made as a part of reforms that are included in the status quo of this RIS.

	poor outcomes from cosmetic procedures.	entities which provide clinical practice placements.

A number of stakeholders commented that there are a limited number of specialist training places and some expressed concern that title restriction might increase the demand for these finite positions. Some stakeholders advocated for the creation of an alternative pathway to support practitioners who have already undertaken extensive surgical training to obtain qualifications that would enable them to use the title 'surgeon', and indicated this would also minimise strain on limited available specialist training places. While demand for specialist training is difficult to satisfy, title restriction – for reasons that are explained in the 'Impacted practitioners' section below – is not expected to significantly increase this demand.

However, as was noted in the Consultation RIS, and in several stakeholder submissions, advanced surgical qualifications do not guarantee a medical practitioner's competency to provide cosmetic surgical procedures. Several case studies are set out in **Appendix D**, and in the Consultation RIS, some of which relate to specialist practitioners.[111]

More generally, title protection, if implemented on its own, may not necessarily address the risk of consumer harm, and adverse outcomes to patients have occurred when procedures were performed by specialist medical practitioners. The Independent Review noted that of a sample of 177 cosmetic surgery notifications, 100 related to plastic surgeons, though the report noted several reasons for caution about drawing conclusions from this data about any cohorts of medical practitioners, including because the total populations of practitioners in each cohort is not known.[112]

Accordingly, it is important that if this option were implemented, to maximise its impact, amendments to restrict the title of surgeon must operate cohesively with the establishment of an endorsement in an area of practice in cosmetic surgery and recognition of associated accredited qualifications (as noted in Option 1, it is assumed as part of the base case that this reform will proceed).

As previously noted, these two reforms in combination are expected to provide consumers with meaningful information to enable them to assess the qualifications of their prospective practitioner, including where consumers seek cosmetic surgery. Consumers will be able to assess whether a medical practitioner has significant surgical training (through use of the title 'surgeon') and whether the practitioner has qualifications relevant to cosmetic surgery (through holding an endorsement).

Most specialist surgeons train for qualifications through training accredited by RACS under delegated authority from the AMC. Some stakeholders noted a concern that title restriction – particularly Option 3.1 – may concentrate training and 'market share' and more generally that the reform may direct consumers to medical practitioners with accredited advanced surgical qualifications over other practitioners.

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[111] For example, case study 1 in Appendix D describes a case where deficient post-operative care was provided by a registered specialist plastic surgeon after performing a liposuction that resulted in the preventable death of a patient.

[112] Independent review, p 60. See also QHQCC (2013) 'Great expectations', 21, 23. In 2013, the QHQCC received cosmetic surgery complaints about 94 medical practitioners and many of these practitioners held medical specialist qualifications including: Surgery: 48% (n. 45); General practice: 22% (n. 21); Dermatology: 2% (n. 2); Ophthalmology: 2% (n. 2); Radiology: 1% (n. 1).; No specialty: 19% (n. 18) ; Unknown: 5% (n. 5). Of the 45 surgical specialists who had received complaints, 87% of these were registered to practice in the specialty field of plastic surgery (n. 35) or general and plastic surgery (n. 4).

It is likely that title restriction would have some market impacts, in that prospective consumers of cosmetic surgery may be more likely to seek practitioners who have significant surgical training and are therefore permitted to use the title 'surgeon' and who have an endorsement in cosmetic surgery. However, to the extent that this would occur, this would be intended, and would demonstrate that consumers are making use of the information available to them to seek out suitably qualified practitioners. This may encourage other practitioners to seek to obtain an endorsement or to obtain advanced surgical qualifications.

It is important to also reiterate that title restriction would not result in any restriction on practice. It would not prohibit other practitioners from performing surgery, as they currently do, and are authorised to perform within their appropriate scopes of practice. Dermatologists, obstetricians, ophthalmologists and specialist GPs, for example, will continue to train with and under the auspices of their respective specialist colleges and perform the procedures they have been trained to perform. Some of these procedures will be surgical.

If Option 3.1 were implemented, these practitioner cohorts would only be prohibited from using the protected title 'surgeon' but would still be able to describe themselves using other specialist titles they are eligible to use such as, for example 'specialist dermatologist', or 'specialist obstetrician and gynaecologist', or 'specialist ophthalmologist' or 'specialist general practitioner'.[113] Under Option 3.2, some of these practitioner cohorts would also be permitted to use the title 'surgeon'.

Impacted practitioners – Option 3.1 vs Option 3.2

If Option 3.1 is implemented, the title of 'surgeon' will be protected under the National Law and narrowly restricted for use only by medical practitioners that have obtained AMC-accredited specialist qualifications in the specialty of surgery. This will result in only those practitioners who hold qualifications in the associated 10 fields of specialty practice being entitled to use the title 'surgeon'.

Across Australia, 6,441 medical practitioners are currently registered as specialist surgeons across 10 fields of specialty practice.[114] If Option 3.1 was implemented, a total of 125,512 medical practitioners may no longer be eligible to use the title of 'surgeon' in marketing or practice.[115] This equates to about 95% of medical practitioners who will no longer be eligible to call themselves a 'surgeon'. However, as noted above, only a small percentage of these practitioners is likely to be currently using the title 'surgeon', or may theoretically want to use this title. Therefore, the proportion of practitioners that is likely to experience a regulatory burden is much smaller. Assumptions that have informed calculations on the regulatory burden estimates are set out in **Appendix C**.

If Option 3.2 is implemented, the title of 'surgeon' will be protected under the National Law and restricted for use by medical practitioners who have obtained AMC-accredited specialist qualifications in specialty fields that are deemed to have undertaken a significant amount of surgical training as part of their qualifications.

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[113] See the Medical Board of Australia's *List of specialities, fields of speciality practice and related specialist titles* for further information. Available at https://www.medicalboard.gov.au/Registration/Types/Specialist-Registration/Medical-Specialties-and-Specialty-Fields.aspx.

[114] Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 9, https://www.medicalboard.gov.au/News/Statistics.aspx.

[115] Calculations based on Medical Board of Australia registration data as at 30 June 2022.

If the Medical Board's advice to health ministers is adopted, under option 3.2, the title of 'surgeon' would be restricted for use only by specialist medical practitioners who have obtained AMC-accredited qualifications in the below specialties, equating to 9,793 medical practitioners:

- Surgery (including Oral and maxillofacial surgery): 6,441 total registrants[116]
- Obstetrics and gynaecology: 2,265 total registrants[117]
- Ophthalmology: 1,087 total registrants.[118]

Therefore, if Option 3.2 were implemented, this will result in a total of 122,160 medical practitioners who may no longer be eligible to use the title of 'surgeon' in marketing or practice.[119] This would equate to about 93% of medical practitioners who would no longer be eligible to call themselves a 'surgeon'. However, it should be noted, again, that most of these medical practitioners will not currently be using the title 'surgeon' in practice, and the number of medical practitioners likely to be impacted by this reform will be much lower.

Further, as with Option 3.1, the implementation of Option 3.2 will not restrict the range of procedures that any practitioner can perform. Moreover, any practitioner in the course of their practice – irrespective of whether Option 3.1 or 3.2 were implemented – is expected always to abide by the Code of Conduct and perform only those procedures for which they have appropriate training, expertise, and experience. Practitioners may continue to perform surgical procedures they deem to be within their competency. Consumers may continue to access cosmetic surgical procedures through these medical practitioners with the understanding that they have undertaken aspects of surgical training.

Regulatory burden estimate

An estimate of the regulatory costs imposed by Option 3 is provided in the table below, averaged over a 10-year default duration.

The key regulatory burdens associated with Option 3 arise from:

- costs to medical practitioners who currently use the title 'surgeon' to revise their advertising and marketing materials to ensure compliance with the new requirements.
- costs to those medical practitioners who wish to use the title 'surgeon', but would be prohibited from doing so, to undertake specialist training leading to eligibility to use the title
- costs to apply for specialist application after the competition of training to use title
- delay cost to the practitioner from waiting for the specialist application to be finalised

Consistent with the methodology and limitations outlined earlier, it is challenging to accurately estimate the quantifiable cost impacts of this reform option given the lack of complete and reliable data. Assumptions underpinning these calculations are set out further in **Appendix C**.

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[116] Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 9, https://www.medicalboard.gov.au/News/Statistics.aspx.

[117] Ibid, p 6. 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.

[118] Ibid, p. 6.

[119] Calculations based on Medical Board of Australia registration data as at 30 June 2022.

Feedback on the Consultation RIS indicates it is highly unlikely that practitioners would choose to undergo several years of specialist training solely in order to be able to use the title 'surgeon'. It is also unclear how many practitioners, outside of specialist surgeons, currently use the title 'surgeon' or would wish to do so and therefore experience a regulatory burden.

Generous assumptions have been made in relation to these matters in order to derive a likely upper bound for the regulatory burden as set out below. With the exception of additional advertising costs (which is imposed on all practitioners who are no longer able to use the title), all other costs components are presented as a range based on the proportion of practitioners who are likely to pursue additional specialist training.

Separate regulatory burden estimates are set out for Options 3.1 and 3.2, reflecting that fewer practitioners would be able to use the title 'surgeon' under Option 3.1 compared to 3.2 (and therefore that Option 3.1 would impose a greater regulatory burden).

The calculations of the regulatory burden estimate and assumptions underpinning these calculations are set out further in **Appendix C**. The tables below set out the expected annual regulatory cost, averaged over a 10-year duration.

Table 7 - Regulatory burden estimate – Option 3.1

Impacted group	Cost item	Annual regulatory cost (averaged over 10 years)
Medical practitioners	Additional training and application for specialist registration	$0.43 – $2.17m
Medical practitioners	Revising advertising and marketing material	$0.41m
Total annual regulatory costs (averaged over 10 years)		**$0.84 – $2.58m**

Table 8 - Regulatory burden estimate – Option 3.2

Impacted group	Cost item	Annual regulatory cost (averaged over 10 years)
Medical practitioners	Additional training and application for specialist registration	$0.34 – $1.69m
Medical practitioners	Revising advertising and marketing material	$0.32m
Total annual regulatory cost (averaged over 10 years)		**$0.66 – $2.01m**

Assessment against the problem criteria

The table below assesses the effectiveness of each option against three problem criteria (reflected in the Problem Statement).

Table 9 - Assessment against problem criteria

	Extent to which option addresses the criteria
Addressing information asymmetry	**Option 1** includes the establishment of an area of practice for cosmetic surgery (and this is part of the base case applicable to all options), which will provide some information to assist consumers to identify appropriately qualified cosmetic surgery practitioners. However, this option would not address consumers' confusion around use of the title 'surgeon' or prevent any practitioner (including practitioners of cosmetic surgery who do not have an endorsement) from using the title 'surgeon' (including in combination with other words). It is likely that information asymmetry would significantly persist or even potentially increase under this option. **Option 2** may have some incremental impact on addressing information asymmetry as guidance would encourage increased responsibility among practitioners in the use of titles. **Option 3** is likely to have the greatest impact, particularly in combination with the establishment of an area of practice endorsement in cosmetic surgery and delivery of a public education campaign will support consumers to better identify suitably trained and qualified practitioners. Where consumers are better educated about medical practitioners' use of title, and practitioners' use of the title of 'surgeon' is limited through legislation, and universally recognised qualifications in cosmetic surgical practice are established, consumers will be better equipped to make informed decisions in selecting practitioners to perform their desired cosmetic surgical procedures.
Improving public protection	Several of the reforms committed to as part of the base case in **Option 1** are likely to have positive impacts on improving public protection including reducing exposure to harm from poorly performed cosmetic surgery. These reforms form part of the other options as well. **Option 3** is expected to have greater incremental benefits than **Option 2** as title restriction is anticipated to work in a complementary manner with the area of practice endorsement for 'cosmetic surgery' and delivery of a public information campaign. This has the potential to have an additive effect on consumers' exposure to risk and harm, as separately outlined in this Decision RIS. If the title of 'surgeon' is restricted in combination with an area of practice endorsement, consumers will be better positioned to select practitioners with appropriate qualifications when seeking a cosmetic surgeon. Consumers will have information both from the practitioners' use of the title 'surgeon' as well as their holding an endorsement in cosmetic surgery (which could be verified through the public register). This is likely to reduce the potential exposure risk of harm from cosmetic surgery performed by practitioners that are not suitably qualified.
Promoting confidence in the National Scheme	**Option 3** is likely to have the greatest impact on promoting confidence in the National Scheme (as well as the cosmetic surgery industry). Restrictions on medical practitioners' ability to use the title 'surgeon' will support increased consumer confidence that any practitioner

	using the title has undertaken suitable training and obtained relevant qualifications in order to be eligible to use the title. Further, increasing consumer health literacy through delivery of information campaigns and development of universal training standards will support consumers to make informed choices regarding proceduralists and address the existing information asymmetry between consumers and providers regarding medical practitioners' qualifications and use of title. The reforms committed to as part of the base case are likely to go some way to addressing consumer concern about the regulatory system and the cosmetic surgery industry. However, this option would not address consumers' confusion regarding use of the title 'surgeon', an issue of current public concern. **Option 2** may have some incremental impact on consumers' confidence in the regulatory scheme but are not likely to be as effective or as simple to communicate to consumers as **Option 3** in this regard.

7. Consultation

Purpose and objectives of consultation

The consultation sought to test health ministers' concerns, outlined in the Consultation RIS, that the current use of the title 'surgeon' by medical practitioners may be confusing the general public, and that this confusion may be contributing to avoidable and disproportionate risks and harms to the public, resulting from poor cosmetic surgical outcomes. This included seeking information to understand and determine:

- if there is widespread belief that cosmetic surgery is regulated in the same way as other surgery
- if current regulation is not helping members of the general public to understand how the regulation of cosmetic surgery differs with that for other surgery
- if the practice of cosmetic surgery and use of the informal title 'cosmetic surgeon' is associated with serious risks and harm to the public
- stakeholders' views about cosmetic surgery regulation and the reform proposals, and
- assess costs, benefits and likely impacts of the reform proposals and identify the recommended option(s) for implementation.

The following reform options were set out in the Consultation RIS:

- **Option 1 –** Maintaining the status quo and existing regulatory and other tools
- **Option 2 –** Alternatives to amending the National Law, including:
    - **2.1 –** Major public information campaigns about the use of titles and provision of cosmetic procedures
    - **2.2 –** increased provider liability for non-economic damages

- **Option 3 –** Strengthening the existing regulatory framework, including existing mechanisms designed to protect the public from harm
- **Option 4 –** Restricting the title 'surgeon' under the National Law, to:
    - **4.1 –** the 10 surgical speciality fields of practice approved by the Ministerial Council, or
    - **4.2 –** specialist medical practitioners with significant surgical training.

As noted under the chapter 'Options for government to address the problem', the options set out in the Consultation RIS have been further refined in the Decision RIS to take into account the rapidly evolving reform context and a range of reforms already committed to by health ministers (as well as Ahpra and the Medical Board) and that are in the process of being implemented (including option 2.1 and a suite or reforms that were considered in option 3). Hence, the base case and options in the Decision RIS have changed since the Consultation RIS.

Consultation and engagement approach

The National Registration and Accreditation Scheme Review Implementation Project Team (project team) in the Victorian Department of Health led the consultation process on behalf of all jurisdictions and the HMM. Public consultation occurred from late December 2021 to early April 2022.

Organisations and individual health practitioners were invited to participate in the consultation by making direct submissions via the Engage Victoria webpage. Key stakeholder organisations were also invited to attend one of three online consultation information sessions in early February 2022.

In addition, the Health Issues Centre (HIC) was engaged to conduct a consumer survey focused primarily on consumption of cosmetic surgery to ensure the perspectives, experience and expertise of consumers could inform consultation and decisions by health ministers.

The consultation (including consumer survey) was promoted by health departments and Ahpra on social media and their respective websites. The HIC extensively promoted the consumer survey in social media using paid advertisements and its own social media accounts, in a rolling campaign (including translating the survey and advertisements into Simplified Chinese,[120] Vietnamese, and Arabic).

Additional information on the consultation and engagement approach is included in **Appendix E**.

Key consultation themes

In summary, key themes and outcomes that emerged through consultation and informed deliberations about whether regulation is necessary and the most efficient and effective regulatory approach to medical practitioners' use of the title 'surgeon' included:

- Broadly, consultation findings and stakeholder responses confirmed that **there are significant gaps in consumers' understanding about medical practitioners' qualifications and use of titles**, including when seeking cosmetic surgery practitioners.

[120] Mandarin and Cantonese are the main languages spoken in China. However, the written language is Simplified Chinese and Traditional Chinese neither of which aligns with either spoken language. Simplified Chinese was chosen because this is used in Australia and specifically in Australian Chinese media.

- Consultation broadly confirmed that **there are significant concerns about the regulation of cosmetic surgery and instances of risk and harm** associated with this industry. A significant proportion of respondents to the consumer survey reported experiences of harm arising from cosmetic surgery.
- Overwhelmingly, **stakeholders do not support maintaining the status quo** (Option 1 in the Consultation RIS). Professional and consumer respondents to the consultation indicated that the current regulatory framework is inadequate to address the identified problem.
- Many stakeholders noted that **implementation of one option in isolation may not be sufficient to address the problem** and that a response combining elements from different options in a coordinated and complementary manner may be required to address the problem outlined in the Consultation RIS.
- There was **general support from stakeholders for the implementation of a major public information campaign** (Option 2.1). Many respondents again noted that implementing this option in isolation may not be effective and that a successful campaign would need to be appropriately targeted and accessible to ensure its effectiveness is maximised (especially in the context of successful and targeted marketing of cosmetic surgery and procedures on social media).
- Overwhelming **stakeholders supported reforms to strengthen the existing regulatory framework** (Option 3). Many stakeholders again noted that implementing this option in isolation may not be enough to address the problem outlined in the Consultation RIS.
- There were **divergent views amongst stakeholders on restricting the title 'surgeon'** under the National Law (Options 4.1 and 4.2). This was the most contested reform option and there was not a consensus view amongst stakeholders about whether this regulatory response was efficient, effective, proportionate, or appropriate. More stakeholders indicated a preference for Option 4.2 (restricting the title to medical practitioners with significant surgical training) than Option 4.1 (restricting the title to the 10 surgical specialty fields of practice).

Responses to consultation

Professional stakeholder responses

The Consultation RIS received 150 direct submissions from professional stakeholders.[121] These included submissions from:

- individual practitioners (n. 103), and
- a range of organisations, including:
    - health practitioner peak bodies (n. 11)
    - specialist practitioner colleges (n. 11)
    - consumer representatives (n. 1)

[121] One submission explicitly refused permission for the collection and use of the data it contained and was required to be excluded from further analysis.

- regulators, government agencies and complaints-handling bodies (n. 7)
- law firms and insurers (n. 4)
- cosmetic representative organisations and cosmetic facilities (n. 11)
- other (n. 2).

Of the 150 direct submissions, 73 used a template submission and therefore contained identical or substantially identical information (referred to in this Decision RIS as 'campaign submissions'). These submissions supported establishment of an 'endorsement model' like that considered in the Independent Review[122] and opposed restricting the title 'surgeon'.

Consumer survey responses

The consumer survey received 1,394 completed responses, including 17 from the translated language surveys and 1,377 from the English language survey.

The majority (81%) of respondents to the consumer survey were women (n. 1,110), and 49% of respondents were aged 26-45 years. All States and Territories were represented in the responses. 62% of respondents reported that they (or someone close to them) had a person experience of cosmetic surgery and one in five respondents reported having undergone more than one cosmetic surgery procedure.

Just over half of respondents to the survey (52% or n. 727) were assessed as having medium to high level health literacy. This level of understanding was well above the national average. According to the Australian Commission on Safety and Quality in Health Care, only 40% of adults have the health literacy level (functional) to understand and follow health messages in as intended. This may in part be attributable to the high proportion of respondents (64% or n. 680) that had a bachelor's degree or higher, compared with the general population (of whom 24.3% have a bachelor's or higher degree). This aligns with some of the known demographics of people who access cosmetic surgery, including that they are predominantly women with higher levels of education and income.

Detailed summary of consultation findings

Consumers' understanding of titles and qualifications

Professional stakeholder responses

Submissions indicate that existing regulation and mechanisms available to members of the public to understand practitioners' titles and qualifications are of limited assistance to consumers in understanding practitioner titles when seeking prospective cosmetic surgical practitioners. Many responses indicated that consumers are confused by the current regulatory framework and have little understanding of medical practitioners' qualifications and varying levels of training and experience regarding surgery generally.

[122] The Independent Review also noted (p 36) that 'Of the medical practitioners who commented on endorsement, over 50 used a template submission that included support for endorsement.'.

Some respondents noted that the title 'surgeon' has a particular significance for consumers. For example, the Office of the Health Ombudsman (Queensland) stated:

> *'[T]he Australian consumer, places a large degree of trust in the title of "surgeon", which identifies that the practitioner has undertaken a significant amount of education and training to provide the service' (**Office of the Health Ombudsman (Queensland), submission #130**).*

The Australian Dental Association commented that:

> *'The public is likely to be influenced by or misconstrue the significance of the term surgeon and may not understand a practitioner's qualifications, experience, or skills. The public is also likely to be influenced by marketing strategies promoted via social media.' (**Australian Dental Association, submission #72**).*

Some respondents indicated that mechanisms should be made available to assist consumers to understand which practitioners may be qualified to perform cosmetic surgical procedures and have undertaken training to perform cosmetic surgery.

There were a significant number of comments on Ahpra's register of practitioners from professional stakeholder respondents. Respondents commented on the limits of the register, noting that it contains only information relating to general or specialist registration and omits information about practitioners' competencies and scope of practice. In addition, respondents stated that, generally, the register does not contain information about practitioners with training in cosmetic surgery which would otherwise support prospective patients' safe selection of practitioners to perform their cosmetic surgical procedures.

Professional respondents further indicated that many consumers are unaware of the register generally. They noted that while it may be useful to display information relating to complaints or disciplinary action against practitioners, this lack of awareness may result in consumers not being deterred from engaging particular practitioners who may be unsuitable to perform cosmetic surgical procedures, as they are unlikely to access the register at all. Further, respondents noted that where consumers are aware of the register, they lack understanding about the content that it currently does contain.

The campaign submissions noted that given there is no 'universal benchmark' for training for cosmetic surgeons in Australia, it may be difficult for practitioners to explain their competency as a 'cosmetic surgeon' to patients, unlike for specialists.

Consumer survey findings

Responses to the consumer survey identified significant gaps in consumers' understanding about medical practitioners' qualifications and use of titles. This was despite the relatively high level of health literacy and educational attainment of the survey respondents.

While consumers generally reported a sound understanding of qualifications and titles, a much smaller proportion were able to demonstrate an accurate understanding in response to survey questions aimed at testing consumers' understanding.

A majority of consumers reported having a 'clear' (or 'very clear') understanding of practitioners' qualifications and titles: 67% of consumers reported having a clear understanding of their practitioner's qualifications (n. 564), and 60% reported a clear understanding of their practitioner's titles (n. 509). Further, 20% (n.174) and 25% (n. 214) reported having an 'unclear' (or 'very unclear') understanding of practitioners' qualifications and titles respectively.

Despite this relatively high self-reported understanding, only around a quarter of respondents (27% or n. 377) demonstrated a clear understanding of the distinction between cosmetic and plastic surgeons, some revealing that they had only recently learned of the differences. Less than half of respondents (43% or n. 598) partially understood the differences. Almost half of respondents (45% or n. 633) were either unsure about the differences, believed they were the same or held incorrect understandings of the meaning of the titles.

Only around a third (34%) of survey respondents reported having used the Ahpra register of practitioners to inquire about a practitioner's registration details (n. 467), an important tool for providing information to consumers and patients about health practitioner qualifications and registration status. The remaining two-thirds of respondents had not used or were not aware of the register.

Two-third of respondents reported that they would consult their GP to find out about a surgical procedure. However, of those surveyed consumers who reported having had a cosmetic surgical procedure, only half (n. 419) reported having consulted a GP before they had the procedure.

Other sources of information respondents indicated they would consult included: Ahpra (27%), family/friend recommendations (41%), online searches (63%) and advertisements and promotions (9%).

One respondent stated that:

> *'People are not fully aware of the qualifications of cosmetic surgeons and rely on heavily marketed procedures and incorrect claims.'*

The findings from consultation on the Consultation RIS were reinforced by the findings of the Independent Review, which also undertook a consumer survey. The Independent Review consumer survey highlighted the importance of medical practitioners' qualifications to consumers, and assumptions by some consumers about practitioner qualifications:

- when asked, 'how important are a doctor's qualifications to you?', 78% of respondents selected 'very important'. Other responses to this question included:
    - 19% selected 'if they are a doctor offering cosmetic surgery, I assume they are qualified'
    - 18% selected 'if they have qualifications listed, I assume they are qualified to perform cosmetic surgery'.[123]

The survey also asked about sources of information consumers accessed to find out about their doctors' qualifications. 53% selected 'information on the doctor's website', 26% selected 'the doctor told me during my consultation', 11% selected 'social media', and 10% selected 'I would be satisfied with what the doctor told me during the consultation'.

Views on regulation of cosmetic surgery

Professional stakeholder responses

Most respondents indicated that they were aware of differences between cosmetic and other types of surgery prior to engaging in the consultation process. While a small number of respondents (n. 2) argued that cosmetic surgeons are subject to similar regulation by Ahpra and the Medical Board as

[123] Independent Review, Final Report, p. 34.

other medical practitioners, most respondents identified significant differences between the regulation of cosmetic surgery and other types of surgery.

Some of these respondents attributed this discrepancy to the fact that cosmetic surgery is not an accredited speciality with associated training and practice standards accredited by the AMC. Several respondents suggested that this is leading to instances of consumer harm and are particularly requiring cosmetic surgery consumers to undergo reparative surgery for adverse surgical outcomes.

The complexity of the regulatory framework for cosmetic surgery was noted by some respondents:

> *'The current context and legislative frameworks to protect consumers using cosmetic surgeons is not supporting the provision of safe and quality care. It is very complex and not readily accessible or understood by consumers. There are state and Commonwealth agencies, statutory and independent bodies that all play a key role in regulation, complaint-handling and investigation of complaints and/or offences, disciplinary action and prosecution … the "cosmetic surgeon" qualifications (including surgical qualifications) are unknown and often unasked about by the consumer.' (**Ahpra Community Advisory Council, submission #64**)*

Respondents also noted the unique status of cosmetic surgery in the healthcare profession, in that patients access procedures solely to achieve aesthetic outcomes as opposed to treatment of illness, injury or disease. For example, Maurice Blackburn Lawyers stated:

> *'Cosmetic medicine and surgery occupies a unique position within the healthcare profession. Normally, medical or surgical treatment is provided in the context of some illness, injury or disease. By contrast, cosmetic surgery or treatment is generally non-essential, motivated aesthetics and instigated by the patient' (**Maurice Blackburn Lawyers, submission #133**)*

Several respondents also outlined that advertising guidelines could be strengthened. This was particularly noting the use of social media in the cosmetic surgery industry. Respondents noted that current advertising guidelines may not be adequately enforced by regulators, and that practitioners may not necessarily adhere to these guidelines as required.

Consumer survey responses

Consumer survey responses indicated that:

- 63% of respondents reported they did not believe cosmetic surgery was regulated in the same way as other surgeries, while 18% thought it was, and 18% were unsure
- 54% of respondents reported that advertising does not explain the benefits of cosmetic surgery, while 25% believes it does and 21% were unsure
- 76% of respondents reported that advertising does not explain the risks of cosmetic surgery, while 10% believes it does and 14% were unsure.

While the responses suggest consumers understand there are differences in regulation of cosmetic surgery and other types of surgery, it was not clear whether consumers understood in what ways regulation was different and (as noted above) many consumers demonstrated incorrect or limited understandings of the differences between 'cosmetic' and 'plastic' surgeons when asked.

Consumer respondents indicated that risks in cosmetic surgical procedures are rarely emphasised, particularly in comparison to the supposed benefits of these procedures which are more heavily promoted, with a belief that this information is intended to entice consumers to undertake procedures. One respondent stated:

> *'There is a big gap in terms of the general advertising being up front about what a procedure will entail and the risks involved….this leaves a psychologically vulnerable patient open to suggestion and sales pitches.'*

Of respondents that commented on regulation and advertising:

- 7% (n. 39) suggested that the cosmetic surgery sector preys on peoples' vulnerabilities, through inducing consumer confusion, taking advantage of information asymmetry regarding consumers' understanding of medical practitioner titles and placing responsibility on consumers to obtain reliable information about suitable proceduralists to perform their desired cosmetic procedures.
- 8% (n. 48) suggested that the industry trades off the inferred trust placed on doctors and surgeons, with comments such as:

  > *'I had no idea until recently that a cosmetic surgeon was not a qualified plastic surgeon. This is misleading and unfair to the average person.'*

Some consumers specifically recommended restricting advertising practices. Some recommended abolishing such advertising entirely. Other consumers advocated putting limitations on advertising, such as preventing a surgeon from being able to advertise 'until they have completed a [relevant] qualification', or restricting who can be targeted by advertising, prohibiting, for example, advertising targeting 'young people' or others who might be particularly vulnerable.

Many consumers also expressed general frustration with regulators or a perceived lack of regulation of cosmetic surgery:

> *'Cosmetic medical procedures need better regulation in general that is more proportionate to the considerable risk involved in these type of procedures.'*

Risk and harm associated with cosmetic surgery

Professional stakeholder responses

Several respondents indicated that at current guidelines, laws and regulations are not effective in deterring instances of patient harm associated with cosmetic surgery. Some respondents suggested inadequate compliance with the regulatory framework by practitioners and enforcement of this framework by regulators.

Several professional stakeholder respondents emphasised that any potential higher risk to patient safety and wellbeing in cosmetic surgical practice in comparison to other areas of surgery may not necessarily be due to higher clinical risk, but may be due to other factors such as:

- practitioners not holding appropriate qualifications, training, or experience to perform cosmetic surgery safely
- ineffective regulation
- subjective views on whether a cosmetic surgical procedure has achieved the intended outcomes for patients
- advertising of cosmetic surgery and the way patients may access information about a provider, such as through social media and/or not via referrals, and
- inadequate informed consent
- inadequate regulation of the facilities where cosmetic surgeries may take place.

Some professional respondents also noted that the current regulatory framework may be ineffective in deterring patient harm, given its complexity, the absence of national standards for cosmetic surgery education and training for practitioners as well as inconsistent surgical facilities licensing legislation and regulations between jurisdictions. It was also noted that misleading advertising, financial motivations for cosmetic surgeons and a lack of consumer awareness and information asymmetry may be contributing factors to occurrences of patient harm.

As previously noted, the complexity of the current regulatory framework was noted as a potential contributing factor to consumers' exposure to risk:

> *'The complexity of the current regulatory framework for medical practitioners and the incomplete understanding that many members of the public have as to its operation means that there is a significant risk that patients are undergoing serious and potentially risky medical procedures without a full and accurate understanding of the training and experience of the provider of those procedures.' (**Australian Medical Association, submission #145**)*

A small number of respondents (n. 6) viewed that the current laws, regulations and/or guidelines were clear, but were not adequately complied with or enforced. Others contended that issues relating to patient harm was a result of inadequate consumer knowledge of cosmetic surgery risks, benefits and costs, and expectations of unrealistic outcomes, as opposed to the regulatory framework itself.

While there is significant anecdotal evidence of harm to consumers, the consultation process confirmed there is limited data available to confirm the magnitude of patient harm arising from cosmetic surgery. However, several professional stakeholder respondents suggested that patient harms or complications may result from practitioners performing surgeries they are not adequately trained or experienced in or where practitioners are operating outside their scope of competence. Several respondents including the campaign submissions suggested a need for recognised training specifically in 'cosmetic surgery'.

Further, some respondents noted that patient harms as a result of poorly performed cosmetic surgical procedures may result in impacts on the public health system, particularly where patients are unable to cover costs for revision procedures.

> *'There are many patients who have complications from untrained practitioners and have no funds for revisionary surgery who finish up in the public health system. That is the right thing to do but adds to the cost of healthcare.' (**Individual practitioner, submission #121**)*

Many respondents acknowledged the important role that GPs play in the healthcare system and that in principle prospective cosmetic surgery patients discussing surgery with their GP may support better outcomes for patients and reduce avoidable harm. However, several respondents that provided feedback on this noted that a mandated requirement to see a GP before accessing cosmetic surgery may not be workable or appropriate given the negative impacts it would have on the availability of GPs in the health system and because this would be inconsistent with how consumers may access other specialists (that is consumers may seek a referral from a GP but are not required to).

Consumer survey responses

Respondents to the consumer survey reported significant rates of harm arising from cosmetic surgical procedures.

Of the respondents who reported that they (or someone close to them) had an experience of cosmetic surgery, 28% (n. 237) of respondents reported an experience of harm from cosmetic

surgery. While it is possible that those that had experienced harm were more likely to respond to the survey, this is nonetheless a significant reported rate of harm, and likely higher than rates of harm arising from non-cosmetic planned surgery.[124]

17% of consumer survey respondents reported experiencing unanticipated health complications, longer-than-advertised recovery periods and difficulty obtaining post-operative care. Respondents reported suffering 'necrosis, infection and staph', permanent disfigurement and chronic pain, and lengthy healing and recovery times.

Several respondents to the consumer survey confirmed that they bore heavy costs for their procedures, including hospital fees for revision surgeries that amounted to 'many times [the cost] of the original surgery'. Respondents reported losing income, time and experiencing 'mental distress'. Others reported feelings of distress from callous treatment as though they were 'rushed through the surgery ... like [they were] on a conveyer belt'.

Other respondents reported being put off by the financial and mental cost of attempting to have their cosmetic surgery corrected, stating that they had run out of money, were too stressed to contemplate taking legal action or too ashamed to seek redress. Some respondents also reported having to sign non-disclosure agreements with their cosmetic surgeon to obtain a refund.

Views on reform options

Professional stakeholders were requested to provide feedback on the reform options presented in the Consultation RIS, including to inform feasibility of implementation and assist to identify issues and/or limitations associated with these options. Professional stakeholder views were also sought regarding the effectiveness of implementing concurrent reform options.

Of the professional stakeholder responses that discussed reform options, fewer than 5% supported maintaining the status quo. Views on options to address this varied significantly.

Options 2.1 (public information campaign) and Option 3 (strengthening existing mechanisms in the National Scheme) were broadly supported by more than two-thirds of respondents. There were mixed views on Option 4 (restricting the use of the title 'surgeon'), with support from 27% of stakeholders, around 7% not expressing any view and the remaining submissions (including the 73 campaign responses) not supporting this option. Nearly all of the campaign responses also indicated support for Option 2.2 (increased provider liability), though this was not discussed in detail in the responses. There was limited support for this option from other professional stakeholders.

Consumer survey respondents were encouraged to read the Consultation RIS prior to completing the consumer survey. The consumer survey did not present each reform option to members of the public or request comments specifically on these proposed options. However, the survey questions were designed to assist in obtaining relevant information about each of the proposed reform options, and many respondents to the survey discussed the reform options.

518 (37%) of the 1,394 consumer survey respondents addressed issues directly related to the reform options. The remaining 63% did not comment on the reform options.

Of the consumer survey responses that discussed the reform options (n. 518):

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[124] International studies have placed the rate of postoperative complications at around 20%, which is 40% lower than the rate of harm reported by consumer respondents – see Ludbrook, G.L. The Hidden Pandemic: the Cost of Postoperative Complications. *Current Anesthesiology Reports* 12, 1–9 (2022). https://doi.org/10.1007/s40140-021-00493-y.

- 0.6% (n. 3) supported Option 1, maintaining the state quo (as set out in the Consultation RIS)
- 43% (n. 221) supported Option 2, reform options other than amending the National Law.
    - Specifically, there was widespread support for Option 2.1 major public information campaign (38%; n. 199) but only marginal support for Option 2.2 increased provider liability for non-economic damages (4%; n. 22)
- 70% (n. 362) supported Option 3, strengthening the existing regulatory framework
- 29% (n. 150) supported Option 4, restricting the title of 'surgeon'.

Overall, consumer survey respondents and many professional respondents noted that implementation of one option in isolation may not be sufficient to address the problem and that a response combining elements from different options in a coordinated and complementary manner may be required.

The below section provides a broad overview of the views of stakeholders on reform options. Further information is included in the assessment of reform options section of this Decision RIS and in **Appendix E**.

Consultation RIS Option 1: Maintain the status quo

Overwhelmingly, consultation indicated that stakeholders do not support maintaining the status quo. Professional and consumer respondents to the consultation indicated that the current regulatory framework is inadequate to address the issues outlined in the Consultation RIS.

Maintaining the status quo was supported in full or in part by fewer than 5% of professional respondents (n. 7). Some respondents did not express a view. The remaining 86% did not support maintaining the status quo (n. 129).

Of the consumer survey respondents that expressed a view on reform options (n. 518), just 0.6% supported maintaining the status quo (n. 3).

A range of issues were noted by stakeholders in rejecting the status quo, including:

- risk and harm to consumers
- a lack of transparency about titles and consumer understanding of the title 'surgeon', and associated confusion for consumers.
- a lack of national accreditation or training standards for cosmetic surgery
- costs associated with harms experienced by patients following adverse events.

Of the stakeholders that supported maintaining the status quo, the following issues were noted:

- concerns around impacts on practice and competition
- limited evidence to suggest that restricting use of title will increase public safety, or that higher qualifications necessarily lead to increased competency
- potential for increased costs to practitioners
- potential to increase consumer confusion.

Consultation RIS Option 2.1: Public information campaign

There was general support for option 2.1, including:

- full support and part support from around 67% of professional stakeholders that specifically responded to this option (n. 101).
- support from 38% (n. 199) of 518 Consumer Survey respondents who discussed reform options. (Note, not all respondents that discussed reform options indicated a view on each option.)

Some of the issues raised by stakeholders about why they support this option included:

- the need to support members of the public to have a better understanding of medical practitioner titles and qualifications
- public information campaigns would support consumers to make informed decisions when engaging prospective cosmetic surgical providers and potentially minimise patient harm and result in fewer patients experiencing complications and incurring costs for revision surgeries
- it would also support members of the public to understand and use existing mechanisms to obtain information about prospective practitioners, such as Ahpra's register of practitioners.

Many professional respondents advocated this option be implemented alongside other reforms and that it should not be implemented only as an alternative to further regulation. It was suggested by several professional respondents that a public information campaign should be implemented alongside restricting use of the title 'surgeon'.

One reason provided for this was that implementing a public information campaign in isolation will result in the onus remaining on consumers (rather than practitioners) to make sense of practitioners' qualifications and titles, while not addressing concerns around practitioners without advanced surgical qualifications being able to continue to use the title of 'surgeon' in practice.

A significant proportion of consumer survey respondents suggested that a major public information campaign would be beneficial, including to counteract the influence and use of advertising and social media in cosmetic surgical practice. Consumers also noted that members of the public lack awareness or potentially experience confusion with health information and their available rights, such as the availability of, and process for, making complaints.

Some of the issues raised by stakeholders about why they did not support this option included:

- doubts about whether public campaigns would address the problem and preferred title restriction or other regulatory reforms, such as standardised training standards for cosmetic surgery
- doubts about whether the benefits of a public information campaign could justify the associated costs
- complexities in developing a successful information campaign which resonates with consumers, particularly given the successful nature of advertising in the area of cosmetic surgery.

Consultation RIS Option 2.2: Increased provider liability for non-economic damages

Most of the campaign submissions (n. 70) indicated support for Option 2.2. These responses (which mostly used identical text) did not discuss the option further beyond noting support. A further 10 organisations and individual practitioners supported this option, though many also noted issues associated with this option.

Of the 518 consumers who provided comments relating to the reform options, there was limited discussion of the proposed reform option relating to increased provider liability for non-economic damages, with only 4% (n. 22) indicating support for this option.

Some submissions noted that consumers had reported difficult accessing compensation after unsatisfactory cosmetic surgery outcomes and may therefore support this reform. Some consumer responses made the general point that there is a need for adequate compensation for consumers where adverse events occur.

Some concerns that were noted with this option included that the proposal:

- could increase medical indemnity insurance costs and impact on sustainability
- would not effectively prevent the problem (harm would still occur)
- may result in appropriately trained and competent practitioners becoming overly risk averse
- would involve costly and complex implementation including legislative amendment in all jurisdictions.

Consultation RIS Option 3: Strengthening existing mechanisms in the National Scheme

There was general support amongst consumer and professional stakeholders for strengthening existing mechanisms in the National Scheme. Reform proposals suggested by stakeholders within this option varied significantly, likely reflecting the breadth of the option.

Of the professional stakeholder respondents, 70% indicated full support or part support for strengthening existing mechanisms in the National Scheme (n. 105). This included the campaign submissions (n. 73).

Of the 518 consumer survey respondents who addressed the reform options, 362 (70%) indicated support for Option 3.

Many respondents also noted that:

- Option 3 should be implemented in a complementary manner along with other proposed reforms, such as a public education campaign (Option 2.1) or restrictions on the use of the title 'surgeon' (Option 3)
- existing regulatory mechanisms should be better enforced to ensure compliance with the regulatory framework.

Key themes that came through during consultation included that the current regulatory framework could be strengthened through:

- 'better regulation' in general, that is more proportionate to the risks faced by consumers
- establishment of an area of practice endorsement for cosmetic surgery
- adequate counselling of risks, benefits and non-surgical options
- improved accreditation and training, standard setting and data collection
- greater restrictions on marketing and advertising.

The ACCSM, along with the campaign submissions, advocated for the establishment of an area of practice for cosmetic surgery. As noted previously, this reform was recommended by the Independent Review and health ministers, Ahpra and the Medical Board have committed to implementing this reform.

These respondents also noted concerns about the absence of universal benchmarks for training as a cosmetic surgeon, and the need to strengthen existing mechanisms through improvements to social media and advertising guidelines.

Consultation RIS Option 4: Restricting the title 'surgeon' under the National Law

Submissions received from professional stakeholders during the Consultation RIS revealed divergent views on title protection.

