REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

COSMETIC HEALTH SERVICE COMPLAINTS IN NEW SOUTH WALES

At Preston-Stanley Room, Parliament House, Sydney, on Thursday 2 August 2018

The Committee met at 9:30 am

PRESENT

Mr Adam Crouch (Chair)

The Hon. Lou Amato
Mr Austin Evans
The Hon. Mark Pearson
The Hon. Walt Secord
Mr Mark Taylor
Ms Kate Washington

MICHAEL MOLTON, President, Cosmetic Physicians College of Australasia Ltd, affirmed and examined

DOUGLAS GROSE, Immediate Past President, Cosmetic Physicians College of Australasia Ltd, sworn and examined

The CHAIR: Would any of you like to make an opening statement?

Dr MOLTON: Good morning, everyone. Thank you for the opportunity to be here this morning. I am Dr Michael Molton, President of the Cosmetic Physicians College of Australasia [CPCA]. I represent 200 cosmetic physicians who perform non-surgical cosmetic procedures. I need to make a very clear distinction between the differences of surgery and cosmetic medicine. We do not do surgery. In 2017 we saw a tragic death in the State. This year there have been media reports of two cases of permanent blindness following cosmetic medical procedures. The CPCA prioritises patient safety in cosmetic medicine and we believe that, in turn, the focus on patient safety will produce a secondary benefit of reducing the burden of complaints on the Health Care Complaints Commission [HCCC]. Today we will raise four key issues regarding patient safety in New South Wales. The first is practice of telemedicine or teleconference. Telemedicine or remote prescribing, as it is sometimes known, has no place in consulting patients for cosmetic medical procedures. In June 2016 the United Kingdom's General Medical Council banned all remote prescribing telemedicine and issued the following directive to doctors:

> You must carry out a physical examination of patients before prescribing injectable cosmetic medicines. You must not therefore prescribe these medicines by telephone, video link, online or at the request of others for patients you have not examined.

This directive resulted from the absence of legislative control over cosmetic medical procedures in the United Kingdom. If that legislation had been in place, it would have protected patient safety. In Australia one issue of patient safety in cosmetic medicine requires that the patient be provided an in-person, face-to-face consultation, taking full medical history, an on-site physical examination and then determining what is the appropriate treatment plan. In Australia before prescribing heart tablets, for instance, or any other prescription medications, the doctor has to perform an in-person physical examination. Cosmetic medical procedures should be held to the same rigorous standards because the medications used in these procedures are at the same class as blood pressure tablets and other medications that doctors prescribe on a daily basis.

The second focus on patient safety is the issue of unregistered persons administering injectables. Last week, Victoria Health publicly announced, "The practice of delivering injectable cosmetic procedures such as dermal fillers in beauty clinics is on the increase." The document went on to say, "Risks exist generally but particularly wherever cosmetic medicine injections are administered by anyone other than a registered health practitioner and without the appropriate oversight of a suitably registered medical practitioner. Even registered health practitioners should have relevant experience in relation to the risks and side effects associated with these drugs." That was a public announcement by Victoria Health last week.

The third issue we have is the use of energy-based devices such as lasers et cetera. These devices can and have caused serious burns, disfigurement and scarring in untrained and inexperienced operators. They are ending up in the wrong hands, and this is happening at a staggering rate in New South Wales. On the way here I passed seven clinics between Double Bay and here. I doubt whether they have the expertise to use them—possibly they do. Despite years of stakeholder consultations, no regulations govern their use in New South Wales. Three other States, Western Australia, Queensland and Tasmania, now have suitable regulatory regimes and New South Wales could do the same.

The fourth issue that we have is national consistency and collaboration. A patient safety summit meeting of key stakeholders—the first ever instigated by our college—took place last evening and it was resolved unanimously that patient safety is more likely to reduce the number of complaints for the HCCC and provide the safest outcome for patients and that this can be best achieved by, one, prohibition of teleconferencing in cosmetic medicine, as has been seen to be necessary in the United Kingdom by the General Medical Council; two, that at the very least the prescribing doctor of medications in cosmetic procedures be onsite at the time that the procedure takes place or within 15 minutes' availability to attend to any complications that may occur as a result of the treatment; three, that the prescribing doctor and any health practitioner that may be delegated to perform a cosmetic medical procedure are themselves trained, competent and experienced in those procedures; four, collaboration between NSW Health and key stakeholders occurs to establish criteria that pertain to the licensing, ownership and use of energy-based devices; and finally, all of the above become national standards to be established. Thank you.

