

EDITORIAL

The changing face of plastic surgery regulation in Australia and New Zealand

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Plastic surgery within Australasia encompasses a broad range of surgical procedures involving both reconstructive and cosmetic surgery. It is the latter, the cosmetic surgical component of plastic surgery, that has experienced an unparalleled expansion in both the number of procedures being performed and the diversity of medical practitioners performing them. In Australia anyone with a basic medical degree can legally perform surgery. Doctors with minimal surgical training have been able to exploit this loophole to select financially lucrative operations that they can perform under local anaesthetic, and then by operating in their own facilities, circumvent the regulations and accreditation procedures that would ordinarily restrict and prevent them from operating, had they attempted to perform the same operations under the medically appropriate general anaesthetic in a licensed hospital.

The recent investigative journalism into this loophole, particularly the *7.30 Report*, *Four Corners* and *60 Minute* programs, exposed the predictable widespread patient harm. Doctors with inadequate surgical training were shown to be performing invasive major surgical procedures in inadequate facilities, without appropriate sterility, ignoring the intrinsic surgical and medical risk. Postoperative management was poor, and when complications arose, the medical practitioners were insufficiently trained to deal with them, and the patients were transferred to the public health system—where surgeons and doctors who *are* trained—treated the complications. Following these programs, the Australian Government has appropriately recognised that the regulation of this industry has

been unsatisfactory, and that there has been an unacceptable risk to public safety.

The two causative factors exposed in these investigations, leading *directly* to unnecessary patient harm, were

1. a deficiency of surgical training, and
2. the facilities in which the cosmetic surgical procedures were being performed.

It is surprising therefore that the initial response by the national health regulator in Australia, the Australian Health Practitioners Regulation Agency (Ahpra), was to develop a new *lower* standard of surgical training, that it would 'endorse', and that practitioners meeting this new Ahpra standard—that is, below that for any other surgical discipline—would now be proclaimed by Ahpra as being

‘trained’. Aphra argues that ‘any standard is better than no standard’, and that it is unable to restrict the scope of surgical practice that a medical graduate can perform. That may be true, and Aphra may not be able to currently restrict scope of practice, but the problem with this approach is that it legitimises and validates a standard of surgical training that is below what is mandated for any other surgical discipline. Cosmetic surgery is real surgery with real risks, and it does not become less dangerous because the word ‘cosmetic’ is placed in front of it.¹ An ethically more responsible and inherently more logical approach, given the severity of patient harm Aphra is now realising is pervasive, would be for Aphra, the national health regulator, to contact the ministers of health, federally and at state level, and ask for their capacity to limit the scope of practice of individual medical practitioners in cosmetic surgery.

The intrinsic problem with the Ahpra endorsement model is that it risks further confusing an already confused public. ‘Why are these practitioners being ‘endorsed’ to perform *cosmetic* surgery when they would not be able to perform *other* similarly invasive surgery, such as breast surgery, or ear nose and throat surgery, or plastic surgery? One alternative, not explored by Aphra, would be to work with the existing accredited surgical colleges that are responsible for training all surgeons to the national predetermined standard, and use their extensive knowledge and training, and established curricula to lift the standard of cosmetic surgery training overall, to the same standard as Aphra expect for *all other surgery*. And further, to then set *this* standard as their ‘Ahpra endorsement level’ or the identified minimum standard required to safely perform ‘cosmetic surgery’, or any surgery. This would establish that there is no difference in standards; all surgeons should attain and satisfy the same standards.

Becoming a surgeon—and surgical training—involves more than simply learning how to perform a particular set of surgical procedures. Through centuries of learning, research and teaching, surgical colleges around the world have learnt that becoming a *good* surgeon involves the mastering of multiple additional other skills and attributes that are essential to wholistic patient centred care. These skills or competencies include but are not limited to an ethical and moral framework, communication, cultural competence, research, teaching and professionalism. Together they form an integral part of the curriculum of

all the surgical disciplines trained by the Royal Australasian College of Surgeons (RACS) to the national accredited standard.²

And this is perhaps the biggest area of concern with the endorsement model as it currently stands. By not involving or working closely with RACS, or the Australian Society of Plastic Surgeons (ASPS) or the Australasian Society of Aesthetic Plastic Surgeons (ASAPS), that is, the accredited trainers of cosmetic surgery in Australia, a valuable opportunity has been lost. The development of the endorsement model—in isolation, without the input of those appropriately trained *surgeons* who are actually working in the field—renders it somewhat tokenistic and disconnected. Further, the failure to insist on comprehensive training—including the RACS competencies—to the same standard as all other surgery means that the reform proposed by Aphra fails at its first step; it will not protect the public from one of the two key causative factors identified in the *7.30 Report*, *Four Corners* and *60 Minutes* programs that directly cause patient harm, that is, insufficient surgical training.

More worrying still, is the recent unilateral overturning of formal assessments by RACS, and two independent reviews into an overseas doctor seeking to become an Australian ‘specialist plastic surgeon’. The Australian Medical Board (AMB) have granted the title of ‘specialist plastic surgeon’ upon an individual despite concerns that they do not have comparable training to that of a RACS trained surgeon with a FRACS qualification. This decision marks a new significant departure to move away from the experience of established accredited trainers in surgery, and signals that the AMB believes it no longer needs to work with plastic surgery in Australia, or RACS to jointly establish minimum standards in Australian plastic surgical training. Nor does it trust the work of independent expert review panels, nor does it need to research and ‘background check’ with the trainers and those who have intimate knowledge of a particular candidate’s past track history. This decision is not perspicacious. By itself and seemingly in isolation, the AMB has granted a new title. That it would grant this new title, directly against the advice of the RACS, is nothing short of courageous.³

To his credit, The Honourable Mark Butler, MP, Minister for Health and Aged Care and through him, the federal state and territory governments have been keen to act, and act swiftly. Just recently, the Queensland Government has passed an amendment to the *Health Practitioner Regulation National Law Act 2009 (Qld)*.⁴ This significant

change to the national law, which is hosted by Queensland, protects the title of 'surgeon' to those practitioners who have actually done accredited surgical training to the national standard. This is both logical and long overdue. It will now allow patients, for the first time, to transparently see who is appropriately surgically trained, and who is not. Doctors who use the title 'surgeon' without having completed the appropriate accredited surgical training will face up to three years in prison and a A\$60,000 fine.

As Queensland MP, Shannon Fentiman, Minister for Health, Mental Health and Ambulance Services and Minister for Women released in her press statement:

The passage of this bill is incredibly important. It will help protect ...all Australians, from potentially unsafe cosmetic surgery.

This amendment was made in response to patient concerns over the lack of regulation and oversight in the cosmetic surgery industry.

Now that this Bill has passed, it means that medical practitioners are only be able to use the title 'surgeon' if they possess the advanced surgical training and qualifications most people would reasonably expect.

Prior to this amendment, any medical practitioner was able to promote themselves as a cosmetic or aesthetic surgeon, regardless of their qualifications and level of training.

In May 2022 an independent review commissioned thorough the Queensland's previous Health Ombudsman, Mr Andrew Brown, was asked to provide a comprehensive report to government, and Aphra, on how to address the short comings in Australian cosmetic health care regulation. The report counselled widely, and equally, to everyone performing cosmetic surgery, including those who were not nationally *accredited* surgeons. Unsurprisingly, there was intense lobbying. When the report was released,⁵ it was controversial, and many of those working within the industry felt they had not been listened to. Clearly compromises had been made.

As an example, the recommendation from ASAPS suggested the minimum standard for training, qualification and surgical care in cosmetic surgery. This body represents over 500 nationally accredited plastic surgeons all trained

and working in cosmetic surgery. This group fixes the botched surgery exposed in the recent cosmetic surgery journalism. While Commissioner Brown noted their proposal, it was not included in his recommendations. The reasoning behind this 'deaf ear' to the single biggest accredited provider of cosmetic surgery in Australia is unclear; the recommendations and proposals seem obvious, reasonable, and represent optimum standards in cosmetic surgery patient management:

1. Surgery should be performed by a registered specialist surgeon (FRACS).
2. Anaesthesia should be performed by a registered specialist anaesthetist (FANZCA).
3. Major surgery should be performed in an accredited facility.
4. The surgeon (and/or his/her delegate) should be available for the management of all postoperative complications for the duration of the postoperative period.
5. The surgeon should have admitting rights to an overnight facility to manage any complications.

The other recommendations around cosmetic surgery advertising, practice management and consent, called the Ahpra 'Guidelines for registered medical practitioners who perform cosmetic surgery and procedures',⁶ have also been problematic and suffer from the same problem as the endorsement model: they were developed in isolation, without speaking to the *surgeons* who consult, and treat cosmetic patients daily. Many of the reforms within the proposal, while laudable and well intentioned, could be better targeted, more user friendly, and impose less unnecessary additional stress on patients had they been developed in close consultation with the existing and readily available specialist fully trained surgeons, and the surgical colleges behind them. Another opportunity lost.

This contrasts with to Aotearoa New Zealand where the national health framework has also undergone significant change with the dissolution of twenty district health boards and the creation of single unified national health authorities for the provision of public health care. These two authorities, Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (the Māori Health Authority), have been developed to improve equity of access to care and outcomes.

Within Aotearoa, regulation for specialist registration is performed by the Medical Council of New Zealand (MCNZ) established under the *Health Practitioners Competence Assurance Act 2003* (HPCAA). The New Zealand Medical Council and Australian Medical Council (AMC) work together to

accredit the vocational training programs offered by Australasian (binational) vocational training providers, including among others, RACS. The Aotearoa regulatory environment is therefore directly tied to administrative decisions in Australia and works in collaboration with the AMC.

However, unlike the MBA and Ahpra, the MCNZ recognises the strength of RACS and specialist societies as the peak bodies to advise on the quality of specialist training, and liaises directly, and closely with them to develop policy. Indeed, the Chair of the MCNZ, Dr Curtis Walker, has publicly acknowledged the importance of this relationship.

Because there is automatic recognition of Australian specialist qualifications and specialist registration under the Closer Economic Relationship (CER) agreement, every decision made regarding the registration of specialists and their scope of practice in Australia, has a direct impact on Aotearoa. And therein lies the problem, while one system in Aotearoa is working closely with the specialist surgical training colleges to jointly develop policy and address public health safety together, its counterpart in Australia, is insular and not consultative.

The recent decision by the AMB is therefore crucially important. Not only does it mark a paradigm shift in how surgical regulation now operates within Australia, this decision will directly impact on the assessment and subsequent ability of *all* future overseas doctors seeking to work as specialist surgeons within Australia, and because of the close relationship detailed above, but it will also directly impact upon Aotearoa as well.

The second causative factor leading to avoidable patient harm detailed in recent cosmetic surgery journalism is the inadequate facilities in which the procedures were being performed. As explained above, ‘cosmetic cowboys’ can only exist because they have been able to exploit loopholes in current Australian regulations. By performing major surgical procedures under local anaesthetic, in their own facilities, these practitioners have been able to avoid the oversight that would ordinarily accompany any doctor attempting to perform the same procedure in a regulated hospital or day surgery center.

Within registered licensed hospitals, a necessary requirement for accreditation is a series of checks and assessment processes that ensure patient safety. These include, but are not limited to, minimum standards of sterility, clinical surgical audit, clear consent processes, reporting of

adverse outcomes and, crucially, assessment of an individual’s training and surgical skill before she or he is allowed to operate and perform surgical procedures within that facility.

By performing surgical procedures under local anaesthetic, the requirements for safety are different, and allow the surgery to be performed when otherwise it would be prohibited. If the facility is accredited but owned by the medical practitioner performing the surgical procedures, the requirement to independently validate the individual’s surgical training and skill, and outcomes, is also avoided.

This point is critical to understanding how so much harm has been able to be perpetrated.

The most recent and now approved changes to the facilities regulation in the Australian Commission on Safety and Quality in Health Care, National Safety and Quality Cosmetic Surgery Standards 2023⁷ are therefore fundamental to reforming the cosmetic surgery sector. These new standards target the second key causative factor outlined above and legislate the minimum requirements for any facility where cosmetic surgery is performed. The document is thorough, well considered and is the result of multiple people from all areas of the cosmetic surgery sector working together to jointly develop policy and regulation in the interests of better patient centered care and improved public health outcomes overall. Its weakness lies in the fact that its implementation must be undertaken by the individual states and territories. Some states are well advanced in facilities regulation and policy, while unfortunately others have a lot of work to do.

The answer to improving patient safety in cosmetic surgery lies in collaboration and working together. Experts in the field and particularly those accredited surgeons who perform cosmetic surgery to the national standard routinely and daily are crucial to the solution. They, and their colleges should be welcomed, and included, and their wisdom sought and harnessed for the valuable asset and unique opportunity to regulators it represents.

As Andrew Carnegie said:

*Teamwork is the ability to work together toward a common vision. ... It is the fuel that allows common people to attain uncommon results.*⁸

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- 3 ‘If you want to be really sure the Minister doesn’t accept it, you must say that the decision is “courageous”’.
.. ‘And that’s worse than controversial?’
‘Oh, hoah hoah. “Controversial” only means this will lose you votes; “courageous” means this will lose you the election.’
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