40 submissions (27%) indicated support for Option 4. Organisations that indicated full or partial support for Option 4 included, for example, colleges and professional organisations such as the Royal Australasian College of Surgeons (RACS), the Australian Medical Association (AMA), the Australasian Society of Aesthetic Plastic Surgeons, regulators and complaints-handling bodies such as the Office of the Health Ombudsman (Queensland) and other organisations such as Maurice Blackburn Lawyers.

Stakeholders that supported this option generally argued that:

- the term 'surgeon' carries significant weight with the general public
- consumers are likely to believe that practitioners using the title 'surgeon' have significant surgical education and training, including postgraduate surgical training
- consumers are likely to be confused or misled by the use of the term 'surgeon' in some circumstances, including the term 'cosmetic surgeon'
- there is potential for consumers to be exposed to unacceptable levels of risk and harm as a result.

Of the stakeholders that supported Option 4, there was a greater level of support for option 4.2 over 4.1. Some stakeholders did not articulate a preference between these sub-options. Some stakeholders who preferred Option 4.2 noted that Option 4.1 would restrict some medical specialists with substantial postgraduate surgical training from using the title 'surgeon' (though it would not restrict their scope of practice), whereas Option 4.2 would provide greater scope to allow practitioners with significant surgical training to continue to use the title.

Some stakeholders suggested a hybrid option. For example, the AMA proposed restricting the title to: 'the 10 RACS fields of practice, Ophthalmology and fields of practice within Obstetrics and Gynaecology that are surgically based'. RACS proposed a similar option.

Several stakeholders who supported restricting the title 'surgeon' noted that this this reform should be implemented in conjunction with other complementary reforms. Some professional respondents contended that if options to restrict the title 'surgeon' were implemented on its own this may have only limited impact in addressing the problems identified in the Consultation RIS.

Many stakeholders, whether or not supporting title restriction, offered views on the appropriate qualifications that should entitle a practitioner to use the title 'surgeon'. A sample of these responses is outlined in Table 10 below.

Table 10 - Example views on level of training to use the title 'surgeon'

Example views on level of training to use the title 'surgeon'

> *'doctors graduate with an MBBS and therefore have the right to call [themselves] a surgeon.' (**Anonymous submission**)*
>
> *'The completion of an accredited medical surgical training program, leading to the award of a fellowship, which is recognised by the Australian Medical Council and Medical Board of Australia, should be the requisite for the use of the title 'surgeon'.' (**Australian and New Zealand Association of Oral and Maxillofacial Surgeons [ANZAOMS], submission #108**)*
>
> *'The title "surgeon" should only be used by those who have undertaken specialist training in surgery.' (**Australian and New Zealand College of Anaesthetists [ANZCA], submission #141**)*
>
> *'FRACS or equivalent. At least 5 years training in an AMC accredited program. It is routine to hear from patients that they had no idea that any practitioner can call themselves a "cosmetic surgeon" '. (**Anonymous submission**)*
>
> *'it is up to the Medical Board of Australia and the AMC to determine the minimum skills, training and standards required for, and the nature of the procedures that fall within the scope of cosmetic surgery practice. This is relevant whether the model adopted under the National Law to regulate cosmetic surgery practice is that of title protection or endorsement of registration.' (**Avant Mutual, submission #131**)*

Title restriction was opposed by a range of stakeholders, including organisations representing cosmetic surgeons such as the ACCSM, businesses providing cosmetic surgery and a large number of individual practitioners and organisations that submitted campaign submissions (n. 73). The ACCSM stated it would support title protection 'Only if specifically linked to training, accreditation and competence in cosmetic surgery, not in isolated form as per current option 4 of the RIS'.

The Australian College of Rural and Remote Medicine (ACRRM) opposed title protection, in particular Option 4.1, stating that moves to impose regulation upon this generic title are likely to involve excessive compliance costs, litigation, and may increase confusion. The Royal Australian College of General Practitioners (RACGP) also noted potential impacts on GP proceduralists, particularly in rural areas, stating that:

> *'It is very important that these individuals and their communities are not negatively impacted, and certain surgical procedures can still be performed by appropriately trained medical practitioners, for example, GPs, rural generalists, dermatologists and obstetricians.' (**RACGP, submission #98**)*

Where consumers discussed the title 'surgeon', they were generally supportive of reforms to provide clarity on what the title 'surgeon' means, and which practitioners would be permitted to use it. Some consumers reported that using the term 'surgeon' was misleading, while others offered suggestions for changes. Of the consumer survey respondents that discussed reform options (n. 518), about 29% indicated support for Option 4 (n. 150). (Note this does not imply that the remaining 71% opposed Option 4 because respondents did not necessarily discuss all options).

Stakeholders' arguments against title protection included that:

- as medical practitioners have obtained Bachelor-level qualifications recognised by the AMC which contain a surgical component, they should be permitted to use the title 'surgeon'
- there may be competent and experienced practitioners currently using the title 'surgeon' but would no longer be permitted to (depending on how the scope of the title restriction was defined)
- title restriction, on its own, would not ensure patient safety
- there may be impacts on businesses and competition
- being a specialist surgeon does not assure cosmetic surgery competency
- concerns that this may lead to a 'monopoly' on surgical training
- an area of practice endorsement should be implemented instead of title protection.

Additional reform proposals suggested by stakeholders

Protection for notifiers

During the consultation process, 15 consumer survey respondents who advised they had experienced harm following cosmetic surgery reported that they signed non-disclosure agreements (NDAs). It is apparent some of these consumers believed this precluded them from taking further action regarding the harm they had experienced.

> *'Please bring greater regulation to this industry. You won't see many complaints when patients like myself are forced to sign NDAs just to get their money back.'*

Similar observations have been made in media reports and in the Independent Review final report. In its public submission to the Independent Review, Operation Redress stated:

> *'NDAs are especially problematic in the cosmetic surgery space because they pose a risk to the public. Patients who feel disfigured, misled, or were critically harmed, may be asked to sign an NDA by the provider. We have heard multiple instances of this occurring at some large cosmetic surgery clinics in Australia. The effect this has on the public is that patients who have had bad experiences are essentially silenced. Breaching their NDA could lead to court action. They have no way to inform the public of what has happened to them. They will normally sign an NDA if it means they will receive a refund, or if the doctor agrees to do revision surgery. If they choose not to sign an NDA, the doctor may refuse to do revision surgery or refuse a refund.'*[125]

Consumers' belief that they are unable to report cosmetic surgery concerns following signing a NDA further displays the information asymmetries that exist in cosmetic surgery. This is noting many consumers may not have ready access to legal advice or understand how the terms of a NDA align with their ability to make notifications about practitioners to regulators, further contributing to ongoing consumer harm.

[125] Operation Redress Pty Ltd (April 2022). Submission to the Independent Review of the Regulation of Health Practitioners in Cosmetic Surgery. Available from <https://www.ahpra.gov.au/News/Consultations/Past-Consultations.aspx>.

Ahpra and the Medical Board have committed to strengthening existing guidance to practitioners that NDAs should not be used to dissuade a consumer from making a notification,[126] while Ahpra has launched a cosmetic surgery complaints hotline, supporting notifiers to raise concerns confidentially.[127] Further, National Law provisions in some jurisdictions refer to complainant protections in health complaints legislation.[128] While other jurisdictions provide protections for complainants in health complaints legislation, these are not incorporated into the National Law.[129]

However, stronger deterrents for other individuals or entities could be achieved by amending section 237 of the National Law to provide stronger protections for notifiers and prospective notifiers.[130] Proposed National Law amendments to provide better protections for notifiers has also been identified in other prior investigations.[131]

To enhance protections for notifiers and prospective notifiers, further consideration may be given to amending of the National Law to create comprehensive, nationally consistent notifier protections, including to:

- specify that notifiers are protected from reprisals, for example intimidation, coercion and bribery
- protect prospective notifiers from legal, financial and administrative action and reprisals, and
- prohibit attempting to prevent someone from making a notification through legal, financial and administrative action and/or reprisals, and for reprisals against notifiers and witnesses, including the introduction of offences that mirror jurisdictional health complaints legislation.

Such amendments would provide Ahpra with stronger tools to deter these behaviours and prosecute offenders where an individual or entity has used or implied a threat of reprisal to attempt to dissuade a person from making a notification.

Review of private facilities licensing

The Consultation RIS noted that while requirements for the delivery of cosmetic surgery, including licensing of facilities, is broadly similar across Australian jurisdictions, there are some differences.

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[126] Ahpra and National Boards, 'The Medical Board and Ahpra's response to the cosmetic surgery review', retrieved 28 October 2022, <https://www.ahpra.gov.au/Resources/Cosmetic-surgery-hub/Cosmetic-surgery-review/Our-response-to-the-cosmetic-surgery-review.aspx>.

[127] Ahpra and the Medical Board (1 September 2022). Media release. *Ahpra and Medical Board accept recommendations of the cosmetic surgery review in full*. Available from <https://www.ahpra.gov.au/News/2022-09-01-Ahpra-MBA-CSR-reply.aspx>

[128] Refer to the *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) s 143A; *Health Care Complaints Act 1993* (NSW) s 98; *Health Practitioner Regulation National Law Act 2009* (Qld) s 146; *Health Ombudsman Act 2013* (Qld) ss 261, 262, 263.

[129] For example the *Health Complaints Act 2016* (Vic) provides significant protections for complainants (s 76), as well as offences for threatening complainants or prospective complainants (s 80).

[130] National Law s 237 states that notifiers are deemed not to be liable, "*civilly, criminally or under an administrative process, for giving the information* [and] *no liability for defamation is incurred by the person because of the making of the notification or giving of the information*".

[131] See Recommendation 7.5 of the *Royal Commission into Institutional Responses to Child Sexual Abuse* in 2017 and Recommendation 9 of the National Health Practitioner Ombudsman's *Review of confidentiality safeguards for people making notifications about health practitioners* in 2019.

Some professional stakeholders in their submissions raised concerns about different private hospital and day procedure centres licensing legislation between jurisdictions and the inconsistencies in these laws. Issues with this licensing was also identified in the Independent Review final report, and its 15th recommendation noted that the Medical Board and Ahpra should suggest to health ministers that work be undertaken to develop a standardised national approach to health facility licensing and accreditation, including the types of cosmetic procedures that can be performed in each kind of facility.[132]

Accordingly, on 2 September 2022 the HMM announced it would: 'task the Australian Commission on Safety and Quality in Health Care (ACSQHC) to immediately begin work to safeguard patients by leading a review of licensing standards and arrangements of private hospitals, day procedure centres and clinics where cosmetic procedures are performed and to develop national standards for the safe delivery of high-quality cosmetic procedures'.[133]

Increasing provider liability for non-economic damages (Consultation RIS Option 2.2)

Option 2.2 in the Consultation RIS proposed increasing provider liability for non-economic damages, to potentially provide greater legal recourse to consumers who suffer harm. This would likely involve amendments to relevant legislation in each jurisdiction.

As noted in the 'Consultation' section of this report, this option was supported by the campaign submissions, though the option was not discussed in in these submissions beyond noting support. Other professional stakeholders who addressed this option were mostly not supportive, stating that this proposal could increase medical indemnity insurance scheme costs and impact on sustainability, and would not effectively prevent the problem. Similarly, very few consumer survey respondents (4% or n. 22) discussed or supported this option.

It was also noted that implementation of this reform option would require legislative amendments across jurisdictions, which would be complicated to implement. Respondents also commented that increasing provider liability may further encourage medical tourism and rogue cosmetic surgery practices, that this option may not address patient harm, and may deter competent practitioners from performing cosmetic surgery due to fear of risk and potential liability.

As there was very limited support from consumers regarding this option, and limited discussion of the benefits of this option among professional stakeholders that supported it or discussion about how the implementation challenges and unintended consequences might be addressed, this option is not being recommended to health ministers at this time.

Out of scope proposals

Several submissions discussed use of title 'surgeon' by health practitioners other than medical practitioners, such as podiatrists and dentists. Reform proposals relating to these practitioners are not considered to be within the scope of this Decision RIS, which is limited to consideration of the use of the title 'surgeon' by medical practitioners. The recommendations in this Decision RIS are not intended to affect any use of the title 'surgeon' within other health professions. Equally, there is no

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[132] Independent Review , Final Report, p. 15.

[133] Health Ministers Meeting (HMM), *HMM statement on cosmetic surgery*, available at < https://www.health.gov.au/resources/publications/hmm-statement-on-cosmetic-surgery-2-september-2022>.

intention to regulate use of the term 'surgeon' in contexts outside of human health, such as 'veterinary surgeon' or 'tree surgeon'.

8. Preferred option

Having regard to the results of the impact assessment outlined in this Decision RIS, and the feedback received in response to the Consultation RIS, the preferred option is **Option 3.2** – restricting the use of the title 'surgeon' to specialist medical practitioners with significant surgical training.

As set out in the table below, and the 'Assessment of reform options' section, Option 3.2:

- is likely to yield a range of benefits to consumers, medical practitioners, government and regulators, and the broader health sector
- along with Option 3.1, is anticipated to have the greatest impact in addressing the problem set out in the Problem Statement in the Decision RIS
- will impact fewer medical practitioners than Option 3.1, and (unlike Option 3.1) will enable certain medical practitioners who have significant surgical training who are not registered in a surgical specialty to continue to use the title 'surgeon'
- will have a lower regulatory burden than Option 3.1, and has a number of other benefits when compared to Option 3.1, such as providing greater flexibility to enable adjustments to occur in future if necessary to adapt to changing surgical training standards or practice, and
- is consistent with the expert advice provided to HMM by the Medical Board of Australia.

Implementation of Option 3.2 would mean use of the title 'surgeon' (including the informal title 'cosmetic surgeon') would be regulated consistently between different areas of surgery, including cosmetic surgery.

As discussed in this Decision RIS, Option 3.2 is expected to work in a complementary manner with a range of reforms already committed to by health ministers, Ahpra and the Medical Board, in particular:

- establishment of an approved area of practice endorsement for cosmetic surgery, and
- a public education campaign in relation to cosmetic surgery.

Implementation of title protection in combination with an area of practice endorsement will provide consumers with meaningful information to enable them to assess the qualifications of their prospective practitioner, including where consumers seek cosmetic surgery. Consumers will be able to assess whether a medical practitioner has significant surgical training (through use of the title 'surgeon') and whether the practitioner has qualifications relevant to cosmetic surgery (through holding an endorsement).

The public education campaign is also expected to amplify the impact of both of these reforms, as the education campaign would further assist consumers to understand practitioners' qualifications and titles, including by explaining these reforms and how consumers can use this information to assist them to choose appropriate practitioners. More generally, the education campaign is expected to inform consumers about risks associated with cosmetic surgery and other avenues for information, assistance or complaint.

It is expected that implementation of each of these reforms in combination will significantly address the problem outlined in this Decision RIS. The 'Implementation and Review' section sets out how the preferred option will be implemented and reviewed.

Table 11: Comparison of options

	Option 1 – base case	Option 2 – administrative reforms	Option 3.1 – title protection (surgical specialties only)	Option 3.2 – title protection (significant surgical training)
Cost-benefit analysis (summary)				
Consumers	No market impacts. Continued confusion about titles and exposure to risk and harm.	Minimal market impacts. Limited potential to address consumer confusion.	Improved understanding of titles and ability to make informed choices. Potential for reduced exposure to risk and harm. Potential price and supply impacts on cosmetic surgery market.	Same as Option 3.1, but potentially simpler to communicate reforms to consumers.
Medical practitioners	No compliance costs or impact on title use. Continued impact on confidence in industry.	Potentially clearer expectations for practitioners. Potential for some costs if practitioners change behaviours.	Practitioners restricted in use of title 'surgeon'. Market shifts between practitioner groups. Costs to practitioners associated with training and advertising.	Same as Option 3.1, but a higher number of practitioners will be able to continue to use the title 'surgeon'.
Government and regulators	No additional costs. Confidence in regulatory system likely to continue to be impacted.	Limited potential to improve confidence in the regulatory system.	Likely to improve confidence in the National Scheme. Expectations of government action will be met. Additional levers for regulators. Implementation costs.	Same as Option 3.1, but greater flexibility to adjust categories of practitioners able to use the title.
Broader health sector	Some continued costs associated with revision surgery.	Some continued costs associated with revision surgery.	Potentially lower costs to the public health system from revision surgery.	Same as Option 3.1.

			Potential strain on clinical practice placements.	
Assessment against criteria (comparative ranking)[134]				
Information asymmetry	**4**	**3**	**1**	**1**
Public protection	**4**	**3**	**1**	**1**
Public confidence in the National Scheme	**4**	**3**	**1**	**1**
Regulatory burden estimate				
Average annual regulatory costs ($)	**(0.0m)**	**(0.20m) – (0.60m)**	**(0.84m) – (2.58m)**	**(0.66m) – (2.01m)**

How the consultation feedback informed the preferred option

As outlined in the 'Consultation' section, both professional stakeholders and consumer survey respondents confirmed overwhelmingly through the consultation process that maintaining the status quo would not be acceptable, given the problems outlined in the Consultation RIS, including:

- public confusion about the use of the title 'surgeon' by medical practitioners, and
- concerns about risks and harm associated with cosmetic surgery.

Respondents raised significant concerns consistent with those articulated in the Consultation RIS, the consultation process indicated that reforms are required to address these issues.

This stakeholder feedback has been an important consideration in not recommending continuing with the 'status quo', noting this was overwhelmingly rejected as an option by both professional stakeholders and consumers. As previously noted, health ministers, Ahpra and the Medical Board have already committed to a range of reforms in relation that will improve on the status quo outlined in the Consultation RIS.

Further, respondents noted throughout their submissions that the implementation of specific proposed options in isolation would be insufficient to address harms to consumers in the area of cosmetic surgery. The ability to implement the preferred option in a complementary manner with the other reforms already committed to (such as establishing an area of practice endorsement for cosmetic surgery and implementing a public education campaign) has been further considered and outlined in this Decision RIS.

It was noted that a significant number of professional stakeholder respondents did not support protection of the title 'surgeon' under the National Law as it was presented in the Consultation RIS. A key concern of some stakeholders was that title protection, on its own, may not address concerns and instances of harm specific to cosmetic surgery, and that advanced qualifications in surgery does not necessarily mean a practitioner is competent in cosmetic surgery.

[134] See section on 'Assessment against the problem criteria'. A ranking of '1' indicates the option is expected to have the greatest impact in addressing the problem criteria.

As previously noted, it is considered that this is best addressed by title protection and area of practice endorsement for cosmetic surgery being implemented in a complementary manner. This will enable consumers both to make an assessment about a practitioner's surgical qualifications, through their use of the title 'surgeon', as well as their specific qualifications in cosmetic surgery, through an area of practice endorsement.

As noted in the 'Consultation' section of this Decision RIS, where stakeholders supported title restriction, Option 3.2 (Option 4.2 in the Consultation RIS) was generally preferred, noting it would enable other practitioner cohorts with significant surgical training to use the title (consistent with the policy intent of the reform) compared to Option 3.1 (Option 4.1 in the Consultation RIS) which would be limited only to the 10 surgical specialties. This has also been taken into account in the assessment of the preferred option in the Decision RIS.

9. Implementation and review

Implementation

Changes to the National Law would be required to implement restrictions on the use of the title 'surgeon'. Subject to the agreement of the HMM, amendments will be prepared for introduction into the Queensland Parliament, as the host jurisdiction for the National Law.

It is anticipated a Bill would be introduced into the Queensland Parliament in early to mid-2023. Timing for passage of the Bill would be subject to the sitting dates and legislative priorities of the Queensland Parliament.

In most jurisdictions, changes to the National Law are automatically applied by the application legislation of that jurisdiction. In Western Australia a corresponding amendment Bill will be required while in South Australia and New South Wales, a regulation is required to apply the changes to the National Law.

Ahpra and the Medical Board will be required to undertake additional implementation and compliance activities relating to the new title restrictions. This may include:

- education and awareness activities
- pursuing complaints in relation to use of the title 'surgeon' or 'cosmetic surgeon'.

In addition, some implementation activities would need to be undertaken by individual practitioners and professional organisations, for example:

- medical practitioners that currently use the title 'surgeon' but will no longer be permitted to use the title may need to take actions to ensure their marketing and advertising complies with the new laws
- professional organisations may need to communicate the changes to their members to ensure they comply with the new laws.

Given the expressed desire for health ministers to take urgent action it is anticipated that the legislation would come into operation as soon as practicable after its passage. However, consideration would need to be given to:

- providing sufficient advance notice to practitioners to ensure they are able to comply with the new laws

- transitional measures to ensure practitioners have a reasonable opportunity to comply with the new requirements (for example, additional time to update 'current' advertising material such as website content).

It is not expected that practitioners would be required to amend 'old' advertising or marketing materials in which they have used the title 'surgeon', as this would have been legal at the time these materials were published. However, if practitioners were to re-publish the same material they would be obliged to ensure it complies with the new laws.

The public education campaign being commissioned by HCEF would also need to take into account the changes to regulation of the title 'surgeon'. Consumer awareness of the changes would support consumer understanding of the significance of practitioners' qualifications and titles, particularly for consumers seeking to undergo cosmetic surgery. The education campaign would also likely need to explain to consumers the interaction between the title 'surgeon' and an area of practice endorsement in cosmetic surgery. Further, given the apparent lack of consumer awareness of existing sources of information under the National Scheme (such as the practitioner register), the education campaign will also need to make the public aware of these resources, where they can be found and how they can best be used.

Review

Overall, the ability to evaluate the effectiveness of the proposed reforms in the present environment is limited given the lack of evidence and data on cosmetic surgery noted extensively in this Decision RIS. However, it is hoped that improvements in this area will be forthcoming given the range of forthcoming reforms and the development of a national plan for improving data collection for cosmetic surgery has been recognised as a priority by health ministers.

In the meantime, the effectiveness of the proposed reforms to achieve the desired objectives identified in this Decision RIS (including reducing information asymmetry, promotion confidence in the national scheme, and improving public protection) can be monitored and reviewed over time through:

- ongoing compliance and monitoring activities conducted by the new Cosmetic Surgery Enforcement Unit based in Ahpra (for example, establishment of a consumer hotline, audit of advertising, practitioner notifications)
- other routine reporting conducted by Ahpra and the Medical Board
- any evaluation and feedback from the impending national public education campaign on cosmetic surgery
- other complaints relating to cosmetic surgery received by health complaints entities, other regulators and government bodies.

The following challenges are noted in evaluating the success of the reforms recommended in this Decision RIS:

- The proposed option is being recommended in the context of numerous other reforms. As such it is likely to be difficult to isolate the impact of title restriction compared to other interventions that are being concurrently implemented.
- Notifications and complaints data is likely to be of limited use in assessing the success of reforms including those recommended in this Decision RIS. One concern that has been noted during consultation is that consumers may have limited awareness of avenues for

complaints. Additionally, the Independent Review noted concerns about the lack of mandatory notifications by practitioners. Accordingly, an increase in complaints or notifications would not necessarily suggest the reforms are not having the intended effects.

The below table outlines the metrics that could potentially be used to measure progress against the stated objectives.

Table 12 Metrics for measuring progress against objectives

Objective	Potential metric	Responsible party
Reducing information asymmetry	Proportion of consumers who indicate and/or demonstrate that they: • understand medical practitioner titles and qualifications • their legal rights, such as the availability of, and process for, making complaints • have confidence in the national scheme in protecting the public	Evaluator of the public education campaign, once completed
Promoting confidence in the National Scheme		
Improving public protection	• Number and type of notifications (and their outcomes) relating to cosmetic surgery and/or use of the title 'surgeon'[135]	Ahpra through existing mechanisms including collection of data relating to mandatory and voluntary reporting[136]
	• Number of consumer complaints raised	Other health complaints entities or regulators that receive such complaints

[135] It is expected that there will be an initial increase in the number of complaints received and associated compliance activity relating to the use of the title 'surgeon' following the proposed change to the National Law. Given levels of confusion and underreporting observed in this RIS, such changes in the short term would in fact validate efforts designed help practitioners and consumers understand on who can lawfully use the title.

[136] Other reforms currently being implemented, such as the establishment of the Cosmetic Surgery Enforcement Unit and Ahpra's cosmetic surgery complaints hotline, may also provide additional sources of data.

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11. Appendices

Appendix A – Other elements in the regulatory framework for the performance of surgical procedures

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.[137] 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 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.[138] 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.[139]

Additional protocols are stipulated for prospective clients who are minors including specific requirements to obtain consent and referrals to other practitioners prior to procedures.[140]

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'.[141] 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

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

[138] Ibid, p. 4.

[139] Ibid, p. 3.

[140] Ibid.

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

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'.[142]

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.[143]

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.[144]

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 injectables.

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 $60,000 for each advertising offence for an individual and $120,000 for a body corporate.[145]

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.[146] 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

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

[143] Ibid, pp. 10-11.

[144] Ibid, p. 16.

[145] National Law s 133(1).

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

- 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.[147]

Where practitioners breach advertising provisions under the National Law, they may be subject to financial penalties.[148]

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.[149]

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 Scheme'.[150] 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.

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)

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

[148] National Law s 133.

[149] *Lotteries and Art Unions Act 1901* (NSW), see definition of 'prohibited prize' in section 2A; *Lotteries Act 2019* (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).

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

- have any reprimands for previous conduct undertaken, or
- have given a National Board an undertaking not to perform certain procedures or to provide services to a category or categories of patient/s.[151]

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[152] – 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.[153]

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.[154] 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,[155] 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.[156] 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.[157] 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.[158] Typically, this discretion is exercised by a Board to maintain the practitioner's privacy,[159] if there is no overriding public interest for recording the information,[160] or if publishing the information may pose a serious risk to the practitioner's health and safety.[161] Finally, cautions given to practitioners relating to their conduct

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

[152] 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.

[153] Ibid.

[154] Ibid.

[155] See National Law s 178.

[156] 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.

[157] 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).

[158] 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'.

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

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

[161] Ibid s 226(2).

may only be made available on the public register in circumstances that the relevant National Board deems necessary.[162]

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.[163]

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.[164] 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.

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 health services.[165] Such procedures are also classed as prescribed health services in South Australia that must be performed in licensed day procedure centres.[166] New South Wales regulation stipulates that cosmetic surgery must be performed in private health facilities.[167] In Victoria surgical

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[162] 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.

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

[164] *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); Med*icines, Poisons and Therapeutic Goods Act 2012* (NT); *Poisons Act 1964* (WA); *Medicines, Poisons and Therapeutic Goods Act 1966* (ACT).

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

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

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

procedures requiring provision of anaesthesia[168] and liposuction procedures involving removal of a minimum of 200 ml of lipoaspirate[169] must be performed in day procedure centres.

Private Health Facility Licensing

Requirements for the delivery of cosmetic surgery, including licensing of facilities, can differ across Australian jurisdictions, albeit moderately.[170]

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[171] and in Queensland and South Australia, 21 specific cosmetic surgical procedures must also be performed in these facilities.[172]

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.[173] 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.[174]

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

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

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

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

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

[173] In the ACT and Victoria for example.

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

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.[175] Performance of defined cosmetic procedures on children is prohibited, unless it is in the 'best interests of the child'.[176]

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.[177] 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 with what is

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

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

[177] 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.

widely held by a significant number of respected practitioners in the relevant field to be competent practice.[178]

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.[179]

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.

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

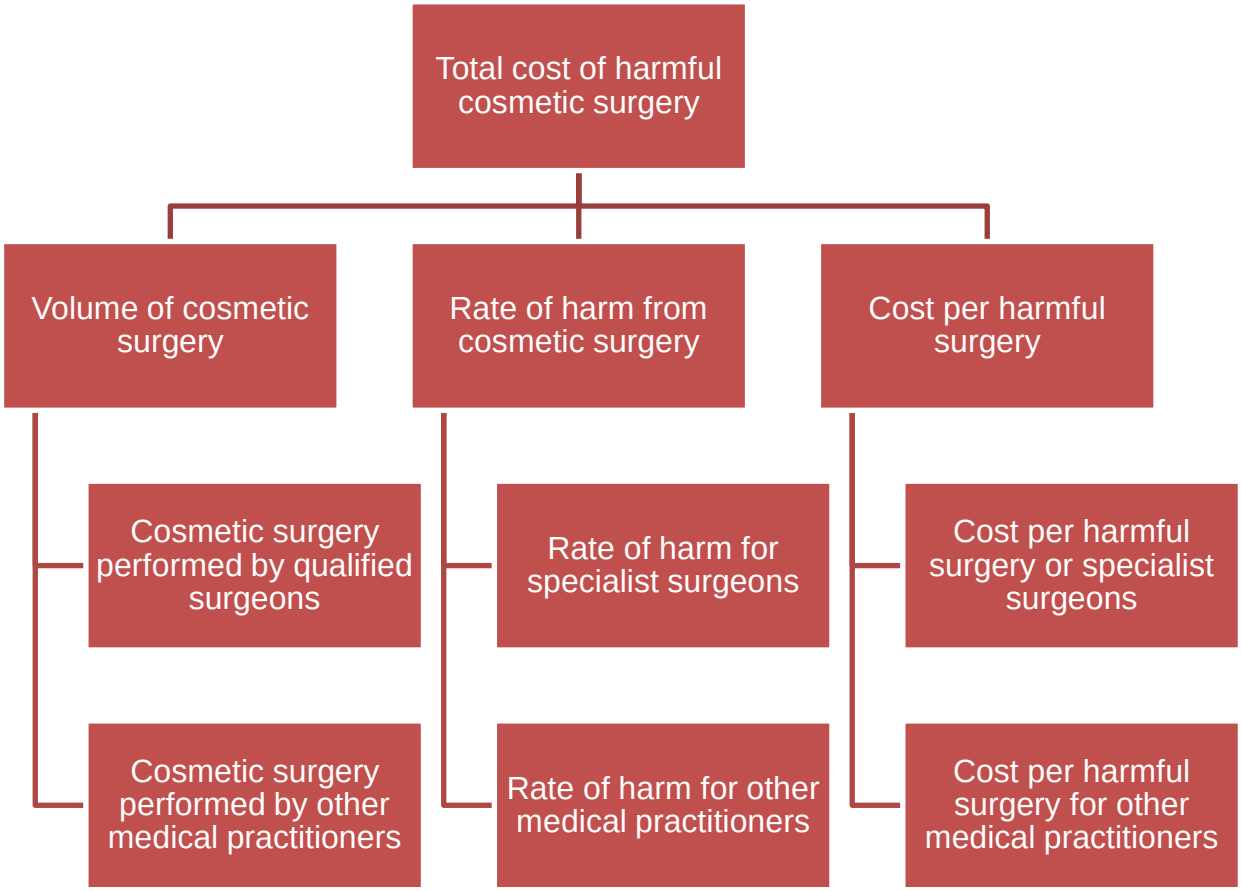
[179] *F v R* (1983) 33 SASR 189 (King CJ), cited with approval in *Rogers v Whittaker* (1992) 175 CLR 479, 490.

Appendix B – Challenges with estimating the cost of consumer harm from cosmetic surgery

A baseline cost of cosmetic surgery harm can hypothetically be calculated as follows:

$$Total\ cost\ of\ harmful\ cosmetic\ surgery = volume\ of\ cosmetic\ surgery \times rate\ of\ harm\ from\ cosmetic\ surgery \times cost\ per\ harmful\ surgery$$

To understand the incremental benefits between status quo and reform options also requires knowledge of the different volume and extent of harm encountered by practitioners at varying levels of qualification (e.g., between a specialist surgeon and other medical practitioner providing cosmetic surgery), as well as knowledge of the extent to which the different options would theoretically reduce this harm.



The table below provide a summary of the state of available data and evidence on key variables in the formula. These are explained in further detail in the sections below. As noted in the table, it is not practicable to calculate a baseline level of consumer harm arising from cosmetic surgery, or estimate how much each option might reduce this level of harm, due to the significant data

limitations. Feedback on the Consultation RIS did not provide sufficient information to be able to reliably estimate these inputs.

Key variable	Available data points	Data limitations	Conclusion
Volume of cosmetic surgery	Survey by the International Society of Aesthetic Plastic Surgery (ISAPS)	• Does not include surgery performed by non-plastic surgeons • Latest available data is from 2018 • Data is based on survey	**Existing data is unlikely to provide an accurate and full picture of volume of cosmetic surgery, with data especially poor for certain cohorts of practitioners (e.g., non-plastic surgeons operating in private settings).**
	Volume of cosmetic surgery in public hospital datasets (e.g., Victorian Admitted Episodes Dataset)	• Cosmetic surgery may be counted differently across different datasets (e.g., some datasets may include reconstructive surgery that are done for therapeutic purposes) • Only counts surgeries in the public system, which is expected to be small compared to activity in the private sector.	
Rate of harm	Ahpra practitioner notifications	• Likelihood of underreporting is high • Not all notifications are confirmed cases of harm • There may be widespread consumer harm occurring below the threshold for a notification to be made	**Existing data is unlikely to provide an accurate and full picture of the frequency of harm associated with cosmetic surgery.**
	Complaints from Health Complains Entities	• Likelihood of underreporting is high • Not all complaints are confirmed cases of harm • There may be widespread consumer harm occurring below threshold for complaint	
	Private transfers to public system	• Challenge to attribute episodes in data set to adverse cosmetic surgical events • There may be widespread consumer harm occurring that does not show up in the data	
	Consultation RIS consumer survey responses	• This may overstate the rate of harm as consumers who experience harm may be more likely to respond to the survey • Difficult to substantiate self-reported instances of harm	

Severity of harm and its cost	Civil claims	• Not-representative, does not provide a sense of what "typical" harm looks like • Medical indemnity insurance covers most liability, however this information is not public	**Existing data is unlikely to provide an accurate and full picture of the severity and distribution of harm associated with cosmetic surgery.**

Volume of cosmetic surgery

There is very little data available to quantify the number of cosmetic procedures that occur in Australia each year, the number of practitioners performing cosmetic surgery, and their background and qualifications. Stakeholder submissions to the consultation did not identify any additional data that could provide better visibility of around the activity of surgery.

Rate of harm from cosmetic surgery

Previous inquiries have identified that there is very little data available to quantify the number of cosmetic procedures that occur in Australia each year, the number of practitioners performing cosmetic surgery, or the realistic number of adverse outcomes. These findings have been confirmed by the feedback on the Consultation RIS, which did not identify significant additional data sources from stakeholder submissions.

There is currently no reliable framework to accurately capture data on notifications in relation to poor cosmetic surgical outcomes. There is also evidence of underreporting of concerns about cosmetic surgeons and data on the number of medical indemnity insurance claims occurring and the amounts claimed is unavailable. The true number of instances of poor cosmetic surgical outcomes that occur per year is therefore unknown.

The final report of the Independent Review undertook a manual analysis to identify cosmetic surgery notifications that were received by Ahpra between 2018-2021.Of the 177 notifications identified, only four resulted in any formal regulatory action being taken against the practitioner (**Error! Reference source not found.**). For the remaining 173 notifications, no adverse findings w ere made against the practitioner, with:

- no further action being taken for 107 notifications, and
- the matter being managed by another regulator in 66 of the notifications.[180]

Table 13: Number of cosmetic surgery notifications received over three years from 2018 – 2021, and registration categories of corresponding practitioners[181]

Practitioner registration category	Number of notifications	Number of practitioners
Plastic surgeons	100	56 (1 caution)

[180] Brown, A. (2022). Final report: Independent review of the regulation of medical practitioners who perform cosmetic surgery, commissioned by Ahpra and the Medical Board of Australia, p. 59-60.

[181] *Ibid*.

General registrants	19	18
General practitioners	18	10 (1 conditions imposed)
Other surgeons (for example, otolaryngologist)	17	14 (2 cautions)
General surgeons	17	13
Dermatologists	5	2
Other	1	1
Total	177	114

The Independent Review report identifies that this is likely to be an incomplete dataset and cautions against drawing definitive conclusions from this data about the competency of any particular cohort of practitioners for the following reasons:

- 'the fact that a notification is made against a practitioner does not of itself indicate any wrongdoing, malpractice or substandard performance'
- 'not all conduct and practice concerns result in a notification being made'
- "without knowing the total populations of practitioners in these cohorts who undertake cosmetic surgery, it is not possible to establish any kind of reliable [notification] rate.'[182]

Available cosmetic surgery notifications data is likely to be incomplete and is likely be an underestimate, noting that consumers may not necessarily complain to Ahpra, the Medical Board or a health complaints entity. Some consumers would likely settle complaints with their treating practitioner and through medical indemnity insurance settlements. The Independent Review also notes the lack of mandatory notifications by practitioners.

Cost per harmful cosmetic surgery procedure

Finally, the 'typical' or 'baseline' cost of a harmful cosmetic surgery procedure is a required input needed to calculate the total cost of harm caused by cosmetic surgery procedures. In practice, this cost is difficult to ascertain because:

Cosmetic surgery occur in the private market and complications are not consistently captured in routine health care data sets. Indeed, there have been reports that practitioners actively dissuade unsatisfied customers from seeking reparatory care from public providers.[183]

Instances of harm are reported inconsistently, via:

- notifications to Ahpra
- complaints to Health Complaints Entities
- media reports

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[182] Reproduced from Table 4 of: Brown, A. (2022). Final report: Independent review of the regulation of medical practitioners who perform cosmetic surgery, commissioned by Ahpra and the Medical Board of Australia, p. 60.

[183] 'Beauty's new normal', *Four Corners* (ABC), posted 13 August 2018, <https://www.abc.net.au/4corners/beautys-new-normal/10115838>..

- anecdotally, for example via reports from other medical practitioners
- legal claims.

Importantly, existing reports of harm provide no clues as to what the true range of harm is, or what might constitute a 'typical' case of harm on which to deduce a baseline cost.

As a result, any attempt to estimate harm and damage will result in extremely large ranges that cannot be used as a defensible numerical basis to provide any reliable estimates of baseline harm or the impact of reforms on baseline harm.

An example is provided below of the types of quantifiable harms that might be associated with instances of harm arising from cosmetic surgery. For the purpose of the calculations below, the *Wrongs Act 1958* (Vic) (Wrongs Act) was used to estimate the range of payments that could hypothetically be associated with economic and non-economic damages awarded due to medical negligence from cosmetic surgery harm and adverse outcomes. These are likely to be conservative estimates of the real-life impacts on people that experience cosmetic surgery harms.

The Wrongs Act applies a cap to the maximum amount that can be awarded for non-economic damages of $644,640 (the maximum that could be claimed in Victoria in 2021-22). The Wrongs Act requires that a person must have suffered a 'significant' injury to be eligible to claim for non-economic loss. The thresholds for 'significant' permanent impairment are 10% or more (psychiatric injury), 5% or more (spinal injuries), or more than 5% (injuries other than psychiatric or spinal injuries).[184] For ease of calculation, the minimum economic and non-economic damages awarded was set to five percent of the relevant cap.

Evidence from the available literature and the consumer survey show that cosmetic surgery consumers tend to be middle aged women, in higher socio-economic groups. The hypothetical affected cosmetic surgery consumer (claimant) is a 40-year-old woman in good health, who has a high level of health literacy. She has a primary school-aged child and has gratuitous childcare responsibilities for 31 hours per week (3 hours each weekday and 16 hours over the weekend). The number of years of gratuitous childcare still to be provided is estimated to be five. This person is working full time earning $1,900 per week. Retirement age is assumed to be 65 years, with a natural life expectancy of 85.3 years.[185]

Based on these assumptions, the range between the moderate and extreme cases used in the hypothetical scenario is very large (damages: $44,000 – $3.5 million, healthy life years loss: 2.3 – 45.3 years).

An alternative measure for valuing avoided harm is to use the value of a statistical life. The Australian Government's Guidance Note states that 'Based on international and Australian research a credible estimate of the value of statistical life is $5.3m and the value of statistical life year is $227,000 in 2022 dollars'.

[184] Victoria State Government, Justice and Community Safety Victoria (2022). Compensation for personal injury. Available from <https://www.justice.vic.gov.au/compensation-for-personal-injury>, accessed 3 October 2022.

[185] Average life expectancy of a girl born in 2018-20. Source: Australian Bureau of Statistics (2021). Life tables. Statistics about life tables for Australia, states and territories and life expectancy at birth estimates for sub-state regions. Reference period 2018-2020. Available from <https://www.abs.gov.au/statistics/people/population/life-tables/2018-2020>.

Compensatory damages		Moderate (5% of most extreme case)	Extreme (Maximum - 100% of most extreme case)
Description of hypothetical poor cosmetic surgery outcome and impacts on claimant		Adverse outcomes that result in a permanent physical impairment of 5% loss of normal function, and a moderate impact on the person's daily life	Catastrophic outcomes such as total and permanent disability (TPD) or death. In this example death is used, not TPD.
Non-economic losses	Pain and suffering: psychological impacts (physical or psychiatric pain resulting from injury)	$32,232	$644,640[186]
	Loss of amenities of life, e.g., social and recreational participation and enjoyment, scarring and disfigurement		
	Loss of expectation of life (shortened lifespan)		
Economic losses	Loss of earning capacity (past and future)[187]	10% reduction in earnings for one month: $760	25 years: $2,470,000
	Gratuitous attendant care expenses[188]	Not required	NA

[186] *Wrongs Act 1958 (Vic)*, and Understanding thresholds and caps in personal injury litigation | Victorian Government Solicitor's Office (vgso.vic.gov.au)

[187] Under the *Wrongs Act* s 28F, the maximum amount of damages that may be awarded for each week of lost earnings is three times the average weekly earnings as at the date damages are awarded. May 2022 was used as the reference date for calculations. The Australian Bureau of Statistics reported the Victorian average ordinary full-time time earnings as $1,751 (Australian Bureau of Statistics (2022), *Average Weekly Earnings, Australia, May 2022*. Available from <https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/may-2022#state-and-territory>)

[188] Damages for gratuitous attendant care services may only be awarded if the services are provided for at least six hours per week for at least six months (source: *Wrongs Act 1958* s 28IA). Costs calculated using the average Victorian employee earnings per hour, up to 40 hours per week (source *Wrongs Act* s 28IB)

	Loss of capacity to provide gratuitous care to claimant's dependents[189] 31 hours per week Resulting in a payment of $1357 per week	NA	Five years of childcare care (260 weeks @ $1357 per week): $352,766
	Health care costs, including costs associated with treatment required due to poor outcomes from cosmetic surgery, for example additional hospitalisation, appointments and revision surgeries.	Estimated at $10,000	N/A
Total		**$43,992**	**$ 3,467,406**

Hypothetical scenario: estimate of the range of years of healthy life lost due to the impacts of poor cosmetic surgical outcomes

	Moderate: 5% of the most extreme case	Extreme: 100% of the most extreme case
Per affected cosmetic surgery consumer	2.3 (0.05 per year, or 18.5 days per year)	45.3 years (assumes an average female lifespan of 85.3 years)

[189] Calculated using the average Victorian employee earnings, up to 40 hours per week (source: *Wrongs Act 1958* s 28IE).

Appendix C – Regulatory burden on medical practitioners

The Australian Government Guide to Regulatory Impact Analysis discusses the importance of avoiding imposing unnecessary regulatory burden on businesses, individuals and community organisations.

All new regulations or changes to existing regulations need to have the increase or decrease in regulatory costs imposed on businesses, community organisations and individuals quantified using the Regulatory Burden Measurement framework. Additionally, all Regulation Impact Statements need to be accompanied by a regulatory costing.

The framework considers the following regulatory costs:

Compliance costs

- administrative costs incurred by regulated entities primarily to demonstrate compliance with the regulation
- substantive compliance costs incurred to deliver the regulated outcomes being sought

Delay costs[190]

- expenses and loss of income incurred by a regulated entity through an application or approval delay.

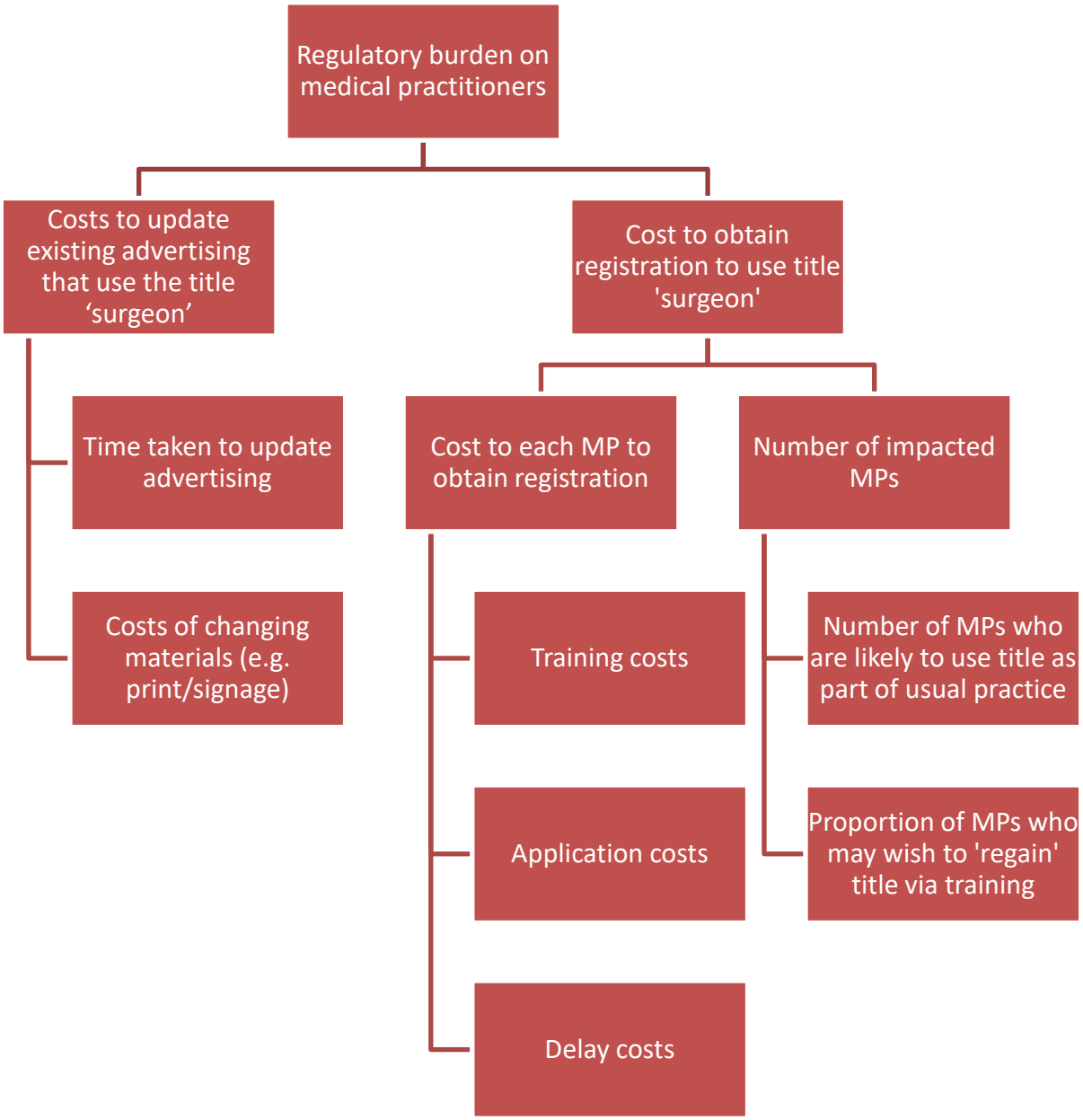
In accordance with the framework, costings of the options 2 and 3 have been developed over a 10-year default duration of the regulation.

It is anticipated that the regulatory burden will fall on medical practitioners who no longer use of the title surgeon, as a result of implementation Options 2 or 3 in the RIS. No other regulatory burden is expected for other individuals, community organisations, or businesses.

The breakdown of regulatory burden on medical practitioners who are affected by the options considered in this RIS is represented in the figure below. These include:

- the cost to update any existing advertising or marketing material that uses the title 'surgeon'
- the cost to undertake relevant specialist education and training to use the title 'surgeon
- the cost to apply for specialist registration to use the title 'surgeon', after completion of relevant specialist education and training.

[190] Opportunity costs not related to a delay is excluded as per Australian Government guidance.



Cost to undertake training to use title 'surgeon'

As a result of the options considered in this RIS, it is anticipated that some proportion of medical practitioners who lose access to the title 'surgeon' would want to regain use the title by undertaking additional specialist surgical training required to obtain a specialist registration.

Cost to each medical practitioner to obtain training and registration

The costs incurred to each medical practitioner are one-off and involve obtaining relevant specialist training to meet requirements to obtain registration that would enable the medical practitioners to

use the title 'surgeon'. These costs are summarised against the cost categories considered in the Regulatory Burden Measurement framework in the table below.

	Description of costs incurred on impacted MPs	Cost per impacted MP
Compliance costs		
Administrative costs	Cost to add specialist registration to a current general registration	$215[191]
Substantive compliance costs	Cost of training required to satisfy specialist registration requirements to use the title 'surgeon'	$28,500[192]
Delay costs	Nil[193]	N/A
	Total costs	$28,715

Number of medical practitioners potentially affected

As at 30 June 2022, there were 131,953 medical practitioners registered in Australia (including 1,367 on the 2020 and 2021 Pandemic response sub-registers).[194] Of these registered medical practitioners, there is no definitive data as to the number of medical practitioners who might

[191] See https://www.medicalboard.gov.au/Registration/Fees.aspx

[192] Cost of training required for a medical practitioner to obtain advanced surgical speciality for cardiothoracic surgery which is used as a proxy for analysis. Costs comprise:

- Administration Fee - exam pending, interruption and deferral (SET) = $370
- Selection registration fee = $595
- Selection processing fee = $840 (applies to Cardiothoracic Surgery)
- Trainees on the SET program will be charged a fee with two components:
- 3.1.1. RACS SET Fee ($3,735.00); and
- 3.1.2. Specialty SET Fee (minimum cost = Cardiothoracic surgery = $2,515.00) (annual fee - up to 6 years of training)
- Clinical examinations: $3,270.00
- Cardiothoracic Surgical Sciences and Principles Examination Fee Part 1 = $2,150.00
- Cardiothoracic Surgical Sciences and Principles Examination Fee Part 2 = $2,450.00.

[193] Delay costs (in the form of foregone income) are not expected as surgical trainees are allocated to accredited training posts as part of their surgical training.

[194] Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 4, https://www.medicalboard.gov.au/News/Statistics.aspx.

currently be referring to themselves or marketing themselves as a 'surgeon', or who perform surgery in practice.[195]

While theoretically all practitioners who would no longer be able to use the title 'surgeon' are impacted by title restriction, in practice a regulatory burden would only be experienced by those who might be likely to use the title and therefore value the possibility of using the title.

An estimate of the number of these practitioners was provided using assumptions detailed in the table below. It is noted this is likely an overestimate of the number of practitioners who are currently using the title or are likely to want to do so.

MPs who may be likely to use title	Scope of surgical practice	Estimated number of MPs affected
All fellows of Australian College of Rural and Remote Medicine (ACRRM)	Emergency (burns; critical; early severe trauma), general (incl. vascular), obstetric, plastic[196]	5,284[197]
Some Fellows of Royal Australian College of General Practitioners (RACGP) who may refer to themselves as GP surgeons	As for ACRRM[198]	5,874[199]
Some dermatologists	Biopsies, curettage, electrosurgery, excisional, complex flap surgery, scleropathy, composite skin grafts	126[200]

[195] Stakeholder submissions to the consultation indicated that at least some medical practitioners in the following categories of medical specialists would be using the title of 'surgeon' in practice, in addition to those with accredited specialist surgical qualifications: specialist ophthalmologists, specialist obstetricians and gynaecologists, specialist dermatologists, general practitioners.

[196] It has been assumed for the purposes of this calculation that all ACRRM fellows may wish to use the title 'surgeon'. ACRR Fellowship Training Handbook 2021, pp. 7, 14, 16, 26. Note that scope is difficult to precisely map to shorthand terms and that the description provided here is a summary only.

[197] ACRRM Annual Report 2021-22, p. 15.

[198] Further details about RACGP training program are at https://www.racgp.org.au/education/education-providers/curriculum/curriculum-and-syllabus/home. This report does not assume that surgical training for RACGP and ACRRM Fellows is identical, only that they are sufficiently similar for comparative purposes.

[199] It has been assumed for the purposes of this calculation that 20% of GP registrants as at 30 June 2022 (after removing 5,284 ACRRM fellows) may wish to use the title. See Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 6, https://www.medicalboard.gov.au/News/Statistics.aspx. At 30 June 2021 the RACGP counted 25,404 Fellows, with 5,579 GPs in training, 6,810 students and 6,813 'other' totalling 44,606 personnel (RACGP Annual Report 2020-21, p. 36). The Australian Bureau of Statistics counted 13, 818 clinical FTE MPs in 'inner regional' areas in Australia in 2020, 5,630 MPs in 'outer regional' areas, 899 in 'remote' areas and 448 in 'very remote' areas. See Health workforce - Australian Institute of Health and Welfare (aihw.gov.au). A figure of 6,931 affected RACGP members comprises roughly one-third of the 20,795 MPs categorised by the ABS as not working in a major city.

[200] It has been assumed for the purposes of this calculation that 20% of registrants as at 30 June 2022 may wish to use the title. See Medical Board of Australia (2022) 'Registrant Data, Reporting period: 01 April 2022 to 30 June 2022', p. 6, https://www.medicalboard.gov.au/News/Statistics.aspx.

Other MPs (e.g., cosmetic surgeon)	Cosmetic surgery and other practitioners	500
All registered Obstetricians and gynaecologists (under option 3.1 only)	Caesarean section, surgery on reproductive organs	2265
All registered ophthalmologists (under option 3.1 only)	Surgery to eye and ocular areas	1087
Total (Option 3.1)		**15,136**
Total (Option 3.2)		**11,784**

It is also expected that only a very small proportion of medical practitioners across these cohorts will seek the training required solely to qualify for use of the title 'surgeon'. The table below therefore models a range between 1%-5%.

It is expected that individuals undergo further training out of vocational interest and very few will seek training to obtain a title alone. This is confirmed by stakeholder responses to the Consultation RIS, which has indicated that it is very unlikely practitioners would wish to undertake training solely in order to use the title 'surgeon'. Instead, they would do so because they are interested in that type of work or value the experience that would be provided by that type of training.

The number of medical practitioners working in cosmetic surgery who may seek retraining to obtain title is also assumed to be very low given its comparatively high costs, as well as the availability of endorsement in cosmetic surgery (though it is not yet known what qualifications will be required for the purposes of that endorsement).

Based on the above, the range of potentially affected MPs who may wish to pursue additional training it estimated to be within 1-5% for both Options 3.1 and 3.2.

What % of affected MPs want to pursue further training?	Option 1 (affected MPs = 15,136)	Option 2 (affected MPs = 11,784)
1%	151	118
2%	303	236
3%	454	354
4%	605	471
5%	757	589

Multiplying the number of medical practitioners who may want to pursue further training to use the title 'surgeon' (as set out in the above table) by the total costs ($28,715) results in a regulatory burden estimate of:

- $4.34 million to $21.74 million for Option 3.1
- $3.39 million to $16.91 million for Option 3.2.

Averaged over a default 10 year duration, this results in an average annual regulatory cost associated with training of:

- $0.43 million to $2.17 million for Option 3.1
- 0.34 million to $1.69 million for Option 3.2.

These figures are reflected in the regulatory burden estimate tables for each option.

Cost to update advertising

All medical practitioners who currently advertise themselves as surgeons and are not in the cohort of practitioners permitted to use the title (following implementation of title restriction) will also need to change advertising as a result of the options under consideration. In the absence of data on the precise number of medical practitioners who currently use the title in their advertising, the figure of 15,136 and 11,784 used above has been used in the calculation of costs for options 3.1 and 3.2 respectively. It is noted again this is very likely a significant overestimate.

The costs included in this calculation have been assumed to include:

- Time taken for medical practitioners to identify advertising changes that may need to be made (1 hour) and to update this advertising (1 hour). It is noted that for practitioners who may only need to make minor updates (e.g., to a few pages on a website), this would likely be an overestimate of the time spent.
- Material costs relating to replacing advertising on print, signage, and website. The materials that might need to be updated are likely to vary significantly between practitioners. For example, some practitioners may only need to update a small number of pages on a website (which will likely have little or no material cost) whereas others may need to replace physical signage or re-print advertising materials (which may have a larger material cost) It is difficult to set out a 'typical' cost so a notional figure of $100 per medical practitioner has been assigned for the purposes of this calculation.

Cost item	Option 3.1	Option 3.2
Number of MPs impacted	15,136	11,784
MP time to update advertising	2 hours at $84.26 per hour[201]	
Material costs of updating advertising	$100[202]	

[201] Estimate of the value of a doctor's time in 2020 – see 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.

[202] The is assumed to consist of costs relating to replacing existing signage, business cards, and other printed material. While some practitioners may also engage in web-based advertising, it is assumed that the cost of changes to web-based content would be minor and within business-as-usual marketing costs.

For Option 3.2, this results in total advertising costs of $4.1 million, which is an average of $0.41 million per year over a 10-year default duration. This average figure is reflected in the regulatory burden estimate table for this Option.

For Option 3.1, the same calculation has been undertaken based on the figure of 15,136 practitioners relevant to that option, resulting in a total of $3.2 million, which is an average of $0.32 million per year over a 10-year default duration. This average figure is reflected in the regulatory burden estimate table for this Option.

Note that Ahpra's Independent Review found that some practitioners have already started voluntarily complying with the 'surgeon' title protection model by avoiding use of the term.[203] They are instead using such terms as 'cosmetic doctor' or 'cosmetic proceduralist', some changing very recently.

Discounting for option 2

Compared to the legislative approaches to title protection considered under Options 3.1 and 3.2, Option 2 is expected to impose a considerably smaller regulatory burden on medical practitioners as it would not actually involve practitioners being prohibited from using the title 'surgeon'. Instead, guidance (in the form of amendments to codes or guidelines) would be provided to practitioners to encourage appropriate use of the title. While it is expected some practitioners would modify their behaviour as a result of this guidance (by no longer using the title 'surgeon'), it is expected that the effect would be significantly reduced compared to option 3, which would prohibit the use of the title. Accordingly, it has been assumed that 30% of practitioners impacted by Option 3.2 might also be impacted under Option 2 and therefore the regulatory burden has been calculated by discounting the regulatory burden imposed by Option 3.2 by 70%.

Cost to update advertising

Medical practitioners who currently advertise themselves as surgeons will also need to change advertising as a result of the options under consideration. Again, in the absence of data on the precise number of medical practitioners who currently use the title in their advertising, the figure of 11,784 used above has been used in the calculation of costs.

The costs included in this area broadly includes time taken for a medical practitioner to update advertising, and material costs relating to replacing advertising on print, signage, and website.

Cost item	Option 3.1	Option 3.2
Number of MPs impacted	15,136	11,784
MP time to update advertising	2 hours at $84.26 per hour[204]	

[203] Independent review, p 40.

[204] Estimate of the value of a doctor's time in 2020 – see 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.

Material costs of updating advertising	$100[205]

For Option 3.2, this results in total advertising costs of $4.1 million, which is an average of $0.41 million per year over a 10-year default duration.

For Option 3.1, the same calculation has been undertaken based on the figure of 15,136 practitioners relevant to that option, resulting in a total of $3.2 million, which is an average of $0.32 million per year over a 10-year default duration.

Ahpra's Independent Review found that some practitioners have already started voluntarily complying with the 'surgeon' title protection model by avoiding use of the term.[206] They are instead using such terms as 'cosmetic doctor' or 'cosmetic proceduralist', some changing in very recent times.

205 The is assumed to consist of costs relating to replacing existing signage, business cards, and other printed material. While some practitioners may also engage in web-based advertising, it is assumed that the cost of changes to web-based content would be minor and within business-as-usual marketing costs.

206 Independent review, p 40.

Appendix D – Case studies – Consumer harm from cosmetic surgery

See also 'Evidence of Consumer harm: case studies' in the Consultation RIS.[207]

Case study 1

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.

Case study 2

The Health Complaints Commission (NSW) filed complaints against a specialist GP 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.

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

[207] Consultation RIS, pp 39-41, available at: https://obpr.pmc.gov.au/sites/default/files/posts/2022/02/Health_Council_-_Consultation_RIS_-_Use_of_the_title_surgeon_-_13_Dec_2021.pdf

also held that the practitioner could not have his registration reinstated for a period of seven years. One of this practitioner's patients took civil action after experiencing a poor surgical outcome from breast augmentation surgery. The resulting decision awarded damages of $204,607.50 and determined that the claim amounted to 32% of a most extreme case.

Case study 3

In this case, a medical practitioner was deemed not competent to perform laser lipolysis 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.

Appendix E – Consultation and engagement approach

The National Registration and Accreditation Scheme Review Implementation Project Team (project team) in the Victorian Department of Health led the consultation process on behalf of all jurisdictions and the HMM.

On 13 December 2021, the Engage Victoria consultation webpage launched and the Victorian Minister for Health announced the upcoming public consultation in a media release. The Consultation RIS was published on the Engage Victoria website on 16 December 2021. The consultation was also promoted to stakeholders by health departments and through the media.[208] The public consultation occurred over about three months, from 21 December 2021 to 1 April 2022.

Direct submissions – practitioners and organisations

Organisations and individual practitioners were invited to participate in the consultation by making a direct submission in response to the consultation questions set out in the Consultation RIS. These submissions were received and analysed by the project team.

Key stakeholder organisations were contacted individually to provide direct submissions and were encouraged to attend one of three online consultation information sessions, which were held on 2 - 4 February 2022.

Consumer survey

The Health Issues Centre (HIC) was engaged by the Victorian Department of Health on behalf of all jurisdictions to conduct a consumer survey, focused primarily on consumption of cosmetic surgery.

HIC extensively promoted the consumer survey in social media using paid advertisements and its own social media accounts, in a rolling campaign. Health departments and Ahpra promoted the consultation and consumer survey to local professional stakeholders and members of the public via social media and their respective websites.

The target audience for the consumer survey was health consumers in Australia who have experienced cosmetic surgery. Provisions were made to also collect responses from consumers that may not have had a cosmetic surgery experience.

HIC made additional efforts to encourage participation by consumers with culturally and linguistically diverse backgrounds by translating the survey and the advertisements into three other languages (Simplified Chinese,[209] Vietnamese and Arabic), and promoting the survey in online news websites that are published for these audiences. These languages were chosen based on 2016 Census data, which showed that, other than English, Mandarin, Arabic, Cantonese and Vietnamese are the languages most frequently spoken at home in Australia.

HIC developed and tested various communication materials and used a mix of static and video campaigns to promote the survey. A mix of real life and drawn imagery were tested. Figure 1 shows

[208] See example "Review into the use of 'surgeon' title", Seven News, retrieved 19 September 2022, https://7news.com.au/politics/review-into-the-use-of-surgeon-title-c-4923401.

[209] Mandarin and Cantonese are the main languages spoken in China. However, the written language is Simplified Chinese and Traditional Chinese neither of which aligns with either spoken language. Simplified Chinese was chosen because this is used in Australia and specifically in Australian Chinese media.

the initial images that were used. The blue image was most successful, and this was the main graphic used in the campaign by HIC and all jurisdictions and Ahpra.

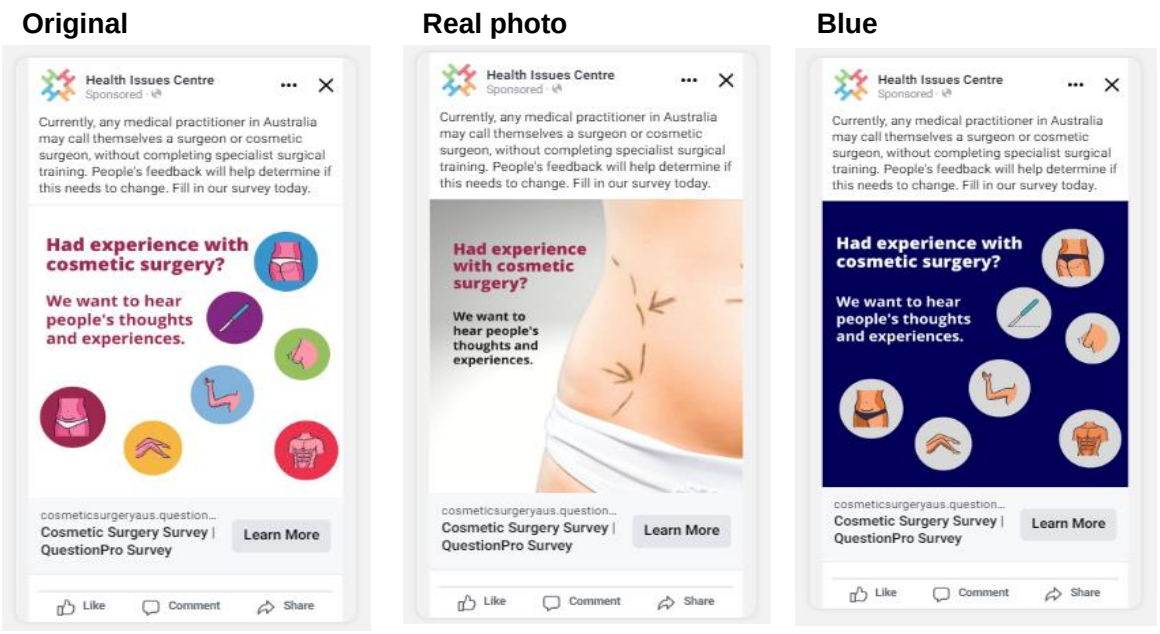


Figure 1: To promote the consumer survey, HIC developed and tested a sample of social media tiles. During testing the blue option proved to be the most successful and was most widely used by HIC and jurisdictional health departments to promote the survey.

When the consultation was promoted by jurisdictions, Ahpra and HIC, the number of people that accessed the Engage Victoria consultation webpage significantly increased (Figure 2).[210] Some website access peaks were not associated with promotion by jurisdictions or Ahpra. Potential explanations for this include that additional organisations promoted the consultation to their networks, that not all jurisdictional and Ahpra social media promotion was captured, and/or that HIC's social media promotion of the consumer survey also prompted visits to the consultation webpage.

[210] The Engage Victoria website transitioned to a new platform on 14 February 2022. Only webpage visits from the new platform are shown in Figure 2. Prior to this, peaks in consultation webpage views occurred on 13 December 2021, when the consultation was announced by the Victorian Minister for Health and the webpage was launched, and 16 December 2021 when the Consultation RIS was published, 21 December when the consultation opened for submissions, and 2 – 4 February 2022 when stakeholder information sessions were held. Further peaks in webpage views occurred from 16 December 2021 - early February 2022, which likely resulted from social media promotion.

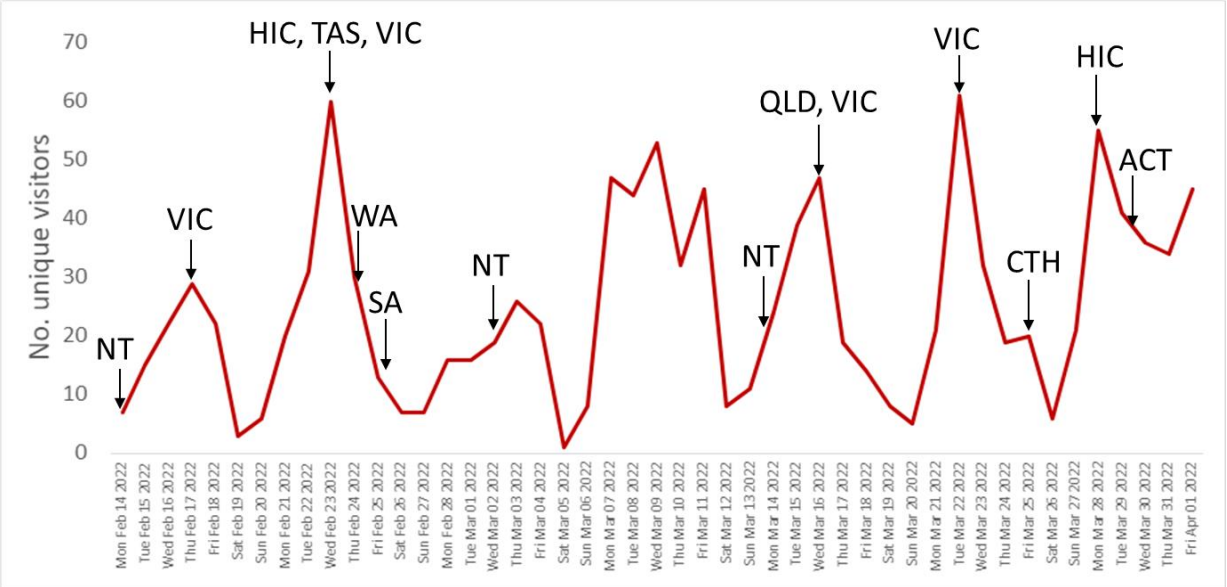


Figure 2: Unique visitors to the Engage Victoria consultation webpage from 14 February 2022 – 1 April 2022, when the consultation closed. Dates when the consultation was promoted by health departments or their partners are indicated by arrows.

The consumer survey promotion campaign ran over about three months, which allowed HIC to periodically review and adapt promotional materials and strategies to try to maximise the size and diversity of the consumer respondent group. Survey response rates substantially increased when the consumer survey was promoted in social media by HIC or health departments, their local partners and Ahpra, which demonstrated that consumers were successfully engaged.

The campaign occurred in two 'streams' or modes of consultation. One mode was planned and implemented by HIC, health departments and Ahpra. The second mode of consultation gained momentum organically due to the combined promotional efforts of these entities. Within the organic mode of consultation, other engaged services, groups and individuals voluntarily promoted the survey to their networks, which assisted in reaching audiences that may have been missed through the planned campaigns. For example, those that were not reached as a result of planned promotional materials, or those who may have been reached but either did not notice or were uncertain about whether to engage in the consultation and did so when cited from another known or trusted source.