The CHAIR: Thank you very much, Dr Molton. Do you have anything to add to that at all, Dr Grose?

Dr GROSE: Not so much to add but just to emphasise, if I may. Firstly, I emphasise the very important point that the work that we do is medical work versus surgical work. Typically, our work is carried out in medical practice rooms and in doctors' surgeries in similar type facilities. The second point that I make is the concept of a medical model. The medical model is a model of care that has existed for centuries; it involves doctors and nurses working together collaboratively for the benefit and the safety of patients. Unfortunately, what has happened in cosmetic medicine because of the lack of regulation of cosmetic treatments is that it has become totally unregulated and we now have a model which is more based on commerce rather than care. I understand the Committee yesterday was made aware that the great amount of remuneration that goes on for some practitioners in large clinics is based on commission.

One of the most important characteristics that we seek in doctors working in this area is their ability to understand when a treatment is not advised and they should advise the patient not to be treated. Anybody who receives remuneration based on commission is under immediate financial pressure to perform treatments which may or may not be of benefit to the patient. So I think it is very important to understand that cosmetic medicine is medicine, it is not surgery, and that it must be based on the medical model not on the commerce model, which is currently what is happening.

Dr MOLTON: If I can add one last thing to what Dr Grose just said, we perform 80 per cent of all cosmetic procedures in Australia. We have ongoing relationships with our patients—they do not come to see us once and get a breast augmentation, they come to see us on a number of occasions, and many of my patients of a 9,000 patient base have been coming to me for 10 to 12 years. We were talking earlier and Dr Grose has some patients who have been seeing him for 20 years.

The second thing that I would say in addition to what my colleague has said is that there is a big difference between someone who is a client and someone who is a patient. A client—that is, you are going to sell that person everything you possibly can whether they need it or not, regardless of any other circumstances. A patient, under the medical model, as Dr Grose outlines, describes a person to whom the medical practitioner owes a duty of care. That is the fundamental difference between the commercial model and the medical model.

The CHAIR: Thank you very much, gentlemen. I will open with the first question. Obviously, part of this inquiry is to focus on the HCCC and what more can be done with regards to cosmetic health services. From your experience and your practices, what more could the HCCC do to raise the level of awareness for members of the public about seeking health services? Do you see that as the role of the HCCC or do you see the role of the HCCC as dealing with complaints, or should they be involved in informing the public as to what cosmetic services are available, the differences between them and the potential risks?

Dr MOLTON: The position for the Cosmetic Physicians College of Australasia is one of safety. To achieve the maximum benefit of safety we believe that it is a partnership of legislation changes that allow us to control or at least to manage the situations that we have much better. We have to consider how those legislative measures can be policed, but we agree with the HCCC that one of the most important things is public awareness. But there is a caveat that goes with this and the caveat is that we are limited in terms of what information we can provide to the public because of the Therapeutic Goods Administration Act that prevents us from mentioning product names. We are very, very much controlled by what we can say about these procedures and products that we use. Let there be no mistake that whilst there may be dermal fillers and anti-wrinkle injections and lasers, there is a whole gamut, a whole range of differences of efficacies and qualities of all of those products and the public are prevented from knowing those differences because of the Therapeutic Goods Administration legislation.

The Hon. MARK PEARSON: You are obviously very clear that there should not be a video or teleconference interview or assessment of a client or a patient who is seeking cosmetic surgery. So if it is face to face—and I agree with that—is there also a psychological examination of the person as well, considering that this is not urgent or emergency or selective surgery which is part of a medical condition? Even though the physician may not be trained in psychological assessment is that something that they turn their mind to when a person is seeking such a procedure which is non-surgical?

Dr MOLTON: Thank you for the question. Patient safety does not just involve performing a procedure; patient safety involves the appropriate evaluation and assessment and candidacy of a particular patient. You raise a very important point, because a number of patients that I see—that we see—are vulnerable. They are not informed. Many of them are young; they bow to peer pressure. None of those things can be fleshed out by a teleconference consultation. As a medical practitioner, what you are trained in is to identify a number of features about the patient, silently, from the moment that the patient walks through the door of your medical practice. One looks at the way the patient is dressed, the demeanour and the affect—in other words, how they appear to be in terms of their mood and so forth. There is a process that goes on in the medical examination that involves

integration into that consultation process before you even shake hands with the patient. You cannot do that in a teleconference. You cannot get that feel about someone's psychological presentation via Skype.

Dr GROSE: