Regulation of Emerging Allied Health Professions in Australia:

A Case Study of the Dermal Clinician

by

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Abstract

This study explored the regulation issues dermal clinicians in Australia experience as an emerging allied health profession—and the processes for effective regulation. The purpose was to establish relevant regulations that emerging allied health professionals, such as dermal clinicians, might consider in Australia. Dermal clinicians are not recognised, regulated, or registered with the Australian Health Practitioners Regulation Agency as an allied health profession. This study examined whether dermal clinicians want to establish registration and regulation standards for their profession. Current research does not address standards or regulations for dermal clinicians or the level of education required to be considered an emerging allied health profession. This study used ground constructivist theory to determine the perspectives of industry professionals regarding the need to regulate; it also aimed to provide a framework that other emerging but unregulated allied health professions could adopt. The study's methods included reviewing existing literature and researching Australia's current regulations and relative legal theory. The study's focus group included graduate dermal clinicians who graduated from Victoria University with a Bachelor of Dermal Science. Because they are not regulated, current standards were examined to determine appropriate regulatory requirements. The focus group's discussions were used to measure the participants' understanding of current regulatory processes; it also helped assess previous regulations that applied to non-medical allied health professionals to determine the appropriate regulatory processes that could be accepted. An evaluation using criteria drawn from previous research of national regulatory bodies and state regulations on allied health professions supports the study's recommendations to bridge the allied health regulation gap.

Student Declaration

I, Rosanna Baini, declare that the Master of Research thesis titled ‘Regulation of Emerging Allied Health Professions in Australia: A Case Study of the Dermal Clinician’ is no more than 50,000 words long, including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes. This thesis contains no material submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my work.

I have conducted my research aligned with the Australian Code for the Responsible Conduct of Research and Victoria University’s Higher Degree by Research Policy and Procedures.

Ethics Declaration

All research procedures reported in the thesis were approved by the VUHREC Committee and Application ID: HRE22-076.

Signature  Date 27/4/2023

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Contents

List of Figures

List of Tables

List of Abbreviations

ACCC	Australian Competition and Consumer Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
AHPA	Allied Health Professions Australia
AHPRA	Australian Health Practitioner Regulation Agency
ALA	Australasian Lymphology Association
AMA	Australian Medical Association
ANMAC	Australian Nursing and Midwifery Accreditation Council
APS	Australian Psychological Society
AQF	Australian Qualification Framework
ARPANZA	Australian Radiation Protection and Nuclear Safety Agency
ASDC	Australian Society of Dermal Clinicians
ATNA	Australasian Trained Nurses' Association
HIFU	High-intensity focused ultrasound
HIS	Health Improvement Scotland
IPL	Intense pulsed light
ISILC	Institute for Sustainable Industries and Liveable Cities
LED	Light-emitting diode
NASRHP	National Alliance of Self-Regulating Health Professions
NHS	National Health Service
NMBA	Nursing and Midwifery Board of Australia
NMP	New public management
NPM	New public management
NPO	Nonphysician operator

NRAS	National Registration and Accreditation Scheme
NSW	New South Wales
NVH	Nederlandse Vereniging van Huidtherapeuten
OT	Occupational therapist
PBS	Pharmaceutical Benefits Scheme
PsyBA	Psychology Board of Australia
RF	Radio frequency
SA	South Australia
TAFE	Technical and further education
VET	Vocational education and training
VU	Victoria University
VUHREC	Victoria University Human Research Ethics Committee
WA	Western Australia

Chapter 1: Introduction

1.1 Background

The history of allied health professions in Australia reveals that several healthcare professions, such as nurses and podiatrists, have faced unnecessary complexities for accreditation. However, current research, such as from Hinchcliff et al. (2012), Moffatt et al. (2013) and McAllister and Nagarajan (2015), has not addressed the standardisation and introduction of policies and practices that regulate emerging industries in allied health, such as dermal clinicians, nutritionists, myotherapists and sonographers. A national regulator, the Australian Health Practitioner Regulation Agency (AHPRA), regulates only some allied health practitioners in Australia. Others self-regulate by complying with the National Alliance of Self-Regulating Health Professions (NASRHP) requirements. NASRHP is a professional association responsible for certifying qualifications, setting and maintaining standards and overseeing professional development.

The present study aims to discover new information and reach a new understanding of why and how standards and policies should be implemented in the allied health arena. The primary purpose is to identify an outline that helps recognise emerging allied health professionals as qualified practitioners—just like nurses, podiatrists and paramedics—without struggling as these professions did in the past.

This is a complex study because it might affect certain aspects of the business community that involve treatments being offered by individuals who do not have the proper allied health or healthcare qualifications. For example, laser treatments use an intense, deep light beam to obliterate abnormal tissue (Tran et al., 2022). According to the American Society for Dermatologic Surgery, millions of lasers and light source cosmetic procedures are performed annually (American Society for Dermatologic Surgery (ASDS), 2019). Further,

procedures such as hair removal, non-ablative treatments and the removal of pigmented lesions, tattoos and unwanted vascular lesions have revolutionised this field. With an increasing number of physicians and nonphysicians performing these procedures and the availability of increasingly powerful laser technologies, the potential for problems and associated legal consequences continues to increase (Goldberg, 2006). According to the Australian Radiation Protection and Nuclear Safety Agency (ARPANZA), no national laws and regulations exist in Australia for lasers, intense pulsed light (IPLs) and light-emitting diode (LED) phototherapy in the skin health and cosmetic industry. The regulatory requirements for these procedures are determined by the state or territory in which the businesses practice.

Only Queensland, Tasmania and Western Australia (WA) regulate what is known as Class 3B and Class 4 laser operators (Thomas & Houreld, 2019). Non-medical professionals in WA, Tasmania and Queensland need a licence to operate lasers for cosmetic purposes. In Tasmania, a licence is also required to operate an IPL for non-medical use (Australian Business Licence and Information Service, 2022). WA only allows medical practitioners to operate cosmetic laser machines, while Tasmania and Queensland require non-medical practitioners to be licenced. The media has often exposed how operators and businesses receive complaints that result in lawsuits against non-qualified laser technicians, allegations of gross negligence in performing procedures, and a lack of adequate training, competence and supervision for unqualified individuals who perform laser procedures. In Victoria, New South Wales (NSW), the Northern Territory and South Australia (SA), no licencing regulations exist for operating and practising laser, IPL, high-intensity focused ultrasound (HIFU), radio frequency or skin penetration services (Leow, 2017). The regulation of these practices is determined by each state in Australia. Therefore, the prerequisites for operating the technologies differ substantially. In a regulatory impact statement, ARPANZA asserted

that WA is the most stringent state regarding cosmetic regulations; it regulates the licences for beauty therapists and unqualified professionals, restricting them from performing treatments using the abovementioned modalities (Australian Radiation Protection and Nuclear Safety Agency, 2015). Therefore, nationally reducing the potential risk of burns, scars, and infection would require standard regulation (Bogossian & Craven, 2021).

Therapeutic modalities include micro-needling treatments that extend below the skin's surface to treat scars, such as acne and skin reparations. The scientific understanding of the skin and these therapeutic tools is critical; it requires appropriate qualifications and clinical training in a skin science degree, such as a Bachelor of Dermal Science from Victoria University. Notably, only Victoria University and two other universities in the Netherlands offer this bachelor's degree.

Despite the invasive clinical nature of specific procedures such as laser or micro-needling, no laws or restrictions exist regarding who can perform them. A beauty therapist who might be trained in the workplace by a representative (with no skin science background) can perform these treatments. Extensive research has revealed case studies in which untrained and unqualified workers leave patients scarred and pigmented. It can be strongly argued that the laws in this industry are too easy-going. For example, beauty therapists do not need a licence or certification to practice treatments like IPL, lasers, HIFU and LED. The overarching argument is that regulation is critically needed to encourage formalised training in such treatments (e.g., undergraduate degrees and qualifications in skin science).

Arie's (2017) study suggested that stopping unqualified individuals from performing treatments and risky procedures is unethical, which might include using a laser machine for permanent hair reduction. This concern stems from the possibility of an unqualified operator passing over a lesion with a laser that could mask a potential melanoma and delay diagnosis (Zipser et al., 2010). However, there is seemingly no statutory control over the standards

required to perform treatments that a dermal clinician is university qualified and clinically trained to perform. It is time that Australia established legislation, regulation, and a registration system to protect the public from accessing treatments in a poorly regulated industry. In this sense, the industry must provide safer delivery of treatments for practitioners and patients. The professional standard of the dermal clinician is not understood, and patients are often misguided about the risks associated with many therapies (e.g., lasers, microdermabrasion, and micro-needling). Although they are unqualified, providers of skin condition services conduct treatments such as minimally invasive laser skin resurfacing and skin needling—but they are not supposed to call themselves dermal clinicians. However, nothing stops them from calling themselves skin, dermal or laser specialists. Ultimately, qualifying as a dermal clinician entail avoiding all risks to the patient and practitioner, conducting a thorough clinical consultation and performing treatments at the highest standards within the scope of practice, which is expected from a trained and qualified dermal clinician. This lack of regulation is currently being investigated with great interest. One example is Robson (2017), who provides the Scottish perspective on regulating cosmetic treatments and discusses common-sense recommendations for tackling these issues by introducing Health Improvement Scotland registration for independent health clinics.

This thesis argues that changes are needed in the law for increased regulation and accountability to protect consumers of any skin health service. Different laws are needed to protect consumers from unskilled operators. Robson (2017) stated that governments must be held accountable if beauty therapists and other non-medical professionals continue to administer procedures outside their scope of practice and without appropriate qualification and registration.

According to Khalifian et al. (2022), regarding the causes of injury and litigations in cutaneous laser surgery, 174 personal injury lawsuits related to laser surgery injuries occurred

between 1985 and 2012 in Australia. In 120 cases with public decisions, 50.8% of plaintiffs reportedly won against laser practitioners. From 2012 to 2020, 69 cases of liability claims due to a cutaneous laser surgery device were identified. Of these, 49 (71%) involved a nonphysician operator (NPO). Previous studies focusing on evaluating trends in laser surgery litigation had identified increasing injury and legal actions when the surgeries were performed by NPOs (Khalifian et al., 2022).

Any focus on regulating emerging allied health professions, or moves towards increasing regulation, could make more stringent entry barriers for those professions. However, investigating professions that focus primarily on patient safety and protection and ensuring an entry barrier (e.g., dermal science) could reduce the patient risks highlighted in the media and industry. The focus must thus be placed on the existing problems of regulatory systems and the limitations of consumers when they receive treatment from allied health practitioners such as dermal clinicians.

Existing research highlights the need to review questionable skin treatments, procedures and modalities used in allied health practices, and the overall regulatory system that should protect patients. For example, the cosmetic procedure field in Australia appears to be out of control, with scant supervision and management. Regulators such as AHPRA currently do not regulate areas in allied health that need stringent administration to protect patients (e.g., skin health). AHPRA and the Medical Board of Australia have identified numerous issues encountered in the cosmetic surgery industry and are responsible for taking action. The onus should be on regulators rather than consumers to improve access to safe and competent care for consumers when they undergo cosmetic procedures (Summerhayes & Algie, 2022).

1.2 Purpose: Aims and Field of Research

With the belief that dermal clinicians should be professionalised, this thesis investigates a regulatory process for this profession. It examines the scope of the theoretical and practical components involved, which require a minimum level of academic studies (e.g., a bachelor's degree). The ensuing criteria will provide a pathway for a qualified dermal clinician to be regulated and recognised as an autonomous practitioner in the allied health profession.

For dermal science to be recognised as a profession, it requires an in-depth and undergraduate-level scientific understanding of complex skin knowledge, intense clinical treatments and patient care plans. Similarly, for dermal clinicians to be considered part of the allied health profession, they must obtain at least a degree before they can perform treatments on more profound levels of the skin. This thesis further examines the integration of theory and practice as students mature in their discipline identity and the requirements needed to upskill as an allied health professional in a regulated system.

1.3 Significance of the Research

A substantial area of health-related education exists at the postgraduate level, such as nursing, psychology, and education. This is arguably stimulated by the strong emphasis on continuous professional development to maintain some form of accreditation, registration, and regulation. However, this is not the case for dermal clinicians.

Dermal science is an emerging industry, but because it lacks a registration or regulatory process, the professional role and title of the dermal clinician are misunderstood. A dermal clinician performs treatments that extend further than the skin's surface through controlled wound health processes. This thesis found that the role is casually claimed as a job title, despite individuals not having the appropriate qualifications—which would be unlawful in certain regulated circumstances. This title was also found in aesthetics (e.g., dermal or

beauty therapist), in which the role of dermal clinician and beauty therapist must be discerned based on qualifications and in-depth knowledge of skin science and health. The research in this thesis is significant in protecting consumers as they seek services from trained professionals, such as degree-qualified dermal clinicians, who possess academic knowledge and clinical proficiency in skin health services. It would thus be appropriate to regulate the activities of dermal clinicians to reduce the risk of consumer injuries such as burns, scars and infections.

The lack of specialised role distinction applies to other job titles in Australia, such as skin therapist, specialist and scientist, and laser therapist, specialist and technician. These titles are often misleading because the training is usually completed on the job and supervised by a company representative whose main aim is to sell a machine and who often lacks formal skin science training at an academic level within an evidence-based system. A regulatory process would distinguish these roles from a qualified skin health practitioner, allowing patients to know the difference between a qualified dermal clinician and professionals trained to use a device while on the job.

A dermal clinician with an undergraduate degree from Victoria University is considered qualified in skin health. Typically, dermal clinicians earn the title when they join the Australian Society of Dermal Clinicians (ASDC) as a student or graduate dermal clinicians (Australian Society of Dermal Clinicians, 2022). The ASDC is a non-profit association for Victoria University graduates and various colleges that offer dermal courses. However, not all members have attained a Bachelor of Dermal Science from Victoria University. The ASDC was established in the early 2000s in Melbourne, and volunteers manage it. However, its ongoing internal education for members has yet to develop postgraduate skin health and disease education. The current education provides refresher one-day courses in applying peels and administering laser treatments (Australian Society of

Dermal Clinicians, 2022). However, these clinical training units are already completed in the bachelor's degree. ASDC standards contrast with the Dutch Society of Skin Therapists, which offers postgraduate disease management training (CIBG, Ministry of Health, Welfare and Sport, 2022). For example, the Dutch Society advocates for ongoing professional training of skin therapists, including post-graduate hyperbaric oxygen training, wound management, and oedema care in a hospital setting. The skin disease and healthcare plans are government endorsed and performed by these postgraduate allied health professionals. To maintain registration under the current regulatory standards, practitioners must undergo further training to continue in a professional role in allied health, just like medical practitioners, physiotherapists, dermatologists, and plastic surgeons (CIBG, Ministry of Health, Welfare and Sport, 2022). The ASDC does not have such a requirement for dermal clinician members because it has not imposed regulatory standards, possibly because not all members have degrees. However, the ASDC committee aims to become self-regulated by 2024. The membership eligibility structure and dynamics would need to focus on the qualified dermal clinician profession as a priority.

1.4 Regulation of Comparative Allied Health Professions: Nursing and Podiatry

As far as the researcher knows, this study has not been conducted for the dermal clinician industry. The researcher sourced research focusing on other allied health professions and investigated how they became regulated (e.g., the professions of nursing and podiatry). Other theoretical components of this research include regulatory reforms for skin health services, such as the requirement for intensive consultation with patients to discover a clinical question and to seek scientific sources of evidence for the diagnosis, clinical judgement and decision-making processes, and the application of evidence-based practices for clinical

intervention. These practices performed by a dermal clinician are not different from those performed by a nurse or podiatrist.

1.4.1 Nursing

The nursing practice became regulated in Australia when the first registration certificates were issued in 1922 (Bennett et al., 2019). The profession's rules and regulations were established by the Australasian Trained Nurses' Association (ATNA), Australia's first nursing association, formed in NSW in 1899. The association subsequently established branches in Queensland in 1904, SA in 1905, WA in 1907 and Tasmania in 1908 (Smith, 1999). It aimed to improve the status of nurses through a registration process and to develop training standards in hospital nursing schools. When these branches were formed, the Nurses' Registration acts were being adopted nationally. In 1922, WA established a register of nurses and midwives by decree of the *Health Act* 1911 (WA; Smith, 1999). The ATNA's objectives were to promote the interests of trained nurses in all matters that affected their work as a class. Establishing a registration system for trained nurses provided the opportunity to share information regarding the work of a nurse. The core concept was to initiate and control schemes that would provide nurses with an allowance, mainly when they cannot work because of sickness, accident, age or other circumstances (Smith, 1999).

The origins of nursing date back to the mid-19th century, when it began to emerge as a profession. Florence Nightingale established nursing and public health (Chatterton, 2019). She laid the foundations of professional nursing with the principles summarised in her book, *Notes on Nursing: What It Is and What It Is Not* (Ellis, 2020). The book was first published in 1859 and professionalised the nursing vocation. It aimed to offer nursing hints to people who were responsible for the health of others. However, Florence Nightingale stressed that it was not a comprehensive guide to teaching oneself to be a nurse but a source of advice to help treat others.

Florence Nightingale was hindered in pursuing her nurse's training by her family, who considered the vocation inappropriate for a woman of her social stature. Despite this, she went against the social convention and became a nurse (Chatterton, 2019; Ellis, 2020). Her vocation reached beyond home management, extending to reduce human suffering. The Crimean War laid the foundation for her bold actions to care for wounded soldiers, given the numerous complaints and public outcry for the poor working conditions, unsatisfactory medical management of soldiers and scarce medical resources observed (Chatterton, 2019; Ellis, 2020). Her main contribution was to recruit women and establish social reform in healthcare and nursing through nursing training, hospital planning, public and military healthcare and efficient collection of medical data and statistics (Ellis, 2020). She established the Nightingale School of Nursing in 1860 at St Thomas Hospital in London and wrote many manuscripts about hospital reform and nursing care. Modern nursing thus became established and changed the service of nursing into a respectable profession (Helmstadter & Godden, 2011).

Mildred Montag created the first school of nursing in the United States in the 1940s as an evolutionary step to address the shortages in the nursing profession (Harker, 2017). She placed nursing students in a critical curriculum beyond the available in-house hospital training. A two-year program was initiated to prepare technical nurses to address the shortages, and to provide a workforce to help the graduated professional nurses Mildred Montag envisaged (Nelson, 2002).

Although nursing was established, it was still not considered worthy of regulation and standardisation (Chatterton, 2019; Ellis, 2020). Because nursing was not an academic curriculum, nurses mainly comprised students who did not complete high school. Further, the nursing course predominantly included 'hands-on' training within a medical setting (Ellis, 2020).

Discussions regarding nursing training schemes in Australia are outlined in the final report of the ‘Review of Australian Government Health Workforce Programs’ (the ‘Mason Review’), publicly released on 24 May 2013 (Mason, 2013). The review confirms that nursing education began changing from hospital-based training to training within a tertiary setting in the mid-1980s, which included a practical clinical training component (Mason, 2013). Efforts to change the delivery of nursing education to include a theoretical component in teaching nurses were made much earlier in the 1970s (Freshwater & Stickley, 2004).

By 1993, all registered nursing students in Australia were entering the profession via the university education pathway (Francis & Humphreys, 1999). In Australia, nursing education first transitioned to the tertiary sector in 1973, when a small group of nurses representing all major nursing organisations in Australia came together to devise a plan of action (Bryant, 2022). This collective produced a proposal, ‘The Goals in Nursing Education—Part II, ' to lobby state, territory and federal politicians for change. Before 2009, the Australian Government controlled the number of funded university places for nursing students. Universities then shifted to a demand-driven system for nursing students (Norton, 2019). The Nursing and Midwifery Board of Australia (NMBA) was established, and it regulated nurses and midwives under the *Health Practitioner Regulation National Law* (2009), a statutory regulation. Nursing has become regulated because it poses a risk to the public if practised by unprepared or incompetent professionals. The NMBA regulates how nursing is practised in Australia, focusing on protecting the public. In this sense, regulation was needed, or policymakers would have had to question nursing credentials and skills' manageability continuously. A lack of regulated common standards would have made determining a nurse's practice's essential quality and safety challenging. Nurses fought hard for their profession to become accepted and regulated, and the nursing degree has since been distinguished as an AHPRA-recognised qualification. A nursing board was further

established through the Australian Health Ministers' Advisory Council (AHMAC), hence the partnership between the NMBA and AHPRA (O'Keefe & Kushelew, 2016).

Today, nursing is one of the most honourable professions in the healthcare industry—one that has evolved beyond the directives of a physician. Nurses can even provide care to patients independently as nursing professionals within a regulated patient-centred care system.

1.4.2 Podiatry

Podiatrists diagnose and treat diseases, disabilities and deformities of the lower limbs, foot and ankle. Ancient forms of podiatry involved using the scalpel (invented by Hippocrates) to help scrape the skin and remove hard skin spots (MacGilchrist, 2020). Until the 20th century, specialist practitioners caring for feet and ankle conditions were called chiropodists, and they were considered separate from other types of organised medicine (Ellapen & Swanepoel, 2017).

The current demand in Australia for podiatrist services is attributed to the growing aging community. It increases in specific exercises (e.g., jogging), the treatment of which is a determining factor for professional podiatrist status (Borthwick et al., 2009). One should consider more than theoretical and high academic achievements to understand what a professional status in podiatry constitutes. Like many other industries, several factors were considered to expand the professional status of podiatrists. Borthwick et al. (2009) reported a stronger self-perception of professional status among podiatrists in the US following the acquisition of privileges as hospital medical staff. As mentioned previously, the increased demands for podiatry attributable to demographic aging and recreational trends and more sophisticated technological advances (e.g., invasive surgery and biomechanics) were considered essential determinants of change (Borthwick et al., 2009).

Although Australian podiatry first attained legislative recognition as an independent profession in 1950, it remained subject to the forces of medical authority and ‘sovereignty’, similar to other non-medical healthcare professions (Borthwick et al., 2009). The role’s boundaries were extended to accommodate more specialised skills and more sophisticated technology, which contributed to improving professional status. Podiatry in Australia was originally closely based on its British counterpart, and introducing a uniform three-year training program in the late 1960s established an educational equivalence that broadly remains today.

To practice in Australia, podiatrists only need a Diploma in Podiatry. However, private training institutions for podiatry were established in Victoria and NSW as early as the 1930s (Causby & Prentice, 2009). These provided standard levels of education throughout the country. In SA, the South Australia Institute of Technology offered a government-funded course in 1959, while NSW formally established a podiatry course in the technical and further education sector (Causby & Prentice, 2009). To reflect the increased complexity of teaching required to meet the growing educational needs of the evolving profession, the Lincoln Institute of Health Sciences in Victoria offered the country’s first undergraduate degree qualification in 1983 (Causby & Prentice, 2009).

Podiatrists must now complete a Bachelor of Podiatry (Causby & Prentice, 2009), have a national registration with the Podiatry Board of Australia and ensure ongoing professional development. Further, AHPRA regulates podiatry as a conventional healthcare source, so it can thus be billed under Medicare.

1.5 Practical Challenges

Regulating the dermal science industry could disadvantage individuals such as beauticians, beauty therapists and laser operators by restricting their scope of work, which currently has no set boundaries. Further, regulation could encourage those unqualified in skin

health to undertake a formal skin science qualification, including practical training at an academic level. It should be noted that many dermal clinicians, nurses and other healthcare and beauty professionals are now seeking to complete a dermal science degree. Specific implications of this trend (e.g., financial or academic capacity), could be an issue. However, encouraging appropriate training has other benefits, such as reducing litigations and insurance claims for injuries. Regulating the industry could help avoid the high number of lawsuits for malpractice and negligence (e.g., burns) that would otherwise be unavoidable.

1.6 A Possible Research Approach to Undertaking This Project

This thesis could be regarded as a trial or pilot study that can be a potential area for further PhD investigation with appropriate data collection and analysis methods. It establishes a transition zone between pure discipline, education and allied health–regulated professional practice.

The study could extend to further research focusing on pay rates, scopes of practice and employment conditions for qualified dermal clinicians. Further, the study could be used to improve the treatment of chronic conditions nationally. For example, acne, hirsutism and lymphoedema regulating health-assisted treatment plans could be subsidised for patients with these health complications.

This research aims to develop a suitable policy framework for dermal clinicians and other allied health professionals to adopt in Australia. It focuses on allied health professionals who:

- are not recognised by AHPRA
- are not self-regulated
- anticipate some regulations, registration, standards and scope of practice
- want to determine the reasons for and against establishing regulation, registration and accreditation standards for their qualifications and practices.

This study will determine the potential requirements for allied health professionals, such as dermal clinicians, to become regulated and the necessary process for regulating these professions. The inquiry aims to understand the challenges other medical and allied health professionals faced to become accredited, and consequently comprehend the influences that might inhibit or prevent emerging allied health professions from becoming regulated and accredited.

This thesis also explores whether allied health professionals, like dermal clinicians, desire formal regulation. Examining whether they seek accreditation through organisations such as AHPRA or self-regulation may provide an appropriate model for regulating dermal clinicians and other emerging allied health practitioners.

1.7 Research Questions

This research aims to develop a theory from the data collected and to promote a better understanding of the accreditation and regulation standards and processes for dermal clinicians and other emerging allied health professions. Regulatory bodies help provide a sufficient foundation to create evidence-based models—with more targeted knowledge concerning the issues—that can be used to regulate emerging allied health professions. This thesis outlines the implications of analysing the accreditation and regulation of allied health professions and aims to enlighten interested readers about why the topic is worth pursuing. The following research questions helped guide this thesis's research design:

- Will dermal clinicians who value compliance support the Ayres and Braithwaite framework of responsive regulation?
- To regulate the dermal clinician profession, what existing frameworks in allied health can be used?
- What are the beliefs and values of dermal clinicians regarding regulation?

1.8 Australian Health Practitioner Regulation Agency

AHPRA regulates some allied health professions through the National Registration and Accreditation Scheme (NRAS), while others are self-regulated through their professional association. Appendix A outlines the 15 national boards that AHPRA supports through NRAS implementation. Additionally, AHPRA manages the registration of all health professionals in Australia. The 15 national boards include the following:

1. Aboriginal and Torres Strait Islander Health Practice Board of Australia
2. Chinese Medicine Board of Australia
3. Chiropractic Board of Australia
4. Dental Board of Australia
5. Medical Board of Australia
6. Medical Radiation Practice Board of Australia
7. Nursing and Midwifery Board of Australia
8. Occupational Therapy Board of Australia
9. Optometry Board of Australia
10. Osteopathy Board of Australia
11. Paramedicine Board of Australia
12. Pharmacy Board of Australia
13. Physiotherapy Board of Australia
14. Podiatry Board of Australia
15. Psychology Board of Australia.

The primary role of the national boards is to protect the public. They are further responsible for practitioner and student registration and other functions, such as the joint development of policy to help practitioners understand their obligations (Australian Health Practitioners Regulation Agency, 2023).

1.9 Allied Health Professions Australia

Allied Health Professions Australia (AHPA) is the peak body that represents and advocates for allied health professionals. Each profession has its professional association, and most associations are AHPA members. The AHPA contains 25 allied health member organisations and 13 affiliates (Delaney & Helyard, 2018). A recognised allied health professional must attain an Australian Qualification Framework (AQF) Level 7 university qualification.

1.10 Australian Society of Dermal Clinicians

The ASDC, an affiliate member of the AHPA, recognises that dermal clinicians provide services and practices that involve allied health, work autonomously, and complement the work of dermatologists and plastic surgeons. Other affiliate members of the AHPA include the Australasian Lymphology Association, the Australasian Society of Genetic Counsellors, the Australian Society of Rehabilitation Counsellors, the Myotherapy Association Australia and the Australian Counselling Association. The ASDC is working with NASRHP to achieve self-regulation as an allied health profession. It is currently recognised as an affiliate member who will become an ordinary member of AHPA by 2024 (Australian Society of Dermal Clinicians, 2022).

The ASDC provides its members with the following eight standards and codes of ethical practice:

- Standard 1—person-centred focus and evidence for practice.
- Standard 2—communication and therapeutic relationships.
- Standard 3—interprofessional and collaborative practice.
- Standard 4—professional ethics and behaviours.
- Standard 5—legal obligations and requirements.
- Standard 6—advertising and the procurement of clients.

- Standard 7—health and wellbeing.
- Standard 8—education, training and research.

Allied health professionals are responsible for working with patients to identify issues, providing appropriate treatment interventions and helping patients improve their quality of life (Freund et al., 2015). Although AHPRA does not regulate all allied health professions, in most cases, it acknowledges that allied health professionals add value to the health scheme and reduce the need for medical treatment or intervention. Allied health professionals conduct their duties as a part of healthcare and ensure the applicable provision of care in a healthcare facility by offering several technical, therapeutic and direct services that involve supporting patient care and exercising diagnostic operations (Brown-Benedict, 2008). Essentially, allied health professionals provide support services considered critical to other healthcare colleagues, physicians and the patients who receive the healthcare services.

Allied health professions are comparable to the nursing, pharmacy and medical professions (Freund et al., 2015). Medical practitioners are healthcare professionals who provide treatment and healthcare for patients. Similarly, emerging allied health professionals such as dermal clinicians have considerable expertise in providing treatment related to healing protocols and wound care to individuals who suffer from specific skin conditions, diseases or disorders (Freund et al., 2015). Some of these treatment services resemble those of professional medical practitioners—such as enabling patients to recover from preoperative and postoperative surgeries; overcoming wound healing challenges or problems; improving the patient's nutritional status; developing communication skills; and restoring confidence skills in day-to-day activities (Freund et al., 2015).

Allied health is diverse and varied in its service delivery. However, the roles and responsibilities in this field are somewhat distinct from those of the medical profession, even though they have specialist skills in diagnosing and treating health challenges and chronic

conditions (Solomon et al., 2015). Further, these allied health practitioners are university qualified. Like dermal clinicians, most other non-regulated practitioners (e.g., nutritionists, audiologists and social workers) represent a significant practice gap in regulation. However, they tend to execute similar responsibilities as regular medics (Brown-Benedict, 2008), especially medical practitioners, which might not always be a favourable option for some health professions. The fact that they conduct their duties as a part of healthcare continues to ensure the applicable provision of care in a healthcare facility, and they continue with the appropriate patient care. These support services are critical to other healthcare professionals, physicians, and patients. These are services that complement each other.

Literature focusing on the history of allied health professions reveals that healthcare professionals have fought to gain accreditation and recognition as standalone practitioners with standards that apply throughout the industry (e.g., the nurse practitioner; Australian Medical Association, 2019). There appears to be no current research focusing on the standardisation or introduction of policies for emerging industries of allied health professions (e.g., dermal clinicians), which this thesis has identified as a research gap. Health policies for emerging allied health industries must be explored to meet the trends and rapid changes allied health professions are experiencing theoretically and clinically. It is thus essential to establish a policy model relevant to health industry professions such as dermal clinicians; this is especially true for professions that consider evidence-based allied health practices in all health-based dealings.

AHPRA regulates some accredited medical groups. Two professional organisations mandated to accredit health professions include the Australian Psychological Society (APS) and the NMBA. The APS is the peak body for psychologists and Australia’s largest non-medical professional health organisation. The Psychology Board of Australia (PsyBA), an agency under AHPRA, oversees the professional conduct of psychologists and investigates

complaints (Kavanagh, 2015). Psychologists who complete postgraduate and supervised practice become eligible for endorsement from this agency (Kavanagh, 2015). If an institution does not provide an accredited psychological education and training sequence, then its graduates do not qualify for professional registration. Currently in Australia, students who are endorsed as psychologists must undertake a three-year accredited undergraduate degree, followed by an accredited course in their fourth year and a further master's degree. General registration with AHPRA is also required for them to be able to practice as psychologists.

The Australian Nursing and Midwifery Accreditation Council appoints Australia's Nursing and Midwifery Board. According to Sheedy (2011), an accrediting authority for midwifery and nursing education is essential to protect the safety and health of patients. Even though these agencies have succeeded in their accreditation processes, how they could execute their mandates to regulate emerging allied health professions remains to be determined. The present study offers insights by reviewing the models that these institutions use to determine how emerging allied health professions can be accommodated.

Researchers have tried to establish processes for adequately regulating emerging allied health professions in Australia (Barraclough & Gardner, 2007). According to McAllister and Nagarajan (2015), accreditation processes require university programs to demonstrate the attainment of clearly defined aims and objectives that prepare the students in their transition to the practical field. Programs must also provide sufficient and useful resources that help students achieve underlying objectives. McAllister and Nagarajan (2015) also advised that the primary aim of accreditation is to ensure the optimal quality of allied health education programs. The accreditation optimises the community's safety by ensuring that every graduate with a bachelor's degree can provide high-quality and safe healthcare.

Dental hygienists are members of the allied health profession and are regulated by AHPRA. In Australia, a dental hygienist or dental therapist completes a three-year Bachelor of Oral Health and provides clinical services within a standard scope of practice. The degree is accredited by the Australian Dental Council, which AHPRA regulates, and students register as dental practitioners with AHPRA once they graduate. The Dental Board of Australia enforces the profession's standards, which denote the scope of practice for all dental practitioners, including dental hygienists. These standards ensure that these professionals only perform dental treatments according to their qualifications (i.e., their education level and competency). Dental hygienists focus on providing services for oral health, including assessing, diagnosing, treating and managing oral health conditions; educating to prevent oral disease; and promoting healthy oral behaviours. Notably, a dermal clinician's protocols for service delivery also include health management and treatment, but with a focus on the skin and acute and chronic skin diseases and disorders (Australian Society of Dermal Clinicians, 2022).

Dermal clinicians complete a four-year Bachelor of Dermal Science, only offered at Victoria University. They develop a comprehensive foundation of knowledge in dermal science and skills in safe and effective dermal treatments. Dermal science procedures performed by a qualified dermal clinician include (Victoria University, 2022):

- acute and chronic wound management
- dermoscopy (i.e., pre–skin cancer and skin cancer screening)
- perioperative care (e.g., scar revision)
- Evidence-based use of skin health methodologies—such as algorithms and diagnostic tools to help create treatment plans for skin conditions (e.g., rosacea, acne, hair loss, psoriasis, dermatitis/eczema, aging or sun-damaged skin, hirsutism, tattoo removal, light-based hair reduction, skin tags and leg veins).

Underlying the Bachelor of Dermal Science qualification is its intention to reliably guarantee the competence and conduct of its graduates in the medical society (Dixon-Woods et al., 2011). Dermal clinicians operate within standardised scopes of practice. They can work autonomously as an allied arm of cosmetic physicians, plastic surgeons, dermatologists and general practitioners in clinics and medical settings.

Unlike dental hygienists, dermal clinicians have no national board or regulatory body to mandate their role. However, they can become members of the ASDC, an affiliate member of the AHPA and directed by graduates of the dermal science degree. Investigating the Bachelor of Dermal Science accreditation at Victoria University can offer insights regarding dermal clinicians' recognition and regulation requirements. Registration for non-invasive medical-grade treatments is needed to promote professional recognition and public safety, achieved by monitoring professional standards and ongoing professional development. However, the consequences of registering the dermal science profession might cause concern for other service providers who offer services without formal dermal science work qualifications.

A recent report by the ASDC and Victoria University listed the following critical knowledge areas that skin health professionals must complete qualifying as dermal clinicians (Victoria University, 2021):

- Public health and working inter-professionally to provide skin health therapies.
- Scientific knowledge underpinning the mechanism of treatment modalities.
- Evidence for practice.
- Skin biology in health and disease.
- Wound and injury management.
- Psychology and comprehension of why cosmetic or aesthetic procedures are sought, as well as common disorders contraindicated for treatment.

- Work, occupational health and safety, licencing requirements, working with non-ionising radiation, infection control, compliance with health regulations and working with chemicals and controlled substances (e.g., topical anaesthetics).

According to the Institute of Allied Healthcare Studies at the University of Applied Sciences (Hogeschool Utrecht, the Netherlands) (2022), skin therapists, who are similar to Australian dermal clinicians, complete the degree and are considered paramedical professionals that work in primary and secondary healthcare. Dutch law in the Netherlands stipulates that skin therapists treat diseased or damaged skin by following a referral from a general practitioner or hospital physician (e.g., dermatologist, vascular specialist, oncologist or plastic surgeon; de Vries et al., 2021). Dutch law further stipulates that patients with acne, hirsutism or oedema must be referred only to a skin therapist. In Holland, health insurance accredits a 100 EUR rebate to patients for attending the clinical services of a skin therapist (van Zanten et al., 2014). This thesis addresses policy-related issues and examines dermal science clinicians' and other allied health professions education requirements and accreditation criteria.

Health professions in Australia must overcome several challenges to become accredited. One is the lack of common frameworks to outline the core elements (Hinchcliff et al., 2012). The Australian Tertiary Education Commission’s (1978) inquiry into nursing education in Australia revealed a lack of data regarding hospital-based nurse education and issues that influenced nurses’ futures. Further, the National Safety Quality and Health Service review accreditation processes protect the public from harm and improve the quality of health services (Flanigan, 2016). This has prompted the development of revised standards, quality and safety review frameworks, and performance indicators for monitoring and assessing managing healthcare systems to achieve efficacy, equity, efficiency and quality (McPhail et al., 2015). McPhail et al.’s (2015) study identified that some accreditation elements

overwhelmed emerging healthcare professions. However, McPhail et al. (2015) noted that the accreditation schemes focused] on optimising the regulatory environment to drive performance and quality in health facilities and enhancing the assessors' importance in what is expected to continue being a value-driven accreditation market.

Previous studies have illustrated the stressful transitions that allied health professions face. The success of emerging healthcare adjusting to future reforms and changes requires a focus on bridging the gap between non-regulated emerging allied health professions (e.g., dermal clinicians) and other regulated allied health professions. Additionally, examining how allied health professions cope with workplace dynamics and expansions in accreditation standards is essential. Periods of significant change can create new challenges or amplify existing barriers to the credibility and reliability of accreditation programs (Greenfield et al., 2015). Even though some health-related studies are dramatic in the challenges, such as policy and standard operating procedure changes, identifying what lessons and reforms are necessary if allied health positions are to be improved and realised is essential. Finally, understanding the specific challenges to regulate emerging allied health professions might help determine the need for regulation—which this thesis aims to address.

1.11 The Dimensions of the Issue

Limited data exist regarding the fields of allied health professionals and practitioners that are unregulated (e.g., those of dermal clinicians). Additionally, there is no documented evidence regarding the value of dermal clinicians’ activities or the number of patients they treat. Therefore, information must be gathered to ensure recognition and regulation. For example, many highly trained health professionals work closely with allied health professionals and other primary care providers to improve the health of Australians. Examples include health practitioners who offer culturally safe care for Aboriginal and Torres Strait Islander people and asthma educators who help patients and their families better

manage their asthma care and minimise its effects on the patient's quality of life. Nancarrow and Borthwick (2021) noted that diabetes educators comprise allied health professionals and nurses who have undertaken additional postgraduate training to help people who have or are at risk of developing diabetes by empowering them to effectively self-manage their care and treatment. In another example, myotherapists also provide physical therapy to treat or prevent soft tissue pain and restricted joint movements. Nancarrow and Borthwick (2021) further noted that one-quarter of the health workforce in Australia and the UK comprises allied health professionals.

Another changing dimension in the allied health field stems from using neoliberal economic policies and market-oriented reform policies in the health sector, which some researchers term 'new public management' (NPM; Steger & Roy, 2021). The rise of NMP in the 1970s in Europe and the US and the 1980s in Australia emphasised output-oriented values. They prompted regulatory scholars to push the case for procedural fairness and accountability (Nagarajan, 2008). The term NMP denotes using private sector management models to render public service more businesslike and to improve efficiencies. Its significance in the context of this thesis is that it reduced the medical profession's autonomy and its power to dictate the terms of participation for a growing number of other health and emerging allied health professionals (e.g., dermal clinicians). This thesis focuses on a significant transition from interprofessional relationships to co-equal partnerships in a shifting profession–state arena (Borthwick et al., 2009). Existing literature states that government reforms encourage a new type of professionalism that is not based on exclusion, control, and special statuses. Instead, new professionalism focuses on reconstructing responsibilities, in which productivity is identified as an individualised professional duty instead of a social control that became increasingly questioned (which often involved professions being depicted as self-serving and unlawfully controlled; Moffatt et al., 2013). A

new approach to regulation will support the development of a more flexible health and care workforce. Australia's healthcare system produces effective outcomes according to international standards, but some parts are not performing as efficiently as possible (Australian Government, Productivity Commission, 2015). According to the Productivity Commission, this inefficiency can manifest as wasteful spending, reduced access to healthcare and substandard quality and safety outcomes. Improving efficiency would thus entail achieving better 'value for money' from health spending—that is, better health outcomes, a higher quality of care, improved access to health services and less waste generated for a given level of funding.

In considering the broader context of interprofessional practices, the researcher recognises the change in the health industry regarding the role of professions as markers of activities (Evetts, 2011). Dermal clinicians adhere to the ethical standards of the medical profession. They are accepted into the allied health field because they possess professional knowledge and skills from a recognised bachelor's degree with a high educational and training level. Dermal clinicians work in interprofessional practices with other allied health practitioners, including plastic surgeons, dermatologists, medical practitioners, nurses, psychologists and physiotherapists. In Australia, a national approach to accreditation programs and the regulation of health professions was adopted in 2010. Accreditation standards and regulatory frameworks can drive change and support interprofessional education and collaborative practice (Bogossian & Craven, 2021). Borthwick et al. (2009) recognised that interprofessional teamwork had become the core of early twenty-first-century health workforce training, development, and delivery. Interprofessional teamwork involves professionals from different disciplines training or working together to understand and sometimes adopt roles that are traditionally performed by others (e.g., dermal clinicians). The motivation for interprofessional teamwork stems from the client or patient's complex needs.

Improving patient access to healthcare and outcomes is imperative, which requires input from various professional perspectives and expertise (Peterson et al., 2021). Interprofessional teamwork is also designed to overcome workforce fragmentation and specialisation problems. No single discipline can fully meet a client's complex needs, especially considering demographic changes that likely increase the demand for healthcare provision. For example, wound care for a diabetic patient is specialised. The patient’s treatment plan must include wound management services from a qualified individual, such as a skin therapist in the Netherlands, who provides topical treatments and uses light-based therapies, compression, and products to maintain the skin’s integrity. Dermal clinicians in Australia, like the Dutch skin therapists, are qualified to treat chronic diabetic wounds; however, unlike skin therapists in the Netherlands, dermal science students at Victoria University do not complete internships in interprofessional settings such as hospitals. Instead, they complete their training on campus in a training clinic. The diabetic patient in this context would also need a medical practitioner to prescribe appropriate diabetic medication, a nutritionist to recommend food intake and a nurse to change the dressings. Dermal clinicians are a part of the interprofessional process, and because of how they deliver services, they require intensive training, a high level of qualification and specialisation. Government regulation of certain aspects of professional practice for dermal clinicians (specifically regarding electrotherapies and laser use) should be overseen nationally by a national professional board such as AHPRA.

1.12 Treatment of Minors: People Under the Age of 18

Children and young people frequently access the services of emerging allied health professionals. This often involves cases requiring treatments for skin health, especially when these young adults are overly conscious of their appearance (e.g., treatment for acne, lesions, abnormal hair growth patterns and wound management). Minors are likely to seek treatment

from professionals such as dermal clinicians. In Australia, children under 16 can consent to treatment if they are competent and intelligent enough to fully understand what the treatment involves (a concept known as ‘Gillick competence’; Zimmermann, 2019). Treatments by a dermal clinician require extensive clinical consultation, evidence-based practice, intensive skin science knowledge and a high academic understanding of procedures that involve electrotherapy and laser devices (Victoria University, 2022). Issues arise when unqualified technicians fail to work within the scope of practice, especially when the patient is a minor. Some technicians commence treatment according to what the client desires, despite the suitability of the desired treatment—that is, the technicians do not prioritise ensuring that the skin has been properly prepared or that they have reduced adverse events, understood the practice’s underlying mechanisms, and promoted optimal outcomes before and after the treatment. This trend of following the client’s desires poses a significant risk, especially for minors.

Further, the patients must clearly understand why the treatment or practice was recommended (Zimmermann, 2019). Working with minors is thus just one justification for regulating dermal clinicians as an emerging allied health profession. Unregulated practices pose a risk to both the technician and the client. Other risks, such as damaging skin or burns, pigmentation, scarring and irreversible injuries, are associated with treatments performed by non-qualified technicians.

1.13 Consultation

Emerging allied health professionals might use specific techniques considered intrusive or dangerous. For example, unqualified technicians performing treatments using lasers, IPLs and LEDs pose a risk of injury to the consumer or technician (e.g., burns). ARPANZA has stated that no nationally uniform laws and regulations oversee the use of lasers, IPLs and LED phototherapy in the cosmetic industry. The laws and regulations are

determined by the state or territory jurisdiction in which a business practices. Using lasers for cosmetic and other purposes is regulated in Tasmania, Queensland, and WA, while using IPLs for cosmetic purposes is only regulated in Tasmania. No regulatory oversight exists for using LED phototherapy in Australia, and licencing requirements differ in each jurisdiction. The regulator in each jurisdiction defines these licencing requirements and assesses any application before issuing a licence. Notably, because no regulatory framework exists in Australia's other states and territories, jurisdictions in these places do not require a licence to perform light-based treatments (Australian Radiation Protection and Nuclear Safety Agency, 2022). In their US study, Khalifian et al. (2022) aimed to identify the causes of injury and liability claims related to skin laser surgery between 2012 and 2020. Public legal documents indicated that 71% of the liability claims involved NPOs, in which laser hair removal was the most litigated treatment, followed by laser skin rejuvenation. The Bachelor of Dermal Science at Victoria University is the only degree providing essential legal and practical theory and training to ensure dermal clinicians understand the importance of thorough clinical consultation. The level of theoretical detail learned to understand these treatment modalities in specific non-medical university courses such as the Bachelor of Dermal Sciences is comparable to, if not higher than, the level observed in specialist dermatology training (Leow, 2017).

A dermal clinician consultation takes 45–60 minutes or even longer for complex and chronic conditions (Australian Society of Dermal Clinicians, 2022). Most franchise clinics employ staff who are in-house trained. Unqualified skin health staff may take 5–10 minutes to analyse the client's skin and propose a treatment based on their observations rather than spend an intense time gathering medical history and data to make a clinical judgement. For example, the technician might observe hair in an area for laser hair reduction and advise the client that this can be treated. Still, the technician fails to examine beyond the hair for any

suspected lesions that require medical clearance because they might be potential melanomas. A laser can mask a potential skin cancer that might not re-emerge until it becomes a late-stage melanoma. Patients often sign consent forms without understanding the treatment's associated consequences or adverse effects. This is apparent when a technician is not formally trained in skin science, skin health or the laws and ethics associated with the service. For example, ensuring that the treatment is appropriate for the client and conducting a comprehensive clinical consultation are requirements that must be completed to receive valid informed consent from the patient before commencing any skin treatment.

Intense clinical consultation is a strong point of difference in the practices that dermal clinicians perform. Many assumed professions in the industry confuse clients by giving themselves job titles that do not equate to a qualification. These titles include laser technicians, laser specialists, paramedical aestheticians, aesthetic medical practitioners, beauticians, and beauty therapists. Some courses for these professions are as little as three days long. No laws prohibit this, which is confusing; patients are misled when they believe the technician is qualified to perform the treatments. This also confuses the patient regarding the level of qualification; dermal clinicians require appropriate consultation and the patient’s medical history before recommending the same treatments as these other assumed professionals. Standards that direct the training that technicians receive on the job from a company representative are thus required.

The consent obtained in some circumstances becomes an ethical issue if patients believe that the technician is fully qualified to perform the services. A fully qualified allied health practitioner will conduct a thorough clinical consultation and apply clinical reasoning and judgement centred on evidence-based systems. Other assumed professionals who do not have formal training are making superficial cosmetic decisions. Dermal clinicians base their assessments on the pathogenesis of the skin disorder; for example, the dermal clinician will

examine the hair that the patient wants to be treated while also examining the skin for lesions that might be potential skin cancers. Selecting parameters based on a visual interpretation of what a technician observes on a patient's skin is not enough. The dermal clinician must implement algorithms and a standardised approach to treatment.

One key issue is that attention is paid to the numerous clinics that focus on clinic profitability and profitable promotional campaigns in Australia. A deeper issue is the astounding number of clinics that operate without appropriate qualifications. A Channel 9 *A Current Affair* report by Mortimer (2021) investigated franchised clinics that have been branded as 'ruthless business models'. The program highlighted the non–university qualified staff who followed treatment application methods provided by the manufacturer representative of the electrotherapy equipment, lasers and LEDs—which is not considered suitable training. Training from a manufacturer representative does not provide adequate knowledge regarding the safe practice of using lasers and other medical-grade equipment.

Further, other issues have been linked to a franchise's discount programs, in which patients become accustomed to the regular '50% off' sales and often choose to wait for the sales period instead of paying full price for the service. A specific science underpins the intervals for such treatments to encourage patients in this choice. However, the skin healing process must be managed and controlled appropriately. Further, pointless adverse reactions such as burns, scarring, paradoxical hypertrichosis and masked melanomas become pronounced after treatments with some modalities. Other considerations are that unqualified technicians recommend too many unnecessary treatments that do not offer any advantages to the client.

Research has highlighted that untrained personnel in the beauty and cosmetic industry have prompted negligence and malpractice lawsuits due to severe injuries (Leow, 2017). A dermal clinician's professional duty is to exercise specific professional skills in skin health

according to an evidence-based system (Victoria University, 2022). A 12-month-long anonymous survey of 430 medical and non-medical practitioners in Australia revealed 416 cases of burns and permanent scarring (of which 268 were considered severe) and 62 cases of skin cancer (including 22 cases of melanoma), in which a practitioner delayed or missed the diagnosis (Leow, 2017). The regulation of these treatments using laser devices differs throughout Australia. Lasers, IPLs and LEDs are only regulated in some jurisdictions in Australia, signifying that administering treatment might be legal for individuals in one state or territory and illegal in others. This knowledge is essential for non-medical practitioners such as dermal clinicians and medical practitioners who delegate treatment to dermal clinicians. The lack of regulation is a significant risk given the potential for burning, scarring, eye damage, and the significant health issue of concealed melanomas when a laser device is used. In another area, one case study focused on laser tattoo removal. The risk of masking skin lesions such as melanoma confirms diagnostic problems that are associated with tattoos and the danger of laser removal, given that lasers can mask potential melanoma lesions. Zipser et al. (2010) stated that using laser therapy to treat pigmented lesions is controversial because it can delay melanoma diagnosis and negatively affect mortality, subsequently preventing appropriate and timely therapy and leading to a fatal outcome. A dermal clinician is trained in dermatoscopy and can request the patient to obtain medical clearance for suspected lesions. The ensuing referral allows a medical practitioner to examine the pigmented lesions carefully before approving the patient for laser treatment.

1.14 Qualification: Practical and Theoretical Training

Overall, the allied health workforce in Australia is either regulated nationally by AHPRA or is self-regulated by a professional association responsible for certifying qualifications, setting and maintaining standards and overseeing professional development. Notably, dermal clinicians are recognised in the allied health field but are not regulated.

Allied health professionals, such as dermal clinicians, have a patient care role. They operate within an interprofessional practice in collaboration with other allied health experts, including medical practitioners and nurses. Further, these professionals comply with similar codes of ethics and specific scopes of practice. A dermal clinician completes an AQF level 7 or higher university health science course, and accreditation is determined by a relevant national accreditation body that includes allied health practitioners who operate autonomously within an evidence-based system (e.g., dermal therapists).

Some emerging allied healthcare professions are not accredited. A bachelor's degree such as the Bachelor of Dermal Science takes an allied health professional 3–4 years to complete if a diploma pathway is selected (e.g., for beauty therapy or nursing). However, dermal clinicians are not standardised, recognised or regulated. Conversely, some groups claim they are allied health professionals or perform the roles of dermal clinicians that require no formalised training or qualifications. Employers train many technicians and beauty staff on the job, and these individuals would rightfully not be considered for formal registration and regulation. Some allied health professions that require higher education qualifications, such as dermal science, are not entirely recognised in the allied health category. In this sense, there is a need for change. How can the public differentiate between qualified and non-qualified professionals without regulation? Where is the line drawn regarding who is regulated and who earns the title of an allied health professional? Ursula and Paula (2001) asserted that one needs only consider the number of negligence claims to answer the question of who should and should not perform the services of a qualified dermal clinician.

The policies established by the national health minister and AHMAC, as well as by AHPRA and other regulatory bodies, demonstrate a government responsibility to ensure the safety of patients. A distinct difference exists between allied health and skin health services (e.g., to treat acne, hirsutism and lymphoedema) and the various services provided for beauty,

aesthetics and cosmetic purposes. Therefore, some necessary factors for regulating qualified allied health within a policy framework should be highlighted. According to the AHPA, many of Australia's allied health professionals are registered under the NRAS for health practitioners. The medical field in Australia has opposed the introduction of the NRAS, with the Australian Medical Association (AMA) stating that the NRAS could lead to non-medically trained people assuming positions that medical practitioners currently hold. The concern is that this 'would strip medical colleges of their control in setting educational and training standards for Medical Practitioners and put into the hands of politicians and people without expertise' (Carrigan, 2008). Some allied health professions that the NRAS does not cover are considered self-regulating (e.g., dieticians). Regulations for many emerging allied health professions are mainly considered through their scopes of practice and the standards that their societies or associations establish. However, a national consensus must be reached regarding these standards and what emerging allied health professions can and cannot do. Regulating allied health professions might highlight those that use the title without qualification or permission.

Further, some allied health professional services are not covered by Medicare or private health insurance. Professionals in this field perform healthcare services to treat chronic health conditions and provide complex care needs that can attract health insurance claims. For example, a dermal clinician can provide chronic acne, hirsutism and lymphoedema treatment and care services, all requiring appropriate training and stringent compliance with scopes of practice. Some of these services are performed by non-qualified beauticians when they should be exclusively performed by degree-qualified skin health practitioners (e.g., dermal clinicians). This situation reveals the research gap addressed in this thesis. Regulation will help determine who should and should not perform specific skin health treatments.

1.15 Thesis Outline

The first chapter of this thesis provides the necessary background and context underlying the research questions. Chapter 2 highlights the relevant literature for situating the research and emphasising the theoretical aspects of regulatory processes; it also highlights existing literature focusing on best practices in regulatory authority. Chapter 3 discusses the thesis's conceptual framework and the processes required to achieve regulation for the dermal clinician profession ultimately. Chapter 4 outlines the research methodology used and the data collected from a focus group of professional dermal clinicians, while Chapter 5 describes and analyses the collected data. Chapter 6 provides a discussion and thematic analysis of the research findings, and Chapter 7 details the study's limitations and offers a conclusion.

Chapter 2: Literature Review

A literature review was used to select the topic for this research and translate the researcher's interests and concerns. Literature reviews are complex, and this study ultimately required a systemised literature review that involved a solid outline and practical guidelines for the study (Machi & McEvoy, 2022). This study's literature review presents a logically argued case founded on a comprehensive and current understanding of the knowledge related to the dermal clinician profession. The literature review was designed to establish a convincing context to help answer the research questions.

The researcher performed the literature search using Academic Search Elite, the Cochrane Library, PubMed, Medline and CINAHL from the Victoria University Library website. Academic literature searches were limited to journal articles published between 2000 and 2022, and allied health literature searches included the keywords of 'allied health', 'healthcare' and 'regulatory authority'. A keyword search was also used for 'research grounded theory' and 'theory' to determine terms related to grounded theory, constructivism and interpretive research in public health. Other keywords included 'grounded theory', 'allied health', 'regulation', 'policy' and 'focus groups'.

The literature review was further conducted to examine the definition of the allied health professional. The Australian Government Department of Health and Aged Care website states that allied health does not have a universally accepted definition (Turnbull et al., 2009) and that different definitions are used internationally and nationally (Dizon et al., 2012). Many professions use the allied health title, though all have different qualifications and expertise in their health-related services (Australian Government, Department of Health and Aged Care, 2022). The Australian Government defines allied health professionals as practising professionals who possess a level 7 or higher university-level qualification of the AQF in a recognised allied health field accredited by the relevant national body. That is,

allied health professionals are part of a national professional organisation with clearly defined membership criteria. They must also have national entry-level competency standards and assessment processes, including autonomy and a defined scope of practice.

Allied health professions usually include those with a patient care role, and allied health roles require practitioners to follow the codes of ethics established by a representative national organisation. As mentioned, these practitioners complete a health science qualification at an AQF level 7 or higher and work according to national entry-level competency standards, the relevant scope of practice and evidence-based systems (Allied Health Professions Australia, 2022). The AQF is the national policy for regulating all Australian education and training. It was first introduced in 1995 to underpin Australia's national system of qualifications, and it encompasses higher education, vocational education and training and other schools (Australian Qualifications Framework, 2022). According to this policy, an AQF level 7 signifies that a student has completed a bachelor's degree at a university.

According to the AHPA, many well-known, non-nurse and non-medical healthcare professions exist, such as those that involve working outside the scope afforded by a dermal clinician's degree qualification. These professions include nutrition, dietetics, social work, speech therapy, occupational therapy, respiratory therapy, dental hygiene, diagnostic medical personnel, medical imaging, exercise science and counsellors (Norris, 2013). The AHPA also regards dermal clinicians as affiliate allied health professionals, though a professional body does not regulate them.

Allied health educational programs aim to prepare competent allied health professionals and leaders within multiple healthcare settings. However, because of the lower level of public investment in higher education, government grants generally amount to one-third of a university's income (Rea, 2016). Scant critical research has focused on educational

standards and allied health professions' current needs, reinforcing the need for the present study.

This thesis's research establishes whether regulation will influence the position of emerging allied health dermal clinicians. Hence, attention is directed to contemporary regulatory theory and the regulatory practice of risk management. This thesis considers Victoria University's recommendation of Ian Ayres and John Braithwaite's (1992) historical work. The subsequent research of Ayres and Braithwaite focuses on the 'responsive regulation' model and other models of enforcing a regulation that deters and encourages compliance (Baldwin et al., 2011b). Accordingly, Ayers and Braithwaite suggested compliance is more likely to occur when an organisation possesses enforcement strategies that persuade appropriate practices to avoid sanctions, civil and criminal penalties, licence suspensions and revocations (Baldwin et al., 2011b).

The AMA has opposed the recognition of other allied health workers to avoid fragmenting patient care and ensure patients have access to a medical practitioner (Australian Medical Association, 2019). To explain this opposition, one could also question whether qualified medical practitioners would experience a loss of work. Further, excluding less qualified practitioners from professional associations and avoiding competition for access to scarce government health insurance funds might also contribute to the AMA's resistance. Conflicts and oppositions of this kind have become common in health and emerging allied health professions. The AMA has opposed registering some of Australia's allied health professionals under the NRAS. For example, the AMA opposed a bid by optometrists to secure funding under the Pharmaceutical Benefits Scheme, in which they described optometrists as medical pretenders (Nancarrow & Borthwick, 2021). In light of such opposition, it can be asked: what chance do other allied health professionals, such as dermal clinicians, have to secure funding for patients with chronic conditions such as acne,

lymphoedema or hirsutism, let alone recognition for their specialised skills in skin health? The medical field in Australia might fear the NRAS potentially leading non-medically trained individuals to medical practitioners positions. However, many allied health practitioners, including medical practitioners, perform skilled skin treatments that they are not trained to do ~~Nurses do procedures that they are not trained to do as well~~. Regulation would reduce the opportunities for medical practitioners to perform services and treatments not within their professional scope. Because several allied health professions struggle to be recognised as autonomous, the first step is gaining recognition. As mentioned previously, current research indicates no standardisation or introduction of policies to regulate emerging industries in allied health (McAllister & Nagarajan, 2015); further, there is no evidence of policy templates for regulating allied health professions. This thesis aims to address this critical gap.

Doing so necessitates understanding the best practice policies of allied health professions. Reviews have been conducted regarding the trends and rapid changes that theoretically and clinically occur in these allied health professions (Solomon et al., 2015). The present research examines regulations, standard operating procedures, and scopes of practice as defined within the conforms of efficient health service delivery. It also identifies how some health industries can change operations within limited academic training. For example, nursing qualifications were previously achieved through practical training; however, nursing is now a highly sophisticated health science degree (O'Brien et al., 2014). Although nursing is an attractive profession, it was not initially considered worthy of being regulated and standardised. The question can be asked regarding what nurses achieved to become regulated and what must be done to offer qualified emerging allied health professions a chance to be regulated.

In 2008, the Council of Australian Governments established a single NRAS (the 'National Scheme') to regulate the Australian health professional workforce. This vision was

realised on 1 July 2010 with the commencement of the Health Practitioner Regulation National Law, enacted in each state and territory (the 'National Law'; Delaney & Helyard, 2018). AHPRA exercises its role through the National Law to determine a health professional's suitability for registration and regulation (Delaney & Helyard, 2018).

Allied health comprises numerous healthcare professionals who are considered fundamental healthcare experts, according to the AHPA (see Appendix A). AHPRA regulates some health professions and provides policy advice to the national boards regarding health practitioner registration standards, codes, and guidelines. In partnership with the national boards, the AHPA ensures that only health practitioners with the required skills and qualifications to provide competent and ethical care are registered to practice. Each profession has a national board responsible for overseeing educational standards, managing complaints against practitioners and verifying that practitioners have met the educational standards for practice. Given this context, critical questions can be asked: What about the healthcare and emerging allied health professions not overseen by regulatory bodies? Who protects their titles and patients from neglectful and careless treatments from non-qualified workers who can cause harm?

2.1 Professions Literature

The present research is not a sociological or economic study of the emerging allied health professions but a study of their appropriate regulation. A significant body of literature on professions and professionalism provides a valuable background. Acknowledging the relevant parts of this literature on professionalism and regulation demonstrates an awareness of existing knowledge and how and where the present study fits, subsequently adding to the existing literature on this topic.

The literature is significant in terms of analysing professions and their regulation. The concept of a profession includes the concept of regulation; that is, the members of a

professional society or association are involved in regulating their membership. This includes regulatory control over training and admission, as indicated in the English definition of ‘profession’. Therefore, ‘profession’ and ‘regulation’ are interrelated. An occupation that requires training will not be a profession unless the individual who practices and conducts it is controlled. Agrawal (2001) argued that regulatory standards are a powerful determinant of a physician’s conduct. The *Oxford Dictionary of the English Language* (2023) defines ‘profession’: ‘an occupation in which a professed knowledge of some subject, field, or science is applied; a vocation or career, especially one that involves prolonged training and a formal qualification’. Hudson (1978) asserted that to be recognised as a profession; an occupation must satisfy the entry requirements of the profession. Those permitted into the profession must also have satisfied an examination from a supervisory body and have reached a satisfactory standard of training.

The Australian Competition and Consumer Commission (ACCC) delivers a rationale for regulating the profession. This thesis subsection discusses specific rationales and certain advantageous properties of regulation. Professional associations' codes or rules for maintaining high standards and ethical behaviour must also comply with the *Competition and Consumer Act* (2010). Regulating market activity might be necessary when additional sets of rights, or the qualifications of rights, are required to help the market operate efficiently and equitably for its participants (Parker et al., 1998). Three possibly legitimate rationales are often given for regulating individual market transactions in occupational services: information limitations, non-voluntary transactions and distributional concerns.

Any individual who purchases a product or service must assess its quality. The consequences, or the risks, of making incorrect judgements for a relatively simple good with few characteristics will likely be minor, given that consumers are likely to estimate the value of the good reasonably and accurately (Parker et al., 1998). Consumers are more likely to

form accurate judgements when they can assess the quality of their purchased goods after consuming them or when they undertake repeat purchases. However, professional services are significantly more difficult for consumers to assess.

Parker et al. (1998) discussed five critical characteristics of professional services that magnify information asymmetry and the ensuing consequences. First, services (e.g., clinical services) are usually not observable before being purchased because consumers cannot inspect a service before purchasing it the same way they can with most goods. However, a dermal clinician's professional services might allow a patient to know the treatment before purchase because the clinician might recommend a test patch as part of the initial clinical consultation. However, this is not the case with unqualified technicians. Second, professional services are complex, and their delivery often requires considerable skill to ensure they are tailored to the consumer's needs (though dermal clinicians are trained to achieve this). Therefore, consumers might find it difficult to assess the quality of procedural services before purchasing them. Third, the quality of many professional services can be difficult to assess even after the services have been purchased (Parker et al., 1998). For example, a patient who wants to access a skin health service might consult a dermal clinician for recommendations and treatment. If the treatment is unsuccessful, the consumer might have difficulty discerning whether the failure was caused by the poorly performed treatment or because the skin condition was inherently challenging. Fourth, most individuals are infrequent consumers of professional services, so they do not have repeat purchases to assess quality. For example, if a patient is on a course of treatments for pigmentation, the treatments must be completed in a set time with equal intervals, and the results will be imprecise. Fifth, the consequences of purchasing poor professional services can be significant. The service might be expensive for the consumer, and a defective service (e.g., plastic surgery) can cause severe and irreversible harm. These difficulties in assessing the quality of professional or procedural services can be

used to justify regulations that aim for quality assurance. Such regulations guarantee consumer service quality and reduce the risks of purchasing unprofessional services (Parker et al., 1998).

To some extent, these regulatory schemes substitute search and information gathering by individuals and assessment through some regulatory mechanism. Regulation can reduce consumer transaction costs and help the market function efficiently. However, the focus in this context is consumer protection. Parker et al. (1998) stated that the need for regulation does not entail that all professional services should be regulated similarly. Different services have different complexities and risks. In some markets, consumers can form reasonably positive assessments of quality and risk through word-of-mouth reputation or 'branding'. A dermal clinician's brand is critical, and it is determined by the clinician's dedication to the patient's valuable service experience and favourable treatment outcomes. Consumer protection is essential, so technicians cannot make false or misleading representations about their services if they have not been formally trained (Australian Consumer Law, 2022).

Non-voluntary transactions are a concern in the beauty and cosmetic industry. Consumers can be coerced and used to justify laws that invalidate contracts entered under duress (Parker et al., 1998). Generally, societies have laws, customs and practices that limit the ability of individuals to coerce others. A case for special protection could be made in markets like the skin health industry, which would become more stringent with regulation. Regulation would reduce the opportunities for unqualified providers to coerce clients into consenting to treatments—especially when they do not understand the laws and consequences associated with coercion.

Distributional considerations are often used to justify regulations that establish the terms on which services are provided, such as price caps that provide lower costs to low-income earners (Parker et al., 1998). Whether distributional concerns should be addressed by

directly regulating occupations or using a better and more direct redistribution mechanism has been debated. Although attempting to redistribute through such regulatory mechanisms is often not transparent, determining whether the policy helps those the government intends to help can be challenging (Parker et al., 1998).

2.2 Literature on the Emergence and Recognition of Professions: Altruism and Benevolence or Self-Interest

The appropriate regulation for a profession depends partly on how it is perceived (e.g., as education, a skill, knowledge, usefulness, exclusivity, or prestige); partly on the wealth of its practitioners; and partly on the functions or purposes that the profession is understood to have. These regulation factors involve persuasion and politics related to recognising and accessing specific funds.

Sociological literature from the first half of the 1900s was sympathetic to the professions. Parsons (1939) stated that the doctor is perceived as issuing ‘orders’, though the only ‘penalty’ for not obeying them is a possible injury to the patient’s health. This professional authority is based on the superior technical competence of the professional individual. Like other elements of professionalism, professional authority is characterised by ‘specificity of function’, and professional individuals are considered ‘authorities’ only in their fields. These individuals were believed to have vocations rather than secure and relatively well-paid employment. Emphasis was placed on their generous and benevolent aspects, in which ethical codes of practice were also regarded as generous and benevolent. There was a tendency to regard them as being above, outside and needing protection from risks caused in the marketplace (Talcott et al., 2006).

A more critical approach observed in subsequent literature from the early 1900s that focused on the emergence of professions as self-enforcing self-regulators tended to argue that professional status is pursued to control an occupation rather than for altruistic reasons. It was

argued that professional groups tend to create and maintain the problems they are specialists in solving and that they create the knowledge on which discourses can be centred and pursued (Brante, 1988). However, these professional groups' reasons may not be mutually exclusive. Thomas Johnson argued that professionalism should be redefined as a peculiar type of occupational control rather than an expression of the inherent nature of specific occupations (Brante, 1988) and that a profession is not an occupation but a means of controlling an occupation. Therefore, contemporary sociology depicts professions as concerned with status, power, and control. Workers in specific knowledge fields have followed similar paths to acquire professional status. They require higher qualifications for entry—so as not to exclude those without qualifications. They are also expanding the existing body of knowledge through research to gain professional status. They are following the example of other professional disciplines, endorsing professional standards in codes of practice, and creating professional associations to enforce entry requirements and adherence to professional standards.

People in professional careers are observed to advance their group’s social status, to capture a market for services and exclude others. At the same time, they search for new activities that they can control. However, they still need to persuade their clients, communities, and governments that they merit their preferred status and influence because their services are desirable and necessary (Saks, 2016). Borthwick et al. (2009) argued the case for a significant transition in interprofessional relationships towards co-equal partnerships in a shifting profession–state arena. Government reforms are now thought to encourage a new type of professionalism not based on exclusion, control and special status (Borthwick et al., 2009).

2.3 Literature on Professions and Change

The literature on change concerning the concept of professions, including their autonomy, indicates that older models and criteria might have become irrelevant or require revision to meet the new expectations of communities, governments, and individual consumer services. This is critically relevant to emerging allied health professions; however, limited scientific evidence exists.

Nancarrow and Borthwick (2021) explained that the medical profession was still dominant and that the British Medical Association and Australian medical practitioners yet belonged to the British Medical Association before the AMA was formed. A scheme was developed to register allied professions supplementary to medicine in the Board of Registration of Medical Auxiliaries (Borthwick, 1997). This scheme established allied professions as accepted professions and made them subordinate to the medical profession. In 1960, the British government developed a new regulatory body to avoid managing numerous interest groups. This led to both the recognition and government regulation of these professions. Nancarrow and Borthwick (2021) further noted how these groups ceased to be 'supplementary' and became allied health professionals and autonomous and independent practitioners for over 30 years. However, they did not become equal to medical practitioners (Borthwick et al., 2009). Alan Borthwick is an insightful author who focuses on the problems of professionalisation and the regulation of allied health professions, especially podiatry. Nancarrow and Borthwick (2021) also asserted that healthcare includes professional groups distinct from those of medicine and nursing in many Western nations. They posited that allied health professions tend to be defined by what they are not rather than what they are. For example, the AHPA defined allied health as a group of professions that are not medical, nursing or dental. Further, each Australian state recognises different professions as allied health: Victoria recognises 27 professions, further divided into therapy and science, and

Queensland recognises 23 professions, many of which the AHPA does not recognise. This makes allied health professions challenging to conceptualise, mainly when all have been grouped and emerged as a collective.

Some scholars avoid using the term ‘profession’, preferring instead ‘knowledge work’ or ‘expert occupations’. According to the National Research Council (2013), the basic meaning of a profession is a paid occupation, especially one that involves prolonged training and a formal qualification. Professionalisation describes education, training and other activities that transform a worker into a professional and the social processes by which an occupation becomes a profession (National Research Council, 2013). The profession of medicine has significantly changed over the past 75 years. Despite individual practitioners committing to the highest ideals of professionalism, the medical profession has lost privilege, power, and public reputation. It has been toppled from the high moral ground of professionalism (Hafferty & Salloway, 1993). This makes the inclusion of emerging health practice fields easier because of the quickened pace of change, which includes the recognition of new practice fields. The concept of the professions and the language used to discuss them remain widespread. Professionals display a proven ability to apply their knowledge into practice, their knowledge beyond what they have studied and their qualifications to build on their brand. A constant state of change has been observed even in professions recognised for hundreds of years, such as medicine and law. For example, it is not widely recognised how the English and Welsh medical and legal professions—significant models for other emerging professions (e.g., accountants)—reinvented themselves in the 1800s and emerged significantly differently in the 1900s. However, the transition to educating all their practitioners in universities was yet to occur in the distant future.

Since the 1980s, ‘knowledge work’ has experienced a shift from collegiality to managerialism (Göransson, 2011) and a focus on efficiency and risk management.

Specifically, Göransson (2011) explored the uneven shift from the traditional collegial form to a new managerial, organisational form. Collegiality and managerialism are often portrayed as opposed ideas or practices. Managerialism is conceived as either a necessary response for attaining higher education sales growth or a betrayal of long-held academic ideals (as supposedly reflected in collegiality; Tight, 2014). Tight (2014) argued that the two concepts are not as dichotomous as some have argued and that both have a role in shaping how the future of higher education is conceptualised. In the collegial model launched by Wilhelm von Humboldt in the 19th century, the autonomy of researchers and teachers and the close connection between research and teaching were considered pivotal. This ensured that non-scientific interests did not influence research and that students benefitted from the latest research in their training (Göransson, 2011). These are essential factors for constructing contemporary regulatory regimes. However, how beneficial any changes in regulatory regimes have been might be contested. The state's increasing intrusion has also influenced the concept of a profession, which is conceptualised as an autonomous body governed through collegial arrangements (i.e., the professionals themselves). Like many other professions, allied health has undergone substantial de-professionalisation recently, commonly explained as lost professional autonomy (Frostenson, 2015). Collegiality was the original British concept, in which the medicine and law fields in the UK established regulatory regimes outside any government structure. The collegial model was then exported to British colonies, including Australia. These professional bodies and their regulatory processes belonged to civil society rather than the state.

Continental Europe opted for a different approach to professions regulated by governmental bodies, including their approach to admission and expulsion issues. Managerialism constitutes the belief in or reliance on using professional managers to administer or plan activities. It is the philosophy or practice of conducting the affairs of an

organised group (as a nation) as planned and directed by professional managers (Merriam-Webster, n.d.). Since the 1980s, government intervention in the UK and Australia has prompted the creation of hybrid systems that combine collegiality with professional associations and the new idea of managerialism (Tight, 2014). These hybrid systems also include state regulatory bodies and their managerialism and use of risk management. The regulation of risk—such as disclosing adverse possibilities caused by procedures and identifying unsuitable practitioners—as a part of managerialism has reshaped the older underlying regulatory approaches. Professionals were once more trusted than they are today. However, there is still truth in what Giddens (1991) observed in 1990 when he examined why most people generally trusted practices and social mechanisms when their technical knowledge was slight or non-existent. He described the modern world as an exceptionally dynamic 'juggernaut' and a 'runaway world' that changed prior systems by making great leaps in change's pace, scope and profoundness.

As previously discussed regarding the project's significance, Borthwick et al. (2009) also claimed that such changes signified the boundaries of professions being redrawn in the health industry. The advent of neoliberal economic policies and managerialism in the health sector has eroded the medical profession's autonomy and power to dictate industry participation to other health professionals.

Since the 1980s, health practitioners in the state-controlled British National Health Service and the hybrid public and private model in Australia have all been affected by NPM—a political theory and policy founded on the notion that governments should operate more like private businesses. The concept emerged in the 1970s, quickly spread worldwide and became a significant fixture of global politics by the 1990s. It involves using private sector management models to make public service more businesslike and to improve efficiencies. NPM has undermined the collegiality and practice of peer review in health

professions. It has also been claimed to have decreased trust in professionals. Professionals must now justify to their managers, regulators, government and insurers why they and their actions should be trusted (Cruess & Cruess, 2005). This political theory and policy have faced criticism despite the nearly worldwide embrace of NPM ideas. Some critics highlighted that the whole movement assumes that the private sector is superior to the public sector, which might not be accurate. Other critics have noted that allowing government officials more flexibility and incentives to produce results could lead to forms of corruption, as leaders might use unethical means to meet or falsely claim to meet their goals (Andrews et al., (2019).

2.4 Regulation Literature

Extensive literature regarding regulatory models relevant to this thesis's proposed outcome of producing a regulatory framework can be found. Robert et al. (2012) effectively and succinctly introduced regulation as an undefinable and discreet mode of government activity; however, this term has been variously defined in other research. Discussing regulatory frameworks and policies is challenging without recognising the criteria in the literature regarding what constitutes 'good' and 'bad' regulation and understanding the contemporary importance of managing, governing, and regulating risk. Historically, some allied health professions adopted the position to be unregulated and to remain free of legislative interference. History has also observed calls for recognising and regulating university-qualified dermal clinicians. However, such recognition and regulation have been irregular, inadequate, and contentious. Current national health legislation in Australia does not provide a legal framework for dermal clinicians. Some registration and licencing schemes currently exist for the allied health field, which was established to help control the practice of allied health professions. However, applying these schemes to dermal clinicians is not

straightforward because these professionals are not included in the definition of the allied health profession.

Further, there is no direct governmental regulation for the dermal clinician's role, although it is not free of regulation. Victoria University dermal clinicians work within the boundaries of other allied health professions, which includes asepsis, occupational health and safety, legal and ethical practices, and practical clinical training. Other organisations are managing the education of students who carry the title of dermal therapist and dermal clinician, though this education and title are not founded on skin science degrees. Even further, other education facilities focus on aesthetics instead of medicine. In some cases, regulation is established to reduce risk—such as to protect the title of a profession. This regulation could be guaranteed according to the qualifications and expertise levels. This may eliminate confusion regarding who is regulated in their scope of work.

2.5 A Focus on Risk

Professional regulation aims to simultaneously reduce the risk of harm to the public while maximising clients' well-being and applying patient-centred care. Contemporary regulatory practices and literature strongly focus on risk, in which its management and governance are a primary emphasis for regulators who work to improve regulatory practices and approaches. This improvement relates to the design and practice of regulatory bodies, which includes a focus on the regulatory body's risk management and governance, as well as on the risk regulation and governance processes] of the bodies they oversee. Black (2010) investigated a broader context of regulatory theory and argued that risk is an explanation that justifies regulation and regulatory strategies, as well as the establishment and structure of regulatory bodies. The risk that unqualified technicians pose to consumers might justify regulation and help form regulatory organisations and their structures, processes and procedures, which regulatory bodies use to frame accountability relationships. Both external

and internal accountability functions exist; with this in mind, Black and Baldwin (2010) suggested that a body must establish and maintain appropriate risk oversight and management systems. Black (2010) also argued that the inherent nature of risk, including its uncertainty, destabilises it and often undermines the justifications for its use. In brief, risk management will always fail as a management strategy, sometimes damaging confidence in the regulator and its processes.

Black (2010) further indicated that acknowledging risk does not answer the acceptable level; it is a decision made in the context of resources and calculations concerning the consequences of not minimising risks through risk management tools. Not all situations are susceptible to measurement where the evaluation of the risks is involved. It is unclear what risk is, who is in the best position to manage it, how it is determined and what it constitutes. Further, the regulation does not appear to be founded entirely on risk; it also relates to ethics and economics or efficiency—that is, cost-benefit analysis. Black (2010) further asserted that risk provides an evaluative and accountability role in that the language of risk is used to structure the responsibility of professionals to make them accountable. In some ways, risk allows regulators to find stability in the processes and procedures of roles in which risk is expected.

2.6 Ayres and Braithwaite's Smart Regulation: A Regulatory Pyramid

Responsive regulation involves regulators being responsive to the culture, conduct and context of those they seek to regulate when deciding whether an interventionist response is needed (Ayres & Braithwaite, 1992). Further, responsive regulation is a leading approach to describe and prescribe how regulatory enforcement action best promotes compliance (Ayres & Braithwaite, 1992; Braithwaite, 2002). Braithwaite (2002) proposes that to be 'effective, efficient and legitimate', regulatory policy should take neither a solely deterrent nor a solely cooperative approach. The most popular conceptual tool used in the past 20 years

to design regulatory structures and processes in several English-speaking jurisdictions (e.g., the UK, US and Australia) has been Ayres and Braithwaite's smart regulation, with its regulatory pyramid. Braithwaite asserts that regulatory pyramids are escalating (Baldwin et al., 2011a). Responsive regulation involves listening to multiple stakeholders and deliberately and responsively choosing from regulatory strategies that can be theoretically arranged in a pyramid.

Regarding stakeholders, the capacity for specific figures to escalate to 'the tough stuff' (Ayres & Braithwaite, 1992) higher up the pyramid (e.g., deterrence and incapacitation) motivates collaborative problem-solving at the base of the pyramid. The bottom of the pyramid includes more frequently used first-choice strategies (e.g., restorative and capacity building), which are less intimidating, less overpowering, and cheaper. Therefore, even if the lowest levels of enforcement are being used, there is an indication and awareness that if they do not receive a positive response, then more disciplinary sanctions at higher levels in the pyramid will be used. The most used strategies, the first or lowest, include persuasion and education to develop a capacity for compliance. These are also cooperative strategies (Ayres & Braithwaite, 1992). They inform regulated bodies of specific requirements and can lead to higher levels, further education, and counselling strategies. As strategies escalate, they include penalty notices for noncompliance; enforceable undertakings; compliance control directions, including limitations to permitted work; enforcement orders that require remedial actions, injunctions, or prohibitions; suspensions; and deregistration. These enforcement strategies must be tailored to regulated activities (Baldwin et al., 2011a).

2.7 Ayres and Braithwaite's Tripartism

According to Ayres and Braithwaite, smart regulation also involves tripartism to prevent the regulated interest group from capturing regulators (Braithwaite, 2002). Tripartism denotes when relevant public interest groups become the fully-fledged third player in the

game (Ayres & Braithwaite, 1992). The risk of regulatory capture can be reduced by having a multi-professions regulator; reducing the regulator's discretion (e.g., having another body such as VCAT review decisions); and rotating regulatory personnel (e.g., those moving between roles as legislators and regulators) and members of the industries that the legislation and regulation affect. Tripartism involves a third party in the relationship between the regulatory body and the regulated group (Ayres & Braithwaite, 1992). The relationship can include one or more public interest groups (e.g., health consumer groups). This approach can be observed in the Australian Commission on Safety and Quality in Health Care (ACSQHC) and its priority to partner with consumer groups. The purpose of this approach is the safe delivery of healthcare, including clinical mandates, procedures, processes and standards that ensure that patients, consumers and staff are safe from harm at all levels of the provided healthcare (Baldwin et al., 2011a).

2.8 Additional Literature: Regulatory Theory and Models of 'Good' Regulation

Additional literature that focuses on applying and critiquing Ayres and Braithwaite's notions of good regulation is also used. Baldwin et al. (2012) developed criteria that they believe effective regulatory frameworks should meet, which could also inform this thesis's conceptual framework. According to Baldwin et al. (2012), the literature examines how a regulation system is determined as good, acceptable or needing reform. The authors discuss several criteria for good regulation—whether legislative authority supports the action or regime; an appropriate scheme of accountability is present; procedures are fair, accessible, and open; the regulator is acting with sufficient expertise; and the action or regime is efficient. After explaining these criteria, this chapter considers their role in assessing regulation, as well as the challenges encountered in measuring regulatory quality (Ayres & Braithwaite, 1992).

2.9 The Dermal Clinician in Australia, and the Skin Therapist in the Netherlands: A Comparison

This thesis compares the standards, scopes of practice and qualifications between Australia and the Netherlands; the aim is to identify how emerging allied health professions in Australia (e.g., dermal clinicians) gain recognition through regulatory processes for the skin health treatments that they provide. Policy recommendations can be made through the comparative analysis of the differences and similarities between the non-regulated dermal clinicians in Australia and the government-regulated skin therapists in the Netherlands. The comparison reveals whether Australia can learn from the regulation processes of skin therapists in the Netherlands. A sound evidence base exists for the appropriate regulation of dermal clinicians, which can provide policy recommendations for regulating this profession in Australia.

Victoria University's four-year Bachelor of Dermal Science (formally known as the Bachelor of Health Science Clinical Dermal Therapies) focuses on skin health. Similarly, the four-year Bachelor of Skin Therapy at Hogeschool Utrecht in the Netherlands' University of Applied Sciences and Bachelor of Skin Therapy at the Hague University of Applied Science specialising in skin health therapies. These three degrees are the only allied health and skin science-focused undergraduate degrees offered worldwide.

The Bachelor of Dermal Science helps students develop a comprehensive knowledge of dermal science and skin health, in which they learn how to perform safe and effective dermal treatments (Victoria University, 2022). The dermal procedures covered in the course include laser and light-based treatments, resurfacing and lymphatic procedures. Students also learn about preoperative and postoperative care for patients who experienced plastic surgery and reconstructive and cosmetic procedures. In the course, students undertake clinical training and learn about treatments and how to identify, evaluate and manage the physical,

psychological and social needs of patients who undergo dermal assessment. Specifically, they learn about (Victoria University, 2022):

- skin disease and skin conditions
- wound management
- scarring
- preoperative and postoperative skincare
- fluid retention
- inflammatory conditions
- skin conditions (e.g., acne, psoriasis and rosacea)
- uneven skin tone and pigmentation
- aging or sun-damaged skin
- the removal of excess hair, tattoos, skin tags and leg veins.

Programs such as *A Current Affair* have aired many stories about the adverse events and treatments received from unqualified operators who perform procedures resulting in horrific burns and long-term consequences. The media has also covered the improper and inappropriate use of advanced technology without legislation or regulation.

Claims have been made by medical professionals who seek to regulate some of the medical procedures so that only medical AHPRA-regulated practitioners can perform them (Australian Society of Dermal Clinicians, 2022). Although the medical profession makes these claims from its position as an AHPRA board, it should be highlighted that the procedures performed by a dermal clinician require in-depth knowledge about the skin and the mechanisms of action involved with electrotherapy modalities that are used on the skin. Medical practitioners are not trained or qualified to do what a dermal clinician does. The dermal clinician's procedures also involve sound critical thinking and intense clinical training in skin health, practice and experience. This further requires the clinician to assess risks and

prevent or manage associated complications or adverse reactions. It must be recognised that most medical professionals do not have adequate knowledge of skin health treatment or modality options. These treatments require a specialised understanding of the mechanism of action and the use of various technologies, energy devices and tissue interactions to achieve desired outcomes and prevent skin damage. Dermal clinicians are non-medical health professionals who have completed a three or four-year health science degree as skin health professionals. They specialise in performing non-surgical, minimally invasive medical procedures on the skin. Bogossian and Craven (2021) investigated the reform of Australian standards and derived an approach to analysing accreditation and practice standards. The goal was to address the fragmented and inconsistent approach used for practice standards and the standards of the health professions. In this degree, student dermal clinicians must increase their proficiency and complete many supervised clinical hours of performing techniques to ensure the safe delivery of treatments to the Australian public.

In their medical degrees, medical professionals do not learn about skin, nor are they taught how to perform non-surgical procedures using the technologies that dermal clinicians are trained to use (Australian Society of Dermal Clinicians, 2022). The ASDC agrees that regulation is required, even though this profession has no formal regulation. Bogossian and Craven (2021) stated that a fragmented and inconsistent approach to interprofessional education and collaboration is evident in some accreditation and practice standards. Generally, the standards of the regulated health professions possess more detailed requirements.

Victoria University (VU), Utrecht University, and Hague University in the Netherlands are the only educational institutions worldwide that offer bachelor-level skin or dermal science qualifications. VU must show accrediting bodies that its processes ensure a comprehensive and evidence-based curriculum that complies with the regulatory

requirements in the industry, including the legal and ethical practices established through the government (Victoria University, 2022). In recognition of their status as an evidence-based emerging health profession, dermal clinicians meet the standard of university-qualified allied health professionals through the ASDC (Australian Society of Dermal Clinicians, 2022).

The industry's main problem is the lack of regulation and recognition regarding the duration, depth, level and relevance of education required to operate in this specialisation and an understanding of how this relates to the scope of practice (Australian Society of Dermal Clinicians, 2022). An additional lack relates to recognising and protecting emerging health professionals trained to manage skin health and treat the most common skin conditions and diseases.

An issue also lies in using outdated titles, such as beautician and beauty parlour. These terms cover everything from beautification procedures to minimally invasive non-surgical aesthetic and cosmetic procedures. The ASDC asserts that the government currently lumps everyone together in the same categorisation, from qualified beauty therapists with a Certificate III to university-qualified dermal clinicians. This categorisation and the description of titles based on qualifications in the industry must be updated. Further, industry endorsements are needed for dermal clinicians to be accepted and respected. So they are consistently used by those endorsed to use them through recognised education and training.

Allied health professionals play a more significant role in preventative health development and managing common conditions within their scope. Dermal clinicians follow essential techniques to detect early skin diseases and disorders and to help Australians age well and healthily. Dermal clinicians can also manage common skin conditions to prevent further deterioration and subsequently help improve poor mental health caused by the burden of skin disease and disorders (Australian Society of Dermal Clinicians, 2022). The ASDC is currently lobbying the government for greater recognition of and respect for the role of the

dermal clinician. The society aims to highlight the scientific nature of the education and expertise that students attain in their bachelor's degree. Regulating the profession may result in gaining respect for the education and encouraging an understanding of the expertise required to manage and perform skin health procedures.

People would not ask a medical practitioner or podiatrist to perform their X-rays, physiotherapy treatments or surgeries because they are not medically trained to perform these services. Although practitioners such as nurses and other allied health professionals might understand skin conditions and the risks of not treating the conditions (e.g., infection), skin health procedures are performed by trained experts who specialise in treating these conditions, such as dermal clinicians.

The Bachelor of Dermal Science in Australia is equivalent to the four-year Bachelor of Skin Therapy from the two universities in the Netherlands. Students of the skin therapy degree are recognised by Dutch law as paramedical professionals who work in primary and secondary healthcare in the Netherlands. The title of 'skin therapist' is protected by Dutch law and is reserved for those with the qualifications prescribed by Dutch law (van de Mortel, 2022). The profession in the Netherlands was established approximately 40 years ago, and it has since snowballed into a reputable, government-recognised organisation. The profession's official body is the Dutch Association of Skin Therapists, or the *Nederlandse Vereniging van Huidtherapeuten* (NVH; van Zanten et al., 2014). According to the Institute of Allied Healthcare Studies, Hogeschool Utrecht in the University of Applied Sciences allows graduates to become skin therapists in the Netherlands and qualifies them to:

- Advise, instruct, and inform individuals and groups of patients with skin-related diseases or disabilities.

- Examine patients to establish the degree of injury or disablement due to oedema, hypertrichosis, pigmentation disorders, scars, dermal vascular disorders, hyperhidrosis, acne and psoriasis.
- Determine the extent of injury or disability resulting from sweat and sebaceous gland problems, circulation problems, hair and nail pigmentation disorders, wounds, lymphatic system disorders, tumour problems, work and sports-related disorders, allergies, eczema and psoriasis and autoimmune diseases.
- Create a care plan or protocol for skin therapy treatment.
- Treat patients by referral from a physician, as stipulated by Dutch law, to abolish, reduce or prevent the effects of skin disorders using oedema therapy, laser and IPL therapy, iontophoresis, microdermabrasion, camouflage therapy, coagulation, demography, hair reduction by electrolysis, cryotherapy, self-supporting resources like therapeutic elastic stockings and massage to support self-care concerning the effects of skin problems (van de Mortel, 2022).

In 1995 in the Netherlands, a multidisciplinary working group was formed to focus on a condition called lymphoedema. Van Zanten et al. (2014) confirm that skin therapists are allied health professionals who help diagnose, treat and manage skin conditions. This includes treating and managing lymphoedema and other oedema and specialising in preventing and managing skin conditions. Skin therapists treat, manage and attempt to cure many skin disorders, such as severe acne, scars, hirsutism, pigmentation disorders, vascular disorders and wounds.

Detailed information about the courses and regulations of skin therapists in the Netherlands is provided by van de Mortel (2022), a team leader and lecturer at the University of Applied Sciences in the Netherlands, a dermal therapist, and a public health scientist. The NVH determined that skin therapists are qualified to treat patients with acute and chronic skin

conditions or disorders, even without a general practitioner or medical specialist referral. Skin therapists treat skin conditions intending to cure, reduce or prevent them and the limitations they cause in patients' lives (van de Mortel, 2022). A skin therapist's scope of practice includes treating surgical, trauma or burn-related scar tissue, acne, abnormal hair growth, venous post-DVT, lymphoedema and chronic wounds. Skin therapists are also qualified to apply complex compression therapy and all aspects of complete decongestive therapy. These professionals work in private practices and interprofessional community health centres or hospitals (Utrecht University, 2023).

The NVH is an allied health professional association that has represented the interests of skin therapists in the Netherlands since 1978, and its members are bachelor-level skin therapy graduates. The title of 'skin therapist' is protected under Dutch law, which also specifies therapists' educational and expertise requirements. Expertise under Dutch law entails treating patients with numerous skin disorders who have been referred to a skin therapist by a general practitioner or specialist. As previously discussed, skin therapists are registered and recognised as allied health professionals in the Netherlands (Dutch Association of Skin Therapists, 2022).

The focus on science is intense in the three dermal and skin science degrees from Australia and the Netherlands. For example, after breast cancer treatment, patients face various challenges, including scar tissue, oedema, and skin damage, especially after radiation therapy. Dermal clinicians in Australia and skin therapists in the Netherlands educate patients about appropriate skin health, treat skin conditions and provide aftercare instructions. A significant focus is placed on wound management in the Netherlands, although this is also a component of Australia's dermal science degree. Treatments in the Netherlands include scar revision, compression therapy, medical compression stockings and exercise. The difference between the degrees in Australia and the Netherlands is that the skin therapist in the

Netherlands completes their clinical training in a hospital,e.g., working alongside other health practitioners in wound or lymphedema wards, and they would be recognised and regulated by the Dutch Government. Dutch law stipulates that patients are referred to skin therapists, and rebates apply to conditions such as acne, lymphedema and hirsutism. In this case, the regulation would reduce the risk of unqualified individuals performing unsafe treatments with limited knowledge about the skin.

The equivalent of AHPRA in the Netherlands is the BIG registration. Registration with this organisation is obligatory for 12 healthcare professionals. The BIG register is a legal, online and public register for professionals in individual health care, which includes skin therapists in the Netherlands (CIBG, Ministry of Health, Welfare and Sport, 2022). Only healthcare professionals registered in the BIG register can independently perform the roles and treatments associated with that profession and use the protected professional title of skin therapist. These regulations are mandated by the *Healthcare Professionals Act* (Wet BIG) to monitor and promote better quality healthcare. The *Healthcare Professionals Act* protects patients from the careless or incompetent treatment of unqualified healthcare professionals (Overheid.nl., 2022).

The website www.business.gov.nl is the point of contact for resident and foreign entrepreneurs wishing to establish a business in or conduct business with the Netherlands. The website collaborates with several Dutch governmental and semi-governmental organisations to provide information about the country's laws, rules, regulations and subsidies. The Netherlands Enterprise Agency provides further information regarding the stricter rules for laser treatments in the Netherlands. It maintains a dedicated register of skin therapists who perform laser skin treatments (e.g., tattoo and hair removal). This agency affirms that only health professionals with relevant educational qualifications can perform the treatments, such as medical practitioners or skin therapists. As noted previously, skin

therapists must be registered with the BIG registration, which protects their title; if practitioners do not comply, they will be liable for disciplinary proceedings (Dutch Association of Skin Therapists, 2022).

2.10 The General Law as the Regulatory Context

To the researcher's knowledge, no specific legislation regulates the allied health industry and profession for dermal clinicians. This thesis's sources of law and regulations were derived from other related professionals, such as nurses, and legal areas, such as equity law, common law and torts. Underlying all regulatory arrangements and schemes is a general law that provides sporadic regulation. The lack of legal protection is a significant problem in the existing context of the dermal clinician profession. This thesis thus considers the limited protection that the existing system provides and offers recommendations for protecting the public and the dermal clinician's role.

2.10.1 The Registration and Deregistration of Practitioners

Equity might be one remedy in terms of legal protection. Before allied health professions are established, their registration and deregistration requirements and remedies for breaches, as per the Australian Law Reform Commission (ALRC, 2019), are typically assessed from equity law perspectives via natural justice or procedural fairness (Kirkham et al., 2019). These perspectives account for the right to be heard and for a reasonable individual to suspect. Additionally, common law is another source of law relating to the relevant regulations of the allied health profession. One precedent relates to 'Wednesbury unreasonableness'—in which 'a reasoning or decision is Wednesbury unreasonable (or irrational) if it is so unreasonable that no reasonable person acting reasonably could have made it' (Associated Provincial Picture Houses Ltd v Wednesbury Corporation, 1948; 1 KB 223) (Greene, 2012). This is an English law case about the unreasonableness of public-body decisions that would make them liable to be cancelled on judicial examination, known as

Wednesbury unreasonableness. It is when a decision is so unreasonable that no reasonable decision-maker would have made it. Rather than outlining a law, this precedent relates to the belief that a court should sometimes intervene, which would be relevant in a regulatory framework that addresses the admission and deregistering of members. Any regulatory regime relating admission and deregistering of members should be fair, given that a person's livelihood is at stake. In a recent UK study by Kirkham et al. (2019) on deregistration, social workers described the present procedures of regulating members in a profession as court-like. Kirkham et al. argued that different models to the court-like model should be considered in a poorly organised and resource-poor profession such as social work, in which disciplined professionals often do not participate in the process.

2.10.2 Practitioner Malpractice, Negligence or Misconduct

In the context of misconduct or negligence committed by health industry professionals in individual cases, consumers might face] liability and damages in [the area of] tort law, [in the form of] trespass to a person (assault and battery) or negligence. Jansen (2022) noted that the tort of negligence involves three characteristics: the professionals owe a duty of care to their clients; the professionals breached their duty to care; and the breach caused damages to the clients, in which the causality between the breach and the damages was not too remote. The standard of care is considered an acceptable level of treatment from a competent professional in assessing and providing the treatment. Failures in this legal context are often described as 'malpractice' cases, which include:

- The failure to properly diagnose a condition.
- The failure to provide appropriate treatment for a condition.
- An unreasonable delay in treating a diagnosed condition.

- Breaches of informed consent principles, in which patients were not informed of the possible adverse consequences of specific treatments and would have declined the treatment had the information been provided.

Complementary to tort law is professional self-regulation codes. Some professional codes of practice could be used to determine an acceptable standard. A practical overview of professional codes can be found in standard textbooks, such as *Health Law in Australia* (2018). An article on malpractice cases against dermatologists considered a low-risk field of practice, indicates the number of claims made and their outcomes. Stevenson (2018) discussed how risk mitigation processes are essential for protecting patients from harm. He argued that it reduces the practitioner's exposure to unnecessary reputational damage and economic loss. The literature further demonstrates that failing to meet patient expectations was the largest source of claims against dermatologists, followed by adverse outcomes. Improved communication from practitioner to patient remains the most effective step for preventing medico-legal claims. However, medico-legal claims are more successfully defended when thorough documentation processes have been established (Stevenson, 2018).

Litigation is expensive, which deters clients who have been injured from suing. The ALRC (2019) confirmed that cost is critical for accessing justice. It is a fundamental barrier for clients wishing to use the litigation system. It could be made more affordable and thus more likely to be used in the context of:

1. A fee contingency agreement with a lawyer, in which the lawyer only receives payment if the action is successful by the client.
2. A class action involving others who have been injured in the same way, which specialised companies often fund.

Regarding the first context listed above, it should be noted that in the Australian system—but not the US system—the client would still be responsible for the other party's

costs if the client is unsuccessful (Australian Law Reform Commission, 2019). This can be a costly exercise for clients, which might deter them from accessing the justice system. Action can also be taken against individual practitioners and manufacturers of equipment or other goods (e.g., nutritional supplements and electrotherapies) used in the treatment that caused harm.

One relevant book on the regulatory effect of general law and litigation was written by Viscusi (2003) from a US perspective. It examined the importance of the regulation–litigation interaction and used the responsibilities and functions of institutions as the theme of a US study focusing on tort law. Viscusi (2003) discussed policy concerns related to narrow policy remedies, such as providing a regulatory compliance defence for compliant firms that follow strict government standards while remaining subject to litigation. With an Australian perspective on medical products, Clark (2007) discussed the litigation involved for products such as IUD devices (Dalkon Shield and Cu-7), breast implants, benzodiazepines, fen-phen, cardiac pacemakers, Vioxx and implantable orthopaedic devices. Wilkinson's (2021) PhD thesis comprehensively accounts for Australian law and practice. Concerning the context described in this section, Wilkinson asserted that risk drives the medical device regulation in each jurisdiction. Further, regulatory theory, especially principles and rules-based theory, is informed by this concept of risk—which is reflected in the design of the current regulatory systems for medical devices.

2.11 Consumer Movements and the Health Industry

Community expectations that could pressure governments to act are relevant for determining standards of regulation for health professionals, as well as for informing the political decisions of governments to intervene. Organised consumer movements have increased such expectations. Government intervention is also a factor, and these expectations are related to the literature focusing on professions. Baldry (1992) explored the notion of the

health consumer movement and asserted that it is inextricably linked to the women's and environmental movements, given that it is shaped by, learns from, draws on and uses their strategies and approaches. Baldry (1992) also characterised these social movements as citizen movements. Their bases are rooted in the conviction that people have rights to a healthy and peaceful environment. The equality of treatment regardless of sex or race, and the chance to voice their opinions and opportunities for being heard and the ability to access information is necessary. These are all affected by a profession's perceived status and the level of trust extended to its practitioners. Consumers treat health services and products like other consumables in a consumer economy and society. In this sense, emerging allied health professionals' services can be strongly regarded as consumer products because they might be perceived as more 'elective' or non-essential. Organised consumer movements can use the media to lobby the government to influence decision-making concerning health regulatory policies. Recognising the importance of consumption in contemporary economies, governments also adopt policies encouraging consumers' confidence in the quality of the goods and services provided.

Well-established consumer movements have occurred in English-speaking countries over the past 200 years, such as the boycott of sugar from slave-worked plantations in England in the 1700s. In another example, British and American Quakers in the 1780s launched an extensive and unprecedented propaganda campaign against slavery and slave labour products. Their goal of creating a broad and non-denominational anti-slavery movement culminated in a boycott of slave-grown sugar in 1791, which nearly half a million British people supported (van Dyk, 2021). Consumer interest groups became more common in the 1900s in Australia to protect consumers. Several factors contributed to the rise of the consumer movement in the 1930s. Craig-Lees's (1991) examination of consumer activism involved a historical analysis of the consumer movement in Australia and a discussion about

the development of a movement that signified social change. However, in her work, Craig-Lees argued that no definitive or viable analytical framework existed for movements. The consumer activism of the early 1900s functioned as a foundation for the consumer movement. Exploring these movements for abstinence enhanced understanding of how consumption was critiqued and how protestor and revolutionary debates were translated into practice. Craig-Lees also argued that numerous examples of the effects of consumer activism included an increase in the regulation level for business, the decline of industries such as the fur industry and direct restraints via boycotts and other pressure tactics as used by certain pressure groups. Consumer activists not only focused on the quality of the products but also on the products' information and safety. In the early 1900s, increasing urbanisation prompted a significant concern about food safety and contamination, resulting in pure food laws and local systems of hygiene inspection. The consumer movement was re-energised in the early 1900s as the new consumer economy matured. It has been a national phenomenon in most developed countries and has formed international networks.

Research indicates that consumer health activism existed in Australia in the late 1900s. According to Short (2020), health policy embraces courses of action that affect the institutions, organisations, services and funding arrangements known as the healthcare system, as well as includes actions or intended actions by the public, private and community individuals and organisations. In 2006, the Council of Australian Governments created the ACSQHC. They defined patient safety as preventing errors and adverse effects associated with health care. Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The Commission aimed to provide better health results and experiences for all patients and consumers and improve the health system’s value by leading and coordinating national healthcare safety and quality improvements. In 2011, the

Commission was permanently established as an independent statutory body of the federal and state governments by the *National Health and Hospitals Network Act 2011* (Cth) and the *National Health Reform Act 2011* (Cth). According to O'Rourke (2007), one of the concerns driving the creation of this statutory body was consumer interest groups. O'Rourke also stated that numerous studies in developed countries indicated deficiencies in healthcare quality. The author further asserted that the ACSQHC intended to address concerns regarding the lack of data about the effectiveness of improvement interventions, the inadequate measurement of and reporting on quality, and the insufficient application of existing knowledge to influence and improve the quality of care. Evidence demonstrates clinical variation between clinicians who treat similar diseases in similar patients. In this sense, discussing best practices does not necessarily signify that they are consistent everywhere (O'Rourke, 2007). Examining the work of dermal clinicians would reveal how some perform their clinical work from an aesthetic or cosmetic perspective. In contrast, others opt for a skin health or medical health perspective. Although it might be appropriate, this variation in practice might not follow a specific standard for best practice.

The stated priority of the ACSQHC is to partner with consumers, as aligned with its 'partnering with consumers' standard. The purpose of the standard is to ensure that consumers are partners in the planning, design, delivery, measurement and evaluation of systems and services and that patients are partners in their care to their preferred extent. It is also claimed that the purpose of the standard is to recognise the importance of involving patients in their care and providing clear communication to patients. Other literature focusing on consumer expectations in the health system from Taylor et al. (2014) indicates that health policy perspectives have shifted, and policymakers have realised that complying with standards cannot be achieved merely by instructing people. Consideration is attributed to education levels and changes in the socio-economic status that caused the shift towards

higher community expectations—especially regarding the patient's autonomy regarding how information is communicated to the patient for them to consent.

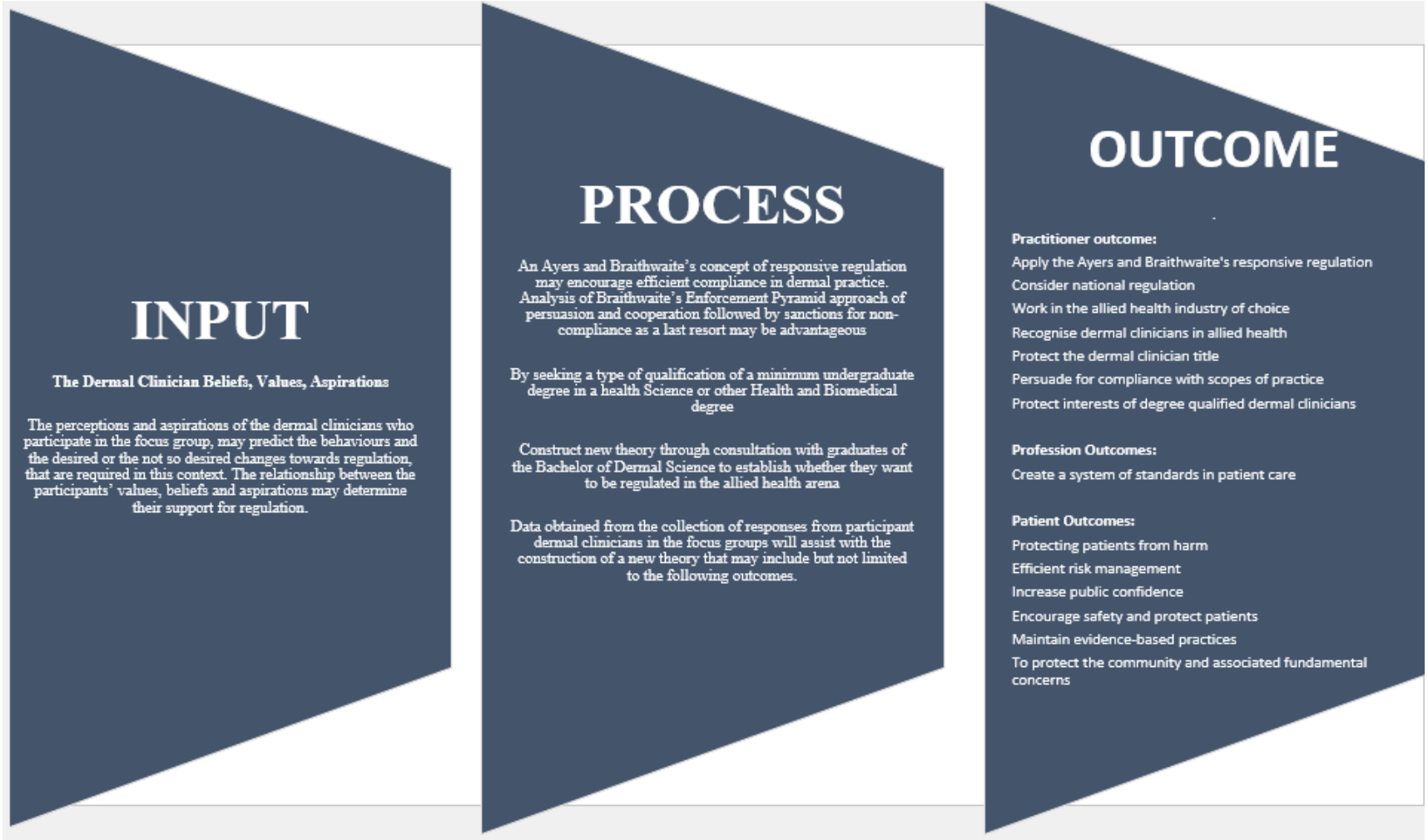
Chapter 3: Conceptual Framework

One primary aim of skin health-related services should be safety. Dermal clinicians provide patients with various skin health treatments and procedures, including theoretical and technologically advanced systems. The conceptual framework is a strategic and essential part of research (Guntur, 2019) that illustrates the expected relationship between critical areas in the research and helps define the relevant objectives of the process used.

The conceptual framework presented in this thesis focuses on the need for a regulatory authority that helps organise and understand the fundamental concepts, theories and relationships involved in regulating the dermal science profession. Figure 1 illustrates the main components of this thesis's conceptual framework and outlines how they relate. The conceptual framework also explains the critical concepts of Ayres and Braithwaite's responsive regulation model and the direction taken by the present research.

Figure 1

Conceptual Framework



Ayres and Braithwaite's concept of responsive regulation encourage communication between the regulator and practitioner. The practitioner's efficient compliance in healthcare would be beneficial. This thesis considers Braithwaite's enforcement pyramid approach of persuasion and cooperation, followed by certain sanctions for noncompliance. The grounded theory approach provides data from dermal clinician participants in the focus group. The degree qualification level is set to no lower than AQF level 7.

The data collected might determine whether dermal clinicians wish to adopt Ayres and Braithwaite's responsive regulation to become recognised as an emerging allied health profession and to protect the practitioner's title. The data also determine whether standards are considered nationally. Overall outcomes might contribute to a system of standards in patient care that protects patients and the community and addresses their fundamental concerns of efficient risk management, increased public confidence and safety in evidence-based practices. Several factors determine whether dermal clinicians who value compliance support the Ayres and Braithwaite framework of responsive regulation. This is especially true regarding the focus group participants who support compliance and are highly trained and degree-qualified dermal science practitioners. It is thus essential to determine whether this group reveals that dermal clinicians want or do not want to be regulated in Australia. Consideration of existing frameworks to regulate the dermal clinician profession is essential. Dermal clinicians can adopt policy frameworks from other regulated allied health professions to regulate their practices. Their standards, qualifications, values, and beliefs can determine the appropriate regulation type.

The research questions predict the process and outcomes according to the participants' characteristics, who they are and their values, beliefs, and expectations. The procedures and relationships of those procedures determine the type of regulation. This thesis thus proposes that people with certain values and aspirations will support a specific type of

allied health regulation. The relationship between the participants' values, beliefs and aspirations establishes whether they support the regulation (i.e., the focus group's perceptions and whether they encourage regulation). This thesis examines what these participants consider desirable and undesirable, in which the desirable regulation is related to the type of regulation. It is suspected that the desirable or undesirable changes are also related to the type of regulation being predicted or related to the observations participants make. The standards and different types of matters associated with regulation are identified in the literature review.

Ayres and Braithwaite's book, *Responsive Regulation* (1992), presents a regulation style many regulators have recognised. Their style is based on an enforcement pyramid, in which regulators design and follow a system that commences with less intervention through codes of practice and conduct (Ayres & Braithwaite, 1992)— the current practice for dermal clinicians. Options to increase the intervention through regulation in the form of enforceable laws might be necessary according to the strict criteria regarding who is regulated to perform specialised skin health treatments and the equipment used to treat patients.

The unique contribution of a responsive regulation theory lies in its regulatory enforcement and influence on compliance. It recognises that different people have various motivations for complying or not complying with enforceable regulations and that the same person can have multiple, potentially conflicting, motivations for compliance, which Braithwaite called 'multiple selves' (Ayres & Braithwaite, 1992). The basic principles of responsive regulation are framed as the regulatory pyramid. At the base of the pyramid are advisory and persuasive measures; in the middle are mild administrative sanctions; and at the top are more punishable sanctions for stopping individuals who continuously offend. This pyramid is more likely to be effective when it has a reliable enforcement peak, such as sanctions, prohibition orders and deregistration. Ayres and Braithwaite (1992) stated that the capacity for escalation must be allowed if persuasion fails. Persuasion promotes informal

interventions to address problems. Further, positive feedback on achievements and strengths is critical because it might persuade a dermal clinician to comply with regulatory requirements and deter others who are not qualified.

The ASDC ensures that dermal clinicians are considered allied health professionals. The role of the dermal clinician requires government intervention, appropriate regulation and a registration process. The responsive regulation model created by Ayres and Braithwaite (1992) might also further encourage insurance funds such as private health insurance funds and Medicare to recognise the dermal clinician role. Part of the regulatory process would include complying with standards for consistent professional development, which is not mandatory (Australian Society of Dermal Clinicians, 2022).

The consequences of registering the dermal science profession might cause concern for the many service providers who offer services without formal dermal science work qualifications. According to some researchers, one reason professional associations such as the ASDC are established is to offer a monopoly to the professionals with whom the professional association is accredited. Another reason for establishing professional associations is to enable quality assurance. However, the underlying economic motive might be the premium charges that can be imposed in a monopoly. One of this thesis's aims is to critically examine the general nature and credibility of professional associations to understand better their relevance to dermal science and the role of the dermal clinician.

This thesis also critically evaluates the educational requirements and recognition criteria of the Bachelor of Dermal Science in Australia, a degree only offered at VU. Notably, no jurisdictions in Australia possess regulations for dermal clinicians. Only two other universities worldwide offer the same undergraduate qualification: the Bachelor of Skin Therapy at the Hague University of Applied Science and the Utrecht University in the Netherlands. Skin specialists such as dermal clinicians complete a regulated and registered

degree that attracts a government rebate (CIBG, Ministry of Health, Welfare and Sport, 2022). The Hague University rushed to regulate its skin specialists. The title of the skin therapist, dermal therapist (different to the dermal therapist in Australia) and dermal clinician as allied health professionals are now protected under Dutch law. In Australia, dermal therapists complete a diploma that focuses on aesthetics. Their role and qualifications differ from those of the degree-qualified dermal clinicians in Australia.

Previous studies have illustrated stressful transitions that indicate how emerging healthcare would adjust to reforms and change. A focus is placed on bridging the gap in the qualification levels and clinical training required to recognise how maintaining skin health is achievable in an evidence-based system. There is no indication of what these studies are nor of what the underlying factors of stressful transitions are. The industry of unaccredited practitioners leads to the loss of businesses, employment, and income—which the literature focusing on emerging professions indicates might be an intended action.

The conceptual framework intends to demonstrate that regulation and appropriate qualifications reduce harm to the community. The input section of the conceptual framework focuses on the data collected from the study's focus group. The regulation aims to promote confidence (e.g., people are confident when they see a nurse or podiatrist because of the regulation). These regulated professionals will use evidence-based practice, have appropriate qualifications for treating people and work within a regulatory framework. People who require treatment for skin diseases and skin health conditions should confidently enlist the services of dermal clinicians, who would work within the boundaries of an evidence-based system. However, they are not regulated. Once regulated, dermal clinicians will be protected by law as a part of allied health. The researcher has evaluated whether enhancing this kind of confidence is too ambitious. Perhaps it would not be easy, but there are certain regulatory bodies to which stricter enforcement could be applied. Concerns could also be raised

regarding self-regulation. However, this is a matter for further research. When applying the Ayres and Braithwaite responsive regulation model, the researcher ensured that a dermal clinician is at least persuaded to comply with the principles of safe skin health treatments. For example, the dermal clinician would comply with the scope of practice and the codes of ethics outlined in the regulations. This signifies that professionals not clinically trained as degree-qualified dermal clinicians should be restricted from performing treatments and handling equipment such as laser machines—which could translate to accepting the Ayres and Braithwaite responsive regulation model.

Chapter 4: Methodology

4.1 Introduction

This chapter outlines the research design and methodology used for this research. The research design included a constructivist approach that further implemented a qualitative research method approach. This design was adopted to develop insights into an area of scant research and develop a mutual construction of meaning (Mills et al., 2006) based on the data collected from the participant dermal clinicians in focus groups. Further, the participants' views and stories will be meaningfully reconstructed and interpreted within a grounded theory model. The literature review was the first step in this research, followed by the review of the present industry publication.

4.2 Constructivist Approach and Grounded Theory

A constructivist approach to grounded theory was used, which included integrating data from a focus group. The focus group comprised dermal clinician graduates who have obtained a Bachelor of Dermal Science from VU. Glaser and Strauss (2017) first described the grounded theory in 1967, which involved constructing a novel theory from collected data and applying inductive reasoning. This method contrasts with the verifying theory in the deductive model traditionally used in scientific research (Timmermans & Tavory, 2012). The researcher tests an existing theory by collecting data and then analysing them to determine whether they support the theory. Grounded theory commences with critical thinking and various moments of philosophical thought (Mills et al., 2006). To formulate a question, the researcher systematically collects data and discovers the theory that emerges from the collected data. Ideas and concepts emerge once the collected data are reviewed through a coding and thematic process (Cresswell, 2016). They can be grouped into higher-level concepts and categories (Glaser & Strauss, 2017). These categories and their properties become the basis for sampling a new theory. Implementing the grounded theory approach

allows the concerns and perhaps the suggestions of the focus group participants to be examined and to determine a resolution for the concerns.

As aligned with grounded theory, this study began with collecting qualitative data on the regulation and standards critical for dermal clinicians, who represent an emerging allied health profession. This study involved collecting and interpreting data to understand the problems associated with being or not being regulated. According to the evidence, solutions to the raised concerns and their resolution prompted the researcher to develop a better theory.

This study aimed to identify the issues involved in regulating or not regulating the allied health professions and investigate the appropriate type of regulation for dermal science and other emerging allied health professions (e.g., Ayres and Braithwaite's [1992] responsive regulation and risk management strategies). Responsive regulation is founded on the proposition that regulators should be responsive to the culture, conduct and context of those they seek to regulate when they decide whether an interventionist response is needed (Ayres & Braithwaite, 1992). Responsive regulation is a leading approach for describing and prescribing how regulatory enforcement action best promotes compliance (Ayres & Braithwaite, 1992; Braithwaite, 2002). It proposes that being effective, efficient, and legitimate requires regulatory policy to take neither a solely deterrent nor a solely cooperative approach.

Mills et al. (2006) claimed that in developing a constructivist grounded theory design, it is vital that the researchers position themselves as the participants' partner in the research process instead of an objective analysts. The researcher could then reflect on their perceptions and awareness of the questions, which would be measured against the participants' perspectives.

4.3 Grounded Theory: Challenges and Benefits

The benefits of using grounded theory primarily include ecological validity. This theory is grounded in data that have been systematically collected, analysed and used to uncover topics such as social relationships and group behaviours (i.e., social processes). The research examined whether the results could be generalised to the more significant population. Other benefits of the grounded theory approach include the discovery of novel phenomena (Randall & Mello, 2012). In this case, the researcher aims to answer an unknown theory and parsimony (Rennie et al., 1988), in which a small sample focus group would provide simple data to explain the unknown phenomenon. A constructivist approach to grounded theory draws on the researcher's and participants' experiences by interpreting the data. This study's conclusions might identify an appropriate regulatory process (Greenfield et al., 2015) and uncover the motivation of allied health professions, such as dermal clinicians, to become accredited (McCann & Polacsek, 2018).

Attention is paid to the relationship between the researcher and participants to ensure that the researcher maintains an objective perspective when interpreting participants' responses. The researcher acknowledges that the meaning of the participants' views must be objective to ensure that bias does not influence the results and construction of knowledge. The purpose is to offer results that are contextual and relatable to the circumstances and that impart a clarity of meaning derived from the participants' subjective views.

4.4 Participant Recruitment and Sample

This research required specific participants to meet the required goals. This is why a purposive sample of participants was selected. Qualitative research was chosen to reach the facts and explore the perceived opinions and ideas of dermal science practitioners in the allied health field (Maia et al., 2021). The proposed research design also assessed the allied health industry's views and desires to regulate the dermal clinician profession.

This study commenced with a focus group of participants who completed a Bachelor of Dermal Science or Bachelor of Health Science (Clinical Dermal Therapies) at VU. The participants were working in the industry, and some had also completed postgraduate studies, such as PhDs, master programs or postgraduate diplomas and certificates, to enhance their opportunities in the allied health arena. The participants' employment statuses ranged from dermal clinicians to consultants, dermal clinicians and assistant nurses, practitioners of dermoscopy, lecturers and business owners in skin health. Some worked in medical and allied health, while others focused on aesthetics.

This purposive selection of dermal clinicians could offer an opportunity to extend the research investigation. It could also be appropriate for adoption in other studies on emerging allied health professions that seek regulation.

4.5 Sample and Procedure

A purposive sample of specific participants was selected to help the study achieve its goals. This was the most effective method because of the extensive background information regarding the research topic and the required participants who met the criteria and characteristics of a degree-qualified dermal clinician. The researcher aimed to eliminate personal bias or preference from the focus group participant responses. These focus group participants had specific characteristics that the researcher needed to evaluate and was best suited to help answer the research question. All participants were over 18 years old and had completed a minimum Bachelor of Dermal Science or a Bachelor of Health Science (Clinical Dermal Therapies) at VU. All seven focus group participants worked as dermal clinicians and had acquired other training for jobs in the allied health field.

The participants shared their experiences and discussed their opinions of what it would mean to be regulated or what it means to be unregulated. The data collected from the focus group helped determine what dermal clinicians wanted to happen regarding regulation.

An evaluation of the incorporated research from previous national and state regulatory bodies helped support the discussion of and recommendations for bridging the allied health regulation gap, especially concerning dermal science. The current allied health regulation gap is identified by emerging dermal clinicians who possess a minimum bachelor's degree and who complement the work of other medical professionals. For example, a dermal clinician receives referrals from plastic surgeons, dermatologists, medical practitioners and other allied health professionals. The gap lies in the fact that when a medical practitioner treats an acne patient, the service is covered by Medicare. However, when the medical practitioner refers the patient to a specialised dermal clinician, they must pay for the service even though they have an accepted medical condition. This issue is mentioned in the review of literature-sourced data in Section 2.2, in which the researcher reviewed the policy guidelines of state and federal regulators in Australia and assessed the regulatory differences observed throughout Australian jurisdictions.

4.6 The Focus Group Interview Schedule

The focus group questions were selected based on previous knowledge and understanding of the dermal clinician profession. The questions were developed after the researcher discovered the information critical for the study's success. They were designed to contextualise the perceptions of the study's dermal clinician participants. The evidence gathered from the focus group pertained to Australian dermal clinicians who provided findings related to their beliefs and values, which were then used to develop a theory. The study's focus addresses a gap in existing practices and highlights that dermal clinicians are not recognised or regulated as an emerging allied health profession. The focus group participants' opinions and shared stories helped offer insights into associated issues and revealed whether they felt regulation would be appropriate. Participants briefly described themselves, including their first name and interest in regulating the dermal clinician

profession. Once the information about regulatory requirements and dermal clinician requests was clarified, the researcher refined the seven preliminary questions and the following probing questions to collect rich data. The scheduled focus group questions are outlined in Table 1.

Table 1

Focus Group Questions Schedule and Probing Questions

Table 1: Schedule of Focus Group Questions and Probing Questions

Question #	Main Question	Probing questions
1	How familiar are you with regulation processes for allied health in Australia?	What are the problems, limitations, or concerns with regulation?
2	What is your understanding of the current regulations for dermal clinicians?	What do you already know about regulatory agencies for dermal clinicians? What is something extra that you would like to learn about?
3	What would be the benefits for a dermal clinician to be regulated?	What is most important to you as a practitioner? How significant is your problem or concern with the regulation of dermal clinicians?
4	What do you believe are the views of patients that access the services of a dermal clinician?	What would you say are the benefits of seeking the services of an allied health practitioner? What are your patients' general feelings about regulations and standards?
5	Should emerging allied health professions like dermal clinicians be regulated in Australia?	Do you believe AHPRA could regulate dermal clinicians, or should they be self-regulated? What words or phrases come to mind regarding non-regulated allied health?
6	What does it look like for dermal clinicians to be regulated?	It would be a massive shift in how we operate as clinicians; what would accountability look like?
7	What trends do you see happening in the dermal Science industry if it becomes regulated?	Should it be self-regulation or AHPRA regulated

It was essential for participants to elaborate on their responses if they were unclear. If participants deviated from the posed question, the researcher guided them back to the intended topic. The researcher progressed to the next question if they continued deviating from the focus group question. The participants were allowed to respond voluntarily to each

other to enhance the dialogue, which involved gentle probing throughout the focus group discussion.

With their consent, participants were allowed to be named in the thesis. Dermal clinicians and focus group participants were purposefully sourced from professional associations, universities, clinics, medical settings and social media channels. All focus group participants were graduates who completed the Bachelor of Dermal Science or Bachelor of Health Science (Clinical Dermal Therapies) at VU. Emails and instructions to participate were sent to interested participants, and a signed consent form was returned to allow them to participate in the focus group discussion. The focus group included the researcher, chief investigator, associate supervisor, a research assistant and seven focus group participants. Overall, seven questions were asked; some often overlapped others during the discussion. The focus group discussion was conducted via Zoom and required over 60 minutes. A series of demographic questions were also asked to ascertain age, gender, primary location, highest qualification level, current workplace title and employment status. Participants came from various allied health settings, such as hospitals, the medical field and private practices. Some clinicians commenced work in the profession immediately. Some clinicians progressed to obtain postgraduate studies, such as a master's in nursing, qualifications for becoming dermal clinicians and registered nurses, PhD research and clinical consultancy.

4.7 Ethical Approval

4.7.1 Privacy and Confidentiality

Ethical elements such as consent and anonymity required ethical clearance, which the Victoria University Human Research Ethics Committee (VUHREC) granted. Because of the VUHREC's intervention, the empirical research initially proposed during the confirmation of the candidature proposal for four focus groups was reduced to one.

Truthful consideration of this project reflects the interaction between the researcher and participants, especially during the focus group discussion. The researcher acknowledges the professional requirements for obtaining informed consent, the problems associated with data collection, the methods implemented to collect information from human participants and how the data were stored and archived.

This research project was conducted in a low-risk category and implemented a simple document for interviews and surveys. The project does not identify any health or safety issues associated with the researcher's or participants' well-being. However, should any problems arise in this area, the researcher will comply with VU policies, including the commitment to provide a safe and healthy working and learning environment.

4.7.2 Consent

All participants were asked to sign a consent form to participate in the study, which included their permission to audio record the focus groups. The recordings were transcribed, coded, and analysed to identify themes, patterns, and supporting quotations from each category.

As mentioned previously, the focus group participants included VU dermal science graduates. They were sourced from the Australian Society of Dermal Clinicians, VU (notably, the only university in Australia that delivers the Bachelor of Dermal Science), medical clinics, other dermal science graduates and social media channels. The invitation to participate (see Appendix B) was delivered via social media platforms (e.g., Facebook, Messenger, and Instagram) and clinical supervisors, medical facilities, and clinics; some participants heard about the invitation through word of mouth.

All interested participants were contacted by email and received instructions for participation, including a consent form (see Appendix C) that had to be returned before the focus group discussions commenced. Once the consent forms and qualification certifications

were returned, the participants received a focus group live online session date and a Zoom link, with an intended time of approximately 60 minutes.

Informed consent was incorporated into the overall research. This study was designed to understand the respondents' experiences within strict ethical guidelines (Husband, 2020) and in consultation with extensive qualitative research and interview methodology literature. The study's research design included a focus group and an analytical framework that allowed the results to be appropriately evaluated and placed in perspective against a larger body of knowledge (Macrina, 2014). According to the National Health and Medical Research Council (2007), designing, analysing, and conducting research must remain within ethical guidelines. The principles of research ethics—including justice, beneficence, and respect—were applied in this research.

The appropriate practice methods for this research involved various degrees of collaboration between the researcher and participants. Therefore, it was essential that from the onset, the researcher was guided by rules from the national statement regarding boundaries; the researcher thus understood these guidelines when they obtained informed consent. These rules were found in the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007), which comprised a series of guidelines from the *National Health and Medical Research Council Act 1992*.

Ethical decision-making commenced with the research design. According to Josephson and Smale (2020), the ethical conduct of research requires informed consent and the voluntary participation of research participants. The informed consent process involves informing participants of their rights as research subjects and their rights to consent voluntarily (Josephson & Smale, 2020). Much effort was dedicated to ensuring autonomy (Kelso, 2016) following the Australian Code for the Responsible Conduct of Research. Informed consent remained part of the ethical practices in the research study.

Further, informed consent links to autonomy and beneficence (National Health and Medical Research Council, 2007); Newman and Kaloupek (2009) defined the principle of autonomy as allowing participants to decide whether to participate in the study. Informed consent also represents the principle of beneficence as a guide for determining whether the participants will benefit from participating in the study.

Informed consent and the associated process ensured that these principles were protected. A focus was placed on ethics, including autonomy, respect for people, beneficence, and nonmaleficence (Newman & Kaloupek, 2009). Newman and Kaloupek (2009) further suggest that the process of informed consent centres on the notion that participants can determine whether their participation is in their best interests. Therefore, persuading or influencing the participants' decision would be unethical and could distort the data results. It was also realised that autonomy prevails over the principle of beneficence. Even if the participants know the benefits of participating in the study, the researcher must respect their decision to ensure their autonomy (National Health and Medical Research Council, 2007).

Ethical considerations are prevalent in this study, despite not containing vulnerable participants. Study processes were introduced to the participants beforehand to help them decide whether they wanted to participate. An ethical consent agreement was also designed for participants to protect their identities and detail any risks. The survey and interview participants were predominantly allied health professionals and graduates, regulatory authorities, and other professionals. There were no underage participants nor people with a limited cognitive capacity to participate.

The data collection procedures included field methods for collecting valuable information from research involving human participants, including the citation of research studies and discussions in the literature that demonstrate the acceptability of the proposed methods. Compliance with VU recommendations for collecting, storing, and sharing data

were also fulfilled, with VU suggesting that the data be saved on the VU research data storage ‘r: drive’.

The ethics literature review suggests that data integrity is essential for managing data collection and storage. According to Laas et al. (2020), an ethical culture exists in research that aims to protect the confidentiality and privacy of research participants. Appropriate technology is essential for adequately protecting and implementing participant data. This was especially critical for the participants who accessed the online surveys using social media platforms. This section emphasises the issues of consent in research involving publicly available but personal content (Benzon, 2019) derived from social media. These ethical research issues obtained through social media include privacy, anonymity, informed consent, confidentiality, recruitment, and autonomy (Benzon, 2019). Because this is a low-risk study, the social media component of data collection could qualify for a waiver of informed consent (Bowman et al., 2012) if the ethics committee determines that the research involves minimal participant risk.

Focus groups and in-depth face-to-face interviews were conducted live via a virtual platform. Consent was also obtained to record participant interviews while maintaining their anonymity. The participant recruitment implemented ethical approaches (e.g., email contact or contacting the society or association for allied health).

One essential aspect of data management was the data’s intellectual property rights and ownership. Section 5 of the Victoria University Intellectual Property Regulations (2013) specifies that unless it is University intellectual property, students own the intellectual property they create in their studies at the University unless otherwise agreed. An agreement would be conferred in a specific instance. Therefore, the graduate researcher has the right to ownership of intellectual property. Under the *Australian Copyright Act 1968*, the owner of

literary content has exclusive rights to reproduce or copy work, publish, and communicate the work to the public via electronic means—including making it available online or via email.

Chapter 5: Focus Group Results

5.1 Descriptive Analysis

This study's qualitative focus group was contacted through VU, word of mouth, an Instagram poll and Messenger. Graduate dermal clinicians who completed a Bachelor of Dermal Science or a Bachelor of Health Science (Clinical Dermal Therapies) were purposefully selected. To avoid bias, the exclusion criteria in either of the two degrees included current active educators in the two degrees and anyone who had been an office bearer of the ASDC in the past two years. Seven participants were purposely selected after they selected 'yes' to participate in the focus group.

An email was initially used to contact all interested participants and to send them participation instructions and a consent form to complete and return. The email also outlined the study's aims and objectives. Seven participants returned the consent form, including consent to display their names at the end of this thesis. The qualitative focus group was conducted via Zoom with the seven study participants. Those present included the thesis researcher, primary interviewer, chief investigator and principal supervisor, associate supervisor and a research assistant.

Once audio recording commenced, the interviewer thanked the participants for returning their consent forms and requested verbal permission to record the focus group discussion and transcribe the data. The data remained confidential and were only used for transcription and data analysis in the research. Verbatim transcripts were subjected to thematic analysis that was triangulated through NVivo and the expert opinions of the supervisors.

The participants, graduates of the Bachelor of Dermal Science or Bachelor of Health Science (Clinical Dermal Therapies), had also completed further studies, including a Master of Nursing, Diploma of Nursing, Master of Nutrition and Master of Dermatoscopy.

Participant ages ranged from 30 to 59 years old, with locations varying throughout Australia. The discussion required one hour and 14 minutes to complete.

Seven main questions were considered (see Table 1), but not all were asked because the participants answered previous questions. Some probing questions were also included to ensure that rich data were collected. Finally, demographic questions were asked before the focus group's official discussion commenced, which included age, location and job title.

Thematic analysis is a qualitative research method used to identify patterns or themes within a given data set (Braun & Clarke, 2022). The analysis is independent of any specific theoretical framework and is the most common form of analysis used in the qualitative research approach. A verbatim transcript was subjected to thematic analysis from a triangulation through NVivo and the expert opinions of the study's supervisors.

The thematic evaluation of the focus group data was examined through NVivo to attain a qualitative dissertation research study. NVivo was influential in coding data and addressing validity threats. According to Zamawe (2015), the key message is that, unlike statistical software, the primary function of NVivo is to aid the analysis process rather than to analyse the data. Ultimately, the researcher must remain in control of the results and their interpretation.

The researcher obtained experience in using NVivo through various training sessions with VU library staff, the chief investigator and associate supervisor, and other ambassadors, mentors and online training. The student researcher attended qualitative courses to further their understanding of the thematic and coding processes. The study's themes and sub-themes were identified in NVivo, which helped the researcher discover a richer insight into the defensible findings.

The study's primary step was to read the transcript repeatedly to familiarise the researcher with the data before assessing any themes or patterns. Braun and Clarke (2022)

stated that no conclusions should be made at this stage. The transcript was coded manually to gauge understanding of participant responses' words, themes and patterns. Coding and the data grouping in its manual form were also performed; however, further analysis using NVivo allowed for more in-depth and accurate reflections on the themes.

To ensure accuracy and validity, the researcher re-examined the data points under each theme to confirm that they logically fit into the pattern established as the basis of each theme (Braun & Clarke, 2022). The researcher continued to review and refine the themes, which ultimately returned the results detailed in Table 2.

Table 2

NVivo Thematic Results

1 : Problems	36	14
2 : Confusion	11	3
3 : Disappointment	6	4
4 : Doubt	12	2
5 : Legal	3	3
6 : Safety	1	1
7 : Unfamiliar	6	2
8 : Unqualified	4	1
9 : Tension	1	1
10 : Vague	1	0
11 : Solutions	14	71
12 : Academic	4	14
13 : Accountability	2	6
14 : Familiar	0	1
15 : Insurance	0	3
16 : Qualification	7	31
17 : Recognition	4	19
18 : Standards	1	20

Table 2 reveals several themes that echoed the problems and solutions that participants highlighted (see also Figures 2–4). This study adopted a constructivist perspective, in which some background information regarding the dermal clinician role was known. The analytical objective was to measure the themes against the research's aims and research questions to construct a theory ultimately.

Figure 2

Problems Highlighted by the Focus Group

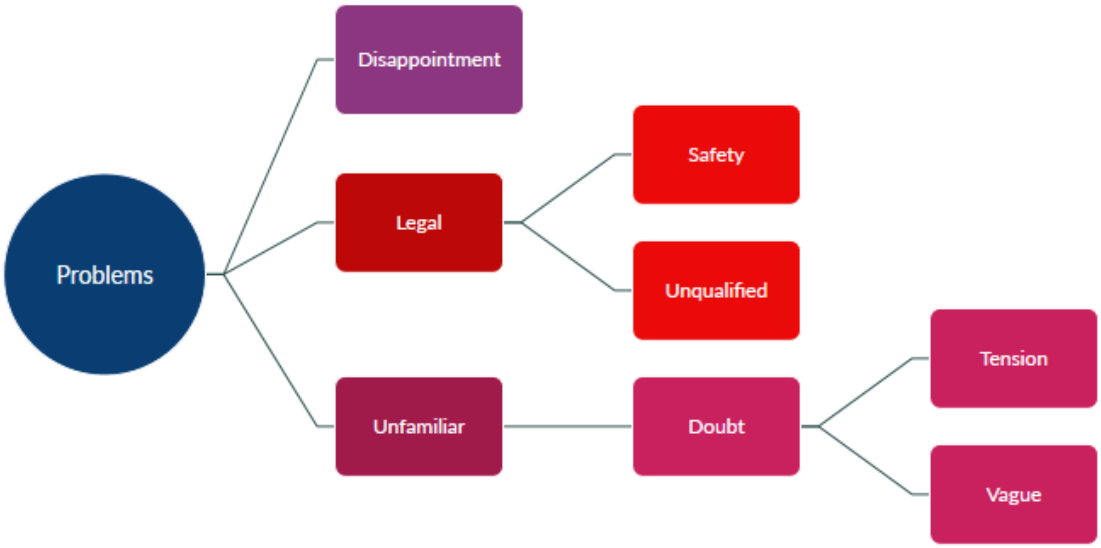


Figure 3

Solutions Highlighted by the Focus Group

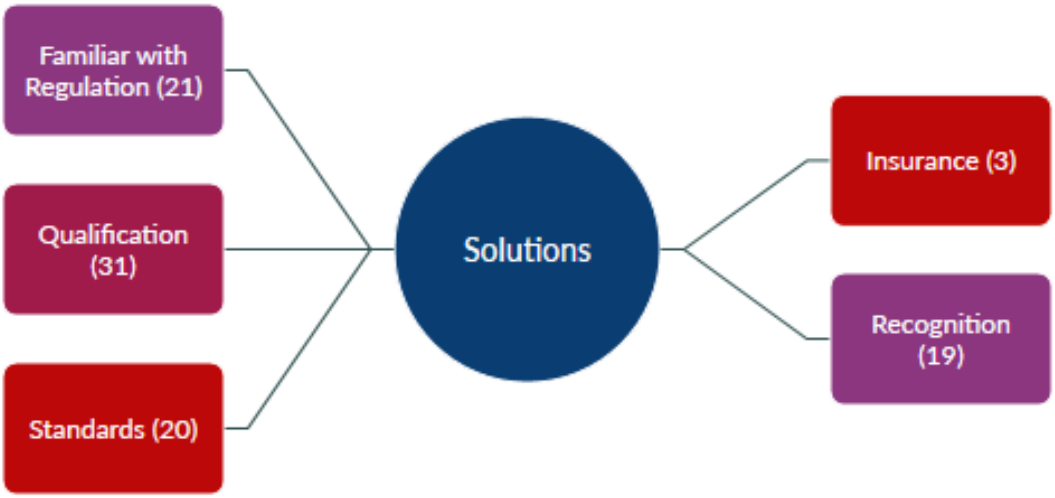
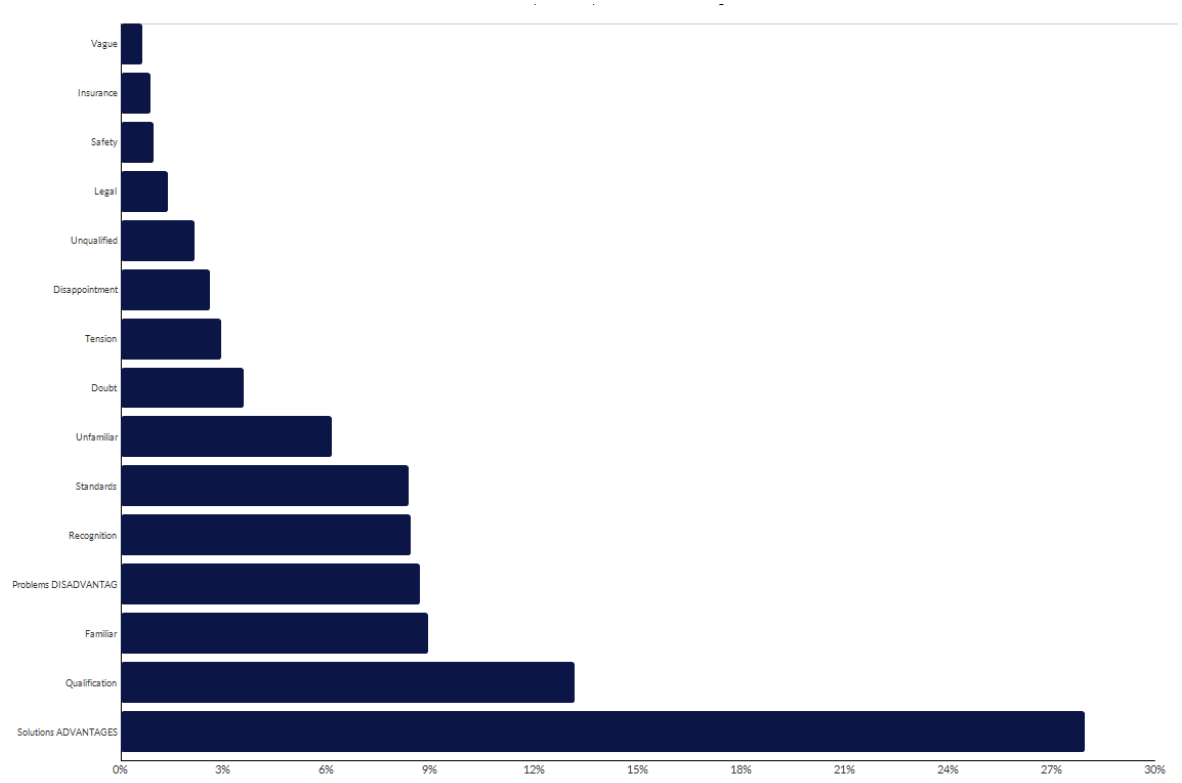


Figure 4

Distribution of Codes



5.2 Results

5.2.1 Familiarity with Regulation

When participants were asked how familiar they were with regulation processes for emerging allied health in Australia, they made six references to unfamiliar with dermal clinician regulations. One participant stated that although they were not entirely familiar with the process in Australia, they were aware of the impressive regulation of skin therapists in the Netherlands. Other participants noted that as dermal clinicians, they were working within the scope of the Bachelor of Dermal Science degree and in alignment with what the ASDC promotes (which they believed was appropriate and available to members). One participant was familiar with the process; they stated that recognition would not occur without AHPRA registration and that many allied health professions are not recognised. Another participant claimed that to be recognised, the matter of qualification had to be questioned; further, they

completed a Diploma of Nursing to obtain AHPRA registration, which has opened many professional doors for them. The participant stated that ‘to have a diploma, you know, after doing ten years of study consecutively, to then go back and do a diploma—and as soon as I’m a student nurse, I get recognised. So, it’s incredibly frustrating [and] heartbreaking’.

When asked about their understanding of the current regulations for dermal clinicians here in Australia, some participants indicated they were unaware of the regulatory processes. Most of the discussion suggested that despite achieving a qualification, there was a lack of recognising of the dermal clinician role. Responses regarding the regulations included ‘Do we have them?’, ‘no-one knows what a dermal clinician is’ and ‘we don’t even come under being anything’. Some participants added that academic student assessments and submissions were not what was expected for a university degree. For example, one participant asserted that ‘students in the dermal science degree get multiple attempts to submit an assignment’ and that ‘some are even being told that they can resubmit because the student missed a big chunk of the criteria’. Most participants confirmed that this constituted short-term learning and memorising and not much in terms of learning anything.

5.2.2 Protecting the Dermal Clinician Title and Role

Although all participants highlighted problems, they shared a common passion for the industry; they indicated their desire to become recognised and regulated. Further, discussions about solutions occurred mainly to protect the community from harm, as well as to protect their roles and their title. Participants stated that Australia might want to consider adopting the regulatory process applied to skin therapists in the Netherlands who remain regulated by the government. PhD graduates oversee the skin science degree in the Netherlands; additionally, medical practitioners who have completed postdoctoral studies are highly published. They scrutinise and ensure the degree constantly stays on par to maintain its regulation. In comparison, participants also said that the dermal science degree in Australia

has not yet considered postgraduate studies beyond the degree. Participants affirmed that being recognised or taken seriously requires a more intellectual conversation and a strong focus on skin disorders. One participant noted that ‘if you would listen to the Netherlands students talk at a postgraduate level, [then] the information shared is about hyperbaric oxygen chambers for eczema, psoriasis and healthcare management programs’.

5.2.3 Qualification

The participants also implied that the benefit of a dermal clinician being regulated is that standards requiring academic qualifications will be established. One participant stated that ‘the benefits for dermal clinicians to be regulated would be amazing—to be rewarded for your allied health role and to be recognised within the industry’. Some participants also stated that ‘although they are respected as allied health professionals working autonomously in medical practices alongside GP, nurses, plastic surgeons and dermatologists, some colleagues look down on what they are doing’. The participants also believed that other professions do not seriously regard dermal clinicians because the scope of the field as a dermal clinician is substantially broad. Some participants were also concerned that the dermal clinician would not become specialised in one specific profession area (e.g., as an acne specialist or a lymphoedema specialist as in the Netherlands). A pattern emerged in the discussion concerning the doubt and confusion of who can call themselves a dermal clinician. Some participants confirmed that this degree should have exclusivity for the title of the dermal clinician, and that restrictions should be placed on work that a dermal clinician with a science degree qualification must only perform. The discussion regarding the confusion is caused when short courses such as diplomas, which are not on par with the Bachelor of Dermal Science, roll out students with the same title as the VU dermal clinician who has completed a four-year degree.

Therefore, the discussions once again demonstrate confusion in the level of education present between Victoria University Allied Health dermal clinicians and other aesthetics courses. Another participant believed that the curriculum at these other institutions was ‘very poor, extremely poor compared to Victoria University.’ They said, ‘that these courses go through TEQSA and [that] the person in the institution is not even looking at the curriculum; they just get the objectives and tick the box’; further, ‘in over four subjects in the exams, there was a total of 100 errors in the exams; and in the anatomy and physiology … anatomy and physiology [sic] is an exact science’.

5.2.4 Specialisation and Training

Participants expressed their concerns regarding how they were viewed by patients who could access a dermal clinician’s services. One main issue raised was that the specialisation of a dermal clinician is vague; if a patient wanted to know the point of difference between a dermal clinician and a beauty therapist, other than the degree, the answer would be vague. The participants suggested that some regulations restrict non-qualified workers from performing specialised treatments that require an intensive science degree. This discussion raised several issues regarding the lack of specialisation observed for the dermal clinician. As one participant stated, ‘one dermal clinician might do tattooing, one might be doing laser and one might be going and working in a doctor clinic’. Specialisation and regulation were discussed widely as a solution. Participants believed ‘other allied health professionals will take dermal clinicians more seriously when they specialise rather than the current broad field of service’. Another participant emphasised that ‘the dermal clinician in Australia does not have a definition, and [it] is vague’. This participant also added that ‘the Netherlands are very, very specific; it is a skin disorder therapy that attracts a government rebate similar to our Medicare for acne, hirsutism, and lymphedema’. Skin therapists in the Netherlands are self-employed in hospitals and clinics. Participants stated that some dermal

clinicians in Australia work in laser clinics and beauty salons, which does not make sense after attaining a four-year science degree qualification. The answer derived was to standardise the scope of practice, which is clear and specific and why the participants confirmed that they would benefit from being regulated. They want people to know what they do.

One participant doubted that regulating dermal clinicians in Australia was beneficial because the profession is young and too small**.** Another participant disagreed and stated that 20 years ago, skin therapists in the Netherlands were regulated and had very small numbers. All participants agreed that the Bachelor of Dermal Science had a point of difference: that students were degree-qualified in allied health and science academics. Several patterns emerged in the discussion regarding the possibility of an overseeing body of academics (e.g., someone in higher education who knows what to check regarding the standards of an allied health degree). Participants mentioned that a postgraduate or someone with published work and a PhD should examine the curriculum. This idea ensures appropriate standards of skin health and healthcare pathways.

5.2.5 Regulation Benefits

The discussion underpinning accountability related to how this characteristic would appear for dermal clinicians to be regulated, especially regarding how a dermal clinician has been trained to operate using clinical judgement and decisions made using evidence-based systems. Because these clinicians operate lasers and have a high level of training, it attracts a very high level of accountability. For example, nurses perform injectables (Botox, fillers) outside their scope of practice when they only have a nursing diploma or degree and very little skin science training. Participants stated that regulators are strict with nurses and that it would be the same for dermal clinicians if they become regulated. One of the participants noted that ‘dermal clinicians would be the same, and so we’ve got to be prepared for when

we make a mistake in a clinic; then, we need to be prepared to accept the higher consequence of what we're doing as well'. Discussion focusing on insurance highlighted the high cost of fees associated with insurance. One participant asserted that 'insurance costs thousands of dollars every year just to be insured for public liability and professional indemnity insurance, which can be very expensive for a non-registered allied health professional or a non-registered provider'. Despite being an arm of dermatology or plastic surgery, dermal clinicians do not fall into any recognised health provision that currently states a policy of accountability. Therefore insurance, the duty of care and the documentation required to be considered a part of the consultation process are critical despite not having the regulation. Participants confirmed that ethically and legally, one would not make a clinical judgement on observation alone. One would need enough information from the patient to make a clinical judgement on the most appropriate treatment. One participant also highlighted that 'you don't just do a treatment and send the patient off and not follow up to see how they are healing. If they burned someone, then they should know how to perform first aid for the burn.'

The discussion revolving around the legal aspects of accountability was considered when the participants discussed the trends in the dermal industry and whether they should be self-regulated or AHPRA-regulated. The focus group discussion focused on diversity in the industry concerning whether practitioners wanted to follow an aesthetic path or the allied health, wound management and medical path. Some participants suggested that dermal clinicians with allied health and medical focus should become regulated to be recognised as specialists in specific treatments. Another participant reiterated that:

> *In the Netherlands, skin therapists specialise in either acne, hirsutism and oedema (lymphoedema) … They have the health care rebates of 100 euro per patient per treatment, and they are eligible for up to 1,000 euros a year, so your acne patient will get 100 euro rebate every time they come through the door for treatment … in the*

curriculum, hirsutism and lymphoedema are very strong areas. They spend six months specialising in these areas.'

Throughout most of the focus group discussion, participants agreed that the academic specialisation and standards in the Netherlands should be adopted in Australia. They positioned themselves very strongly in the Netherlands as skin disorder professionals. One participant noted that:

Even all the assignments are geared towards skin disorders, such as, of course, they remove pigmentation—and they still have their perception of pigmentation, but it is not that. It is just an ugly mark on my skin; it is a potential skin cancer.

The mindset of skin therapists is that they must treat that pigment immediately. One participant further noted that 'their perception of rosacea or vascular is a medical skin condition … and our perception is that it's cosmetic'.

Discussion pertaining to the need for dermal clinicians to understand, read and prepare care plans were on the agenda. Some participants questioned whether dermal clinicians could understand the immediate attention that was needed, or how further investigation can be requested from a GP (e.g., in providing a care plan for eczema from head to toe). Participants stated: 'Can we do oedema? Do we know how to run hyperbaric oxygen chambers? Can we work in a hospital?' The recommendation that these participants offered was that because dermal clinicians already have four years of an undergraduate science degree, regulation is appropriate. It would 'syphon out the beauticians and beauty therapists who go into these chain clinics—who get a two-week laser certificate—and it will eliminate the risks of burns'.

Concern was raised about dermal therapists calling themselves dermal clinicians who undergo other forms of training but not at the AQF level 7 of a dermal clinician. These

concerns included associated degrees or diploma programs that focus only on aesthetics. One participant stated that:

> *Torrens University has a Diploma in Dermal Therapy, and the Australasian College of Health and Wellness has an Associate Degree in Applied Aesthetics (Dermal Therapy) … they are technically a 12-month to three-year study in aesthetics, but dermal science is a four-year skin science degree.*

Some participants further stated that 'despite the qualification of these other institutions, they call themselves dermal therapists/clinicians and have also been accepted as members of the ASDC once they completed their studies'.

5.2.6 Regulation: Tension

Participants raised other concerns regarding regulation, emphasising that some of them would oppose a move towards regulation. The discussion focused on the point that regulation might create tension for those not degree qualified, such as 'I think it would create a little bit of tension in the industry'. Further:

> *All of a sudden, the regulation comes along, and my little, nice, happy clinic now has to change just because it has exploded into something that I have to regulate and change. I don't mind doing that; I am actually for regulation. But you think of so many dermal clinicians in that field that their whole businesses and things could just blow up overnight if their staff are not all qualified. So, that's where the tension can come in.*

5.2.7 Patient Safety

The procedures that allied health professionals must follow are well known and apply to emerging allied health professionals such as dermal clinicians. In ensuring patient safety, regulating this profession might provide a more apparent distinction between qualified and non-qualified dermal clinicians. The current regulation and certain policy frameworks from

other regulated allied health professions can help determine the level of regulation needed for dermal clinicians. The attitudes of dermal clinicians and their observations of regulation might need further investigation, especially concerning non-qualified technicians. Standards and qualifications should be applied nationally to all dermal clinicians as emerging allied health professionals.

Unqualified technicians, especially those using laser machines, have been discussed at length. One participant expressed concern for the unqualified laser technician, noting that regulation would cause chaos if laser becomes regulated; they further added that laser clinics would close overnight because most technicians are trained on the job and do not require formal skin science training. Another participant asserted that they:

> *Have spoken to people who work in a laser clinic … they're doing a full leg within 15 minutes. Now, a full leg laser cannot be done properly, nor can assessing the skin be done in 15 minutes. So, all those clinics would be completely panicked because now they can't operate their lasers.*

Most participants suggested that if technicians want to be registered, then they must upskill to obtain a license, such as technicians in Queensland, WA and Tasmania. The problem with unqualified technicians who operate laser machines is that they do not have the intensive theoretical or practical training in treating the skin like dermal clinicians do. If they have not been trained appropriately to conduct a clinical consultation, which takes approximately 60 minutes, then treatment options might be hindered. A dermal clinician is thoroughly trained in collecting the patient's medical history, conducting a comprehensive skin analysis, diagnosing conditions and performing a risk assessment before commencing the treatment. Analysing what these professionals observe on the skin could save a life and reduce the risk of masking a lesion that could potentially lead to skin cancer.

The discussion relating to professional standards occurred as a point for resolution. One participant said, ‘I think there need to be different levels of regulation, and this goes back to the scope of where you want to specialise as a clinician’. Safety was one of the discussions centred on additional points such as standards, safety and patient protection. The participants believed that regulations and standards could guarantee public safety. Protecting the public from harm and reducing their risk of being treated by unqualified individuals requires specific standards and regulations. Finally, the participants agreed that dermal clinicians would benefit their patients if regulated and received a Medicare provider number for three or four specialist services they provide in the allied health field (e.g., treating acne, lymphoedema, hirsutism, rosacea and eczema).

Chapter 6: Discussion

6.1 Thematic Analysis

Thematic analysis was performed because of its flexibility in several qualitative research approaches (Braun & Clarke, 2022). It involves understanding participants' responses as being tied to the context of regulating emerging allied health professions. The constructionist approach has provided an exploratory framework (Braun & Clarke, 2022) for the researcher to reflect and reinforce a reality about dermal clinicians in the focus group, their position in their profession and how they fit into the allied health field. The theoretical assumptions guiding this research were based on the study's questions and overall aims. Thematic analysis is one of the most popular qualitative and analytic techniques in psychology and the social and health sciences (Braun & Clarke, 2022; Castleberry & Nolen, 2018). Various approaches to conducting a thematic analysis can be taken. However, according to Braun and Clarke (2022), the most common form follows a six-step process that includes becoming familiar with the data, coding the data, generating and reviewing the themes, and defining and naming the themes with writing the analysis of the data. Thematic analysis is an appropriate method for this research, in which patterns can be explored throughout the qualitative data collected from the focus group. The thematic analysis also provides a purely qualitative, detailed and nuanced account of the collected data (Braun & Clarke, 2006).

Ayres and Braithwaite’s model of responsive regulation theory is appropriate because of the relationship between the regulator and regulatee. Enforcing rules and regulations might encourage a cooperative attitude towards complying, committing and an improved probability of recognising the dermal clinician’s role.

This study adopted the social constructivist approach to grounded theory using the qualitative research approach to understand the perspectives of the focus group participants.

The social constructivist approach was implemented to build knowledge and develop a theory. Additionally, the interaction between the participants and the researcher allowed the researcher to construct more knowledge about the participants' values, beliefs and perceptions regarding regulation. The researcher emphasised the focus group's responses and the notion that answering the research questions might establish procedures that should be followed to regulate dermal clinicians and other emerging allied health professionals in Australia.

The focus group also helped determine the policy framework that must be developed and applied to emerging allied health professionals to regulate their practices. The aim was to establish whether dermal clinicians knew which regulatory processes were appropriate and which standards and qualifications should be applied to emerging allied health professions such as dermal clinicians.

The qualitative approach that was adopted involved collecting and analysing responses from a focus group to understand the participants' perceptions, values, beliefs, opinions and experiences; it was also used to gather in-depth insights into the underlying issues of regulation and to generate new research ideas. These methods helped this study obtain deeper insights into the perspectives and experiences of the focus group participants. It also enlightened the research regarding the participants' perspectives on how regulation is appropriate and how it can improve the standards, scopes of practice, safety and recognition of the dermal clinician profession. The qualitative research approach focused on understanding the unique interactions of participants. Rather than predicting what the participants would say in the focus group, the study intended to obtain an in-depth understanding of their perspectives (Patton, 2002).

The researcher attempted to comprehend and interpret phenomena through an interpretive approach to the subject matter—one that encompassed the theories and

perspectives of the participants and helped construct a meaningful theory for regulatory authorities, governments, universities and dermal clinicians. This qualitative research approach involved collecting personal experiences. It used semi-structured interviews, observations and interactions to examine participants' perspectives in the focus group to outline the problems and solutions related to regulating the dermal clinician profession. The researcher also searched for divergence in how the focus group discussed dermal science. For example, some participants were more confident about being a dermal clinician from a cosmetic or aesthetic perspective; in contrast, the least optimistic dermal clinicians were focused on a more academic, scientific and medical perspective. This study prompted the researcher to recognise the various vocational stances between dermal clinicians with a medical focus and clinicians with a cosmetic or aesthetic focus. Further, it helped the researcher determine what obstacles hinder regulation and why the participants believed it is essential.

After collecting data from the focus group, which included the researcher interacting in the research setting, the goal was to generate a proposition that guided new understanding and interpretation of the participants' perspectives. Further, the research aimed to determine whether this new proposition aligned with the current literature and other similar professions.

This was the first study that investigated the opinions and thoughts of graduates with a Bachelor of Dermal Science and a Bachelor of Health Science (Clinical Dermal Therapies) from VU in Australia. According to this study's findings, the focus group's responses were divided into two professional statuses: those with a medical and allied health perspective and those with a cosmetic or aesthetic perspective. Further, the data collection, literature review and research into other similar professions (e.g., Dutch skin therapists) demonstrated that the Dutch Government also recognises that the Bachelor of Skin Therapy in the Netherlands is a specialised profession. The training for skin therapists is legally recognised and included in

the *Individual Healthcare Professions Act* (Wet BIG, article 34), as is their quality registration in the Quality Register Paramedics (CIBG, Ministry of Health, Welfare and Sport, 2022). This study investigated whether specific Dutch procedures could be adopted to promote regulation for this industry in Australia. Specifically, the research investigated the policy frameworks of skin therapists in the Netherlands to determine how these processes can be applied to regulate the practices of dermal clinicians in Australia. As previously discussed, certain Dutch organisational bodies have developed a policy framework. The Dutch Society of Skin Therapists approached the government to regulate the profession of skin therapists, and the university developed a bachelor's degree to align with this regulation. This framework could be implemented in Australia because it works well in the Netherlands. However, the Dutch model is not a criticism of what is currently performed in Australia—the Australian dermal science degree deserves recognition from the government for shaping the profession and for aligning the action standards with Dutch processes.

This study learned that graduate skin therapists in the Netherlands specialise in acne, hirsutism, wound care and lymphoedema. Skin therapists do not just learn a little about all matters of the skin; they become specialised in specific areas of skin health. Skin therapists are employed in hospitals and medical practices and work autonomously, as can dermal clinicians. They are also employed as part of interprofessional allied health settings. In contrast, dermal clinician in Australia does not specialise in one specific field. Dermal clinicians have knowledge that covers several skin health issues, but they do not specialise in one practice, such as chronic skin conditions, acne or wound management. The Dutch Government recognises the skin therapy degree, which demonstrates the profession's specialisation, similar to the mental health profession, which has different types of therapies for graduate specialisation.

It was worth noting how the participants in this study's focus group responded to some of the questions and how they conceptualised them concerning regulation. Some participants indicated little knowledge about the regulation processes for allied health. The main concerns raised were that the dermal clinicians in Australia are not specialised and that the industry is not gaining the recognition it deserves in light of the four-year university degree that must be completed. Participants argued that the clinical studies required them to be refined in determining skin conditions, the appropriate electrotherapy or modality and the precise parameters for avoiding transient adverse effects (e.g., downtime, scarring and pigmentation or burns).

The research further demonstrated how some participants were unfamiliar with current regulatory processes for dermal clinicians. In addition to recognition and specialty in the profession, participants raised the issue of not having a solid representation of dermal clinicians. Some resented being regarded as a 'glorified beauty therapist', despite their four years of study in a science degree. Another issue was that operators with no skin science background or degree perform treatments outside their scope of practice, in which they duplicate the work of degree-qualified dermal clinicians. An even further issue was the dermal clinicians' concern regarding fixing the mistakes of other technicians in the field. The skin therapist title in the Netherlands is protected by Dutch law. In Australia, the dermal clinician title is not protected. Because of the industry's lack of regulation, there is nothing to stop beauticians or beauty therapists from attributing themselves to the title of the dermal clinician, skin therapist or laser specialist. If regulations were established, the patients and clients who use the services would not be misled about the practitioner's qualification to treat skin conditions.

One focus group participant noted that although she had completed all formal clinical training in the dermal science degree—including intensive laser safety theory and

treatments—she is prohibited from performing laser treatments in Queensland by law. This is because she does not fall in the category of a qualified laser operator according to the Queensland jurisdiction's laser laws. The regulatory inconsistencies between the states further evidence why a national regulation should be implemented, and standard operating procedures for the dermal clinician role should be a national government interest. A straightforward reason relates to the safety of the patient who receives treatment. The focus group participants affirmed the importance of recognition and felt that standards and regulations should be applied to emerging allied health professions. The regulatory processes would be appropriate if dermal clinicians were recognised as a part of the allied health profession.

In the focus group discussion regarding the whole spectrum of regulations, some participants stated that self-regulation was just one part of gaining recognition in the skin health industry. The concern related to facing some heavy-handed regulations, deregulations or re-regulations that would be introduced in the whole industry (i.e., likely the 'one size fits all' model). A transitional period has been observed for the pre-regulations of other professionals. However, the government might believe that because this involves a relatively chaotic status, they should stop the confusion by not doing anything until they determine what is happening in the industry.

One significant discovery from the participants' discussion was that the Netherlands' skin therapist profession seemed far ahead of the Australian dermal clinician regarding regulatory design. One of the noted themes, 'vagueness,' in terms of appropriate regulations, displayed a stunning point in favour of the responsive regulation concept detailed in the literature review (see Section 2.12). There appeared to be different levels of dermal practitioners according to where they categorised themselves as allied health professionals in the medical services profession instead of professionals who focus on the aesthetic or

cosmetic profession. Braithwaite's fieldwork was also considered concerning nursing and other social services areas. To regulate dermal clinicians as a profession, a dual focus of allied health and autonomous practitioners must be applied regarding what ensures that the dermal profession is recognised as a profession. Data collected in this study suggests that dermal clinicians want their profession to be recognised as a standalone profession. Dermal clinicians desire to be recognised for their extensive knowledge and skills in skin health. The academic, scientific, theoretical, and practical points of difference must also be emphasised. Even though no specific honours programs or postgraduate studies exist for dermal clinicians, the focus group participants in this study had completed postgraduate studies in other disciplines (e.g., nutrition, nursing and dermoscopy). Postgraduate studies were necessary for the clinicians to obtain recognition, become members of allied health organisations and register with AHPRA. This signifies that the university might need to examine an appropriate postgraduate program. Presently, AHPRA might not be an option for graduate dermal clinicians. The first step is the self-regulation of dermal clinicians with the ASDC and the bachelor's degree dermal clinicians encouraging membership. Responsive regulation adopts the fundamental principle that regulators realise the culture, conduct and context of those who wish to be regulated; they also determine how much intervention is needed by persuading the regulator to comply as a starting point and then determining sanctions as a last resort. Responsive regulation has inspired regulators, social movement advocates and scholars to visualise new regulation methods for public interest and safety. The boundaries between state, business and civil society are changing, so a dominant reliance on government regulation is no longer considered legitimate (Parker, 2013). The research process provides leverage for the regulators to observe and recommend policies that involve lawmakers offering industry-appropriate guidelines and more flexibility in regulation and standards. The Australian Taxation Office is one of the first agencies that immediately adopted the

guidelines outlined by Ayres and Braithwaite's (1992) research. The regulatory response model was applied for regulatory compliance, and it would work the same as for the qualified dermal clinician.

A hybrid approach was used when asking participants about their perspectives on regulation. An active process to construct themes prompted the discovery of similarities, relationships, problems and solutions within the data. A theory-driven lens analysed some theories, which helped gather data from the focus group. An analytical form was also sourced using thematic analysis. It was the most accessible form because this study did not have a substantive analysis. It comprises a general approach—the most cited approach (see Braun, 2022). Other types of analysis have also been applied to comprehend the qualitative data. Discourse analysis has been applied to identify the anxiety underlying how people talk, which indicates the experience of frustration. Some off-the-cuff messages were also made, in which participants unpacked both positive and negative views of the dermal clinician role, including its recognition as an allied health professional. Implementing different techniques was a practical step in illustrating dermal clinicians' perceptions, given that they fit into the allied health profession and in terms of establishing whether regulation is a possibility in the current climate.

This study generated the following recommendations:

- Embrace a curriculum that aligns with the skin therapist degree at Hague University in the Netherlands.
- Adopt the Netherlands' process for regulation.
- Request a panel of experts to review the VU Bachelor of Dermal Science curriculum and focus the degree on the role of the dermal clinician from an allied health perspective.
- Regulate who can use the title of dermal clinician.

- Regulate and create scopes of practice specifically for dermal clinicians.
- Regulate the standard requirements for using laser machines nationally, aligning with Queensland, WA and Tasmania.
- Encourage dermal clinicians to become specialised in a specific area of skin health (e.g., acne, wound management, skin conditions, and disease).
- Consider establishing a national board for allied health with AHPRA.
- Provide professional development and higher education opportunities (Honours, Masters) to high achieving students and the Bachelor of Dermal Science staff.

6.2 Bias: Value of Impartiality

The researcher's vulnerability as a dermal clinician is acknowledged, so they are not considered more than a researcher, reviewer and evaluator of the focus group's personal experiences and opinions. The researcher might personally encounter positive and negative responses because of the power and political sensitivities of the responses they observed in the focus group. Constructing meaning and allowing the literature to influence the mode of thought was based on the focus group's opinions and insights. This study was used to examine the possibilities of regulating emerging allied health professions while simultaneously trying to remove any biases. This required the researcher to self-judge regarding the position they held in this study (i.e., a researcher and evaluator only).

6.3 Reliability and Validity

Words and themes from the semi-structured interview of the focus group were constructed to identify patterns and meanings in the data source. A hybrid approach was used to clarify the coding and implementation. Further, a social constructionist analysis included an interaction between the researcher and participants and consultation with assistant researchers, supervisors, and pieces of literature. The types of thematic analysis incorporated more pragmatic approaches that might also be improved to develop policy frameworks. The

researchers' views and values permitted several approaches to be used to determine if they best fit the collected data. The idiopathic approach was then used to focus on the individual participants and to emphasise the unique personal experience of human nature (e.g., what these participants said that illustrated relevant themes and patterns). The approach also focused on two participants to highlight a detailed understanding of their views and experiences. The participants' responses demonstrated consistency; as such, the study's results accurately represented what the study intended to measure.

Chapter 7: Conclusion

7.1 Summary of Results

Experts in the field have further reviewed this study's results, and the researcher has used their expertise to assess these results. Recently, some investigations have been conducted focusing on the accreditation of cosmetic clinics in Sydney. A significant investigation, as displayed on *60 Minutes*, *The Sydney Morning Herald* and *The Age*, has revealed horrific evidence regarding the toxicity of the cosmetic industry (Tozer, 2022). The skin health industry is demanding inquiries and much more significant oversight and regulation of the cosmetic industry. Against the whole spectrum of regulation, self-regulation is just one part. However, to the other extreme, some heavy-handed regulations, deregulations or re-regulations that are introduced act against the whole industry. In brief, there may be a transitional period in which the government might believe that because of this relatively chaotic status, they should not act just yet. In the current environment, any improvements are unlikely until the relevant professionals understand the social and medical problems evident in all cosmetic practices.

Therefore, it is assumed that some heavy-handed regulations should be introduced to the cosmetic sector. They might affect allied health and the relevant sectors, which would probably have less to do with beauty and more to do with clinical allied health services. Ultimately, this depends on what profession falls under the heading of cosmetics. These professions can be categorised into beauty, aesthetic, cosmetic or allied health dermal services—a reasonably large umbrella with many loopholes. Therefore, many operators exist in the skin care industry, ranging from those who have completed Certificate III in beauty therapy to those who have completed a skin science degree at a university. Some similarities exist in the type of treatments provided by beauticians, beauty therapists, and dermal clinicians, regardless of whether the operator follows existing scopes of practice or has an

appropriate qualification. The highlight in this context is the operators who perform paramedical-grade services within and outside their scope of practice or qualification. A specific definition is thus needed in terms of what is categorised under the term allied health—cosmetic, aesthetic or dermal clinician—because it is a large and complex industry. Students who had completed the Bachelor of Dermal Science at VU were divided in their focus between skin science and allied health and cosmetic and aesthetics. This was evident with the characteristics and professional status of the focus group, in which some participants concentrated on healthcare, allied health and the medical profession.

In contrast, others focused on aesthetics and cosmetics. Much can be done to streamline the degree, but whether it should be completed at a higher standard within a scope becomes an issue for dermal clinicians, who only want to consider themselves as healthcare providers in the allied health world. This will equally affect the less qualified provider, who would then be unable to perform treatments outside their scope of practice. Dermal clinicians have a duty of care, and a scope of practice binds them; however, there is not enough to hold someone less qualified accountable, except for the effects felt from the legal profession and insurance. Practitioners who are regulated with AHPRA lose their registration if a medical practitioner's misconduct is proven or they are not competent in their practice. This is a severe consequence, but there is no framework to outline the role of some emerging allied health professions (e.g., dermal clinicians). This might be because dermal clinicians represent a small profession with little recognition. Some participants in the focus group stated that dermal clinicians with the degree qualification might need distinctive representation. Other participants confirmed that, as clinicians, they were frustrated because they struggled to become recognised. Others further explained that they were moving on and changing their pathways to different areas of specialisation (e.g., nutrition, nursing, and research) and that they were finding their paths outside the role of the traditional dermal clinician (or even the

qualified cosmetic practitioner). This research considers that dermal clinicians have unique strengths and different requirements for their professional pathways.

7.2 Thesis Limitations

Some issues noted during the focus group discussion and other discussions with field experts, legal advisors and educators echoed the investigatory process. No clear pathway exists for a dermal clinician, so some focus group respondents indicated a lack of specialty. A significant factor was the distinction between ‘what constitutes a dermal clinician with an allied health (medical science) focus’ and ‘what is a dermal clinician with an aesthetic/cosmetic focus’. The significant factor in this context is that the dermal science degree at VU is focused on science and allied health. The fact that some clinicians graduate with an aesthetic mindset from the Bachelor of Dermal Science rather than a health focus might require further investigation. This is significant when considering the degree’s heavy science and medical content.

This research was reduced from being a mixed-method study to a qualitative one and reduced from having four focus groups to one that specifically included dermal clinicians. Care was taken to avoid data alteration during collection and any bias by the researcher in interpreting focus group responses. The qualitative approach was used to understand better the complex reality and reasons underpinning the focus group’s perspectives on professionalising and regulating the dermal clinician. The study requires additional investigation to validate the data further.

7.3 Concluding Remarks

The study aimed to discover new information and to understand how more rigorous standards and policies for emerging allied health professions like dermal clinicians affect the industry and how regulations and standards can be introduced. Developing a policy framework could help achieve this. This study incorporates a practical approach to solving a

problem by investigating what other researchers have explored and their collected data informing their conclusions. A comparative analysis of the skin therapist from the Netherlands—who possesses a similar qualification as the dermal clinician, and has gained government-regulated recognition—revealed similarities in the science content of the degrees taught in Australia and the Netherlands. The differences included how the Dutch skin therapist is government regulated. By law, all referrals for conditions such as acne, hirsutism and lymphedema must be sent to a skin therapist. In Australia, the dermal clinician is neither recognised nor regulated. Further, certain limitations are associated with regulating the dermal clinician industry, which might prevent electrotherapy equipment such as lasers or minimally invasive procedures from being performed by individuals who do not have an appropriate degree or qualification in skin science. This research also considered why dermal clinicians should be regulated, given that it was designed to identify the best practice for attaining regulation in this area.

The researcher maintained ethical conduct throughout the research process and protected the participants' autonomy, beneficence, confidentiality and privacy. Because this was a low-risk study, no risks affected the human participants regarding the safety or other risks associated with the research. Some focus group participants consented to receive credit and being named in the thesis as participant contributors to the research.

The matter of consumer deception is relevant in this context. Much psychological research has suggested that factfinders cannot distinguish truths from lies at levels significantly greater than chance (Bradford & Goodman-Delahunty, 2008). No documented literature relates to the deceptive aspects of the skin science and skin health industry. However, consumers might agree to receive treatment from practitioners, believing that they are accredited professionals in a regulated profession that recruits only skilled practitioners, whose professional framework comprises formalised complaint procedures with appropriate

remedies (Australian Competition & Consumer Commission, 2022). In this context, the key is to have the qualifications for performing specific treatments, such as using lasers for skin health. It would be appropriate for restrictions to reduce the confusion regarding the qualification practitioners need to perform some of the treatments that a dermal clinician can perform because they are degree qualified. In cases where practitioners have been negligent or worse, the ACCC has identified some broad issues of concern across all professions that might lead to breaches of the law. They have indicated reservations regarding the work or monopoly of one profession, especially when a practitioner from another profession possesses the credentials to perform the same work. Reservations were also expressed regarding individuals who have used unnecessary and intrusive procedures or have even assaulted patients. Patients may feel misled or deceived (Australian Competition & Consumer Commission, 2022). This study aims to fill the research gaps concerning regulating emerging allied healthcare professions. The research could also inform advanced knowledge of emerging allied health professions' regulation standards and processes. Regulatory bodies have sufficient grounds to create evidence-based models to regulate emerging allied health professions—but they require more targeted knowledge concerning the relevant issues.

Finally, it is known that specific procedures in allied health professionals must be followed, which could apply to dermal clinicians as emerging allied health professionals. To ensure patient safety, regulating this profession could more strongly distinguish between qualified dermal clinicians and other unqualified practitioners. Current regulations and some of the policy frameworks from other regulated allied health professionals can help determine the level of regulation required for the dermal clinician profession. The attitudes of dermal clinicians and observations of regulation might require further investigation to avoid discouraging anyone, especially non-qualified technicians. Finally, standards and

qualifications should be nationally applied to the dermal clinician profession to encourage more explicit guidelines and scopes of work for this emerging allied health profession.

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Appendices

Appendix A—AHPRA-National Boards

National Board	Description
Aboriginal and Torres Strait Islander Health Practice	AHPRA approves the programs of study for the Aboriginal and Torres Strait Islander Health Practitioners' workforce.
Chinese Medicine	The Chinese Medicine Board of Australia (the National Board) has established the Chinese Medicine Accreditation Committee (the Accreditation Committee) to exercise several accreditation functions under the Health Practitioner Regulation National Law as in force in each state and territory (the National Law).
Chiropractors	Like other healthcare professionals, chiropractors in Australia receive their title of 'Doctor' through national registration with their professional body. Chiropractors are not medical practitioners because they do not hold any medical degrees. However, they must undergo extensive chiropractic training to become licenced chiropractors. Chiropractors generally start their education by earning a bachelor's degree that is focused on the sciences.
Dental	The Dental Board of Australia is established under the Health Practitioner Regulation National Law, which is in force in each state and territory (the National Law). The Board regulates dental practitioners in Australia under the National Registration and Accreditation Scheme (the National Scheme).
Medical	The Medical Board of Australia refers the most serious concerns about medical practitioners to tribunals in each state and territory.
Nursing and Midwifery	The Nursing and Midwifery Board of Australia (NMBA) regulates nursing registrations. AHPRA maintains a publicly accessible and searchable national register of nurses and midwives who are registered with the NMBA. The register also identifies any conditions or restrictions related to professional practice.
Medical Radiation Practitioners	Some registered practitioners might need to undertake supervised practice by the Medical Radiation Practice Board of Australia (the Board). Supervised practice enables practitioners to provide medical radiation services under the supervision of a medical radiation practitioner who holds general registration. Medical radiation practitioners are registered healthcare practitioners who perform diagnostic imaging studies on patients, plan and administer radiation treatments or prepare and administer nuclear medicine.
Occupational Therapy	Anyone who works under an occupational therapist must be registered with AHPRA. According to the registration data from the Occupational Therapy Board of Australia, a significant increase has been observed in the number of occupational therapists in Australia in recent years.

Optometry	The Optometry Board of Australia has recently reminded optometrists that no provision in the Health Practitioner Regulation National Law prohibits a practitioner from using titles such as ‘Doctor’, though it has given a warning regarding the potential to mislead or deceive if the title isn’t applied clearly.
Osteopathy	The Osteopathy Board of Australia nationally regulates osteopathy for the Australian Health Practitioner Regulation Agency (AHPRA). Osteopaths are required, by law, to maintain ongoing professional development and education every year to stay in practice.
Pharmacy	The functions of the Pharmacy Board of Australia include registering pharmacists and students; developing standards, codes and guidelines for the profession; handling notifications, complaints, investigations and disciplinary hearings; and assessing overseas trained practitioners who wish to practise in Australia.
Paramedicine	The Paramedicine Board of Australia (the Board) is established under the Health Practitioner Regulation National Law (the National Law). The Board regulates paramedics in Australia under the National Registration and Accreditation Scheme (the National Scheme).
Physiotherapy	Registration with the Physiotherapy Board of Australia is required for all physiotherapy practitioners. Falsely claiming to be a registered physiotherapist, or claiming to be registered, is an offence under National Law.
Podiatry	The Podiatry Board of Australia’s functions include developing standards, codes and guidelines for the profession; notifications, complaints, investigations, disciplinary hearings and assessments of trained practitioners overseas who wish to practice in Australia.
Psychology	Psychology is a regulated profession like medicine, psychiatry and law. To call yourself a psychologist and to practice as one requires registeration with the Psychology Board of Australia (PsyBA), which is part of the AHPRA.

Source: AHPRA

Appendix B—Information to Participants

Will you participate in my research study?

I am a student researcher at Victoria University, and I completing a Master of Research with the Institute for Sustainable Industries & Liveable Cities.

Dermal clinicians in Australia who have completed a Bachelor of Dermal Science or the equivalent Bachelor of Health Science (Dermal Clinical Therapies) are invited to participate in a research project titled **Regulation of Emerging Allied Health Professions in Australia**

You will be required for a 60-minute focus group discussion via Zoom, which will be held on Wednesday, 27 July 2022, from 7.30 pm to 8.30 pm. The inclusion criteria is that you are a graduate of the above university degrees, and the exclusion criteria are that you have not been an ASDC office bearer in the last two years.

If you are interested in participating, please send me a message inbox or an email to rosanna.baini@live.vu.edu.au with your contact details. I will send you the confirmed date, consent form and participant information form.

I look forward to hearing from you soon.

Appendix C—Consent Form

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS: We would like to invite you to be a part of a study into

"Regulation of Emerging Allied Health Professions in Australia"

CERTIFICATION BY PARTICIPANT

I, _____

of _____ Suburb_____ Postcode _____
certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:
"Regulation of Emerging Allied Health Professions in Australia"

This research project is being conducted by Rosanna Baini, a Master of Research student at Victoria University – Institute for Sustainable Industries & Liveable Cities (ISILC)
The principal supervisor (Chief Investigator) is Professor Anona Armstrong AM, and Associate Supervisor is Dr Yongqiang Li, Victoria University.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:
Rosanna Baini (Master of Research Student)
and that I freely consent to participation in the focus group involving the below-mentioned procedures:

1. Participate in a 60-minute focus group discussion where a series of questions will be asked.
2. Participate in an audio recording of the focus group discussion
3. The focus group will be conducted online via zoom
4. This is a low-risk research project which includes the following:

a) The researcher will explore the processes for effective regulation of emerging allied health professions in Australia, particularly Dermal Clinicians.
b) This research aims to develop a policy framework that may be suitable for adoption by allied health professionals such as dermal clinicians in Australia that are not recognised by regulatory bodies or are not self-regulated and may wish to establish registration and accreditation standards for their qualifications and work.
c) The study will allow for a better understanding of the potential for dermal clinicians and other allied health professions to become regulated and the process necessary for this to happen where regulation is a preferred option

I certify that I have had the opportunity to have any questions answered and understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

Consent to participate - I have been informed that the information I provide will be confidential.

Signed: _____ Date: _____

In recognition for my participation in the focus group for this study

Consent for naming credit - I _____ give consent to display my name in the credits at the end of the thesis.

Signed: _____ Date: _____

Any queries about your participation in this project may be directed to the Chief Investigator

The Chief Investigator is Professor Anona Armstrong AM, anona.armstrong@vu.edu.au 0429 056 524

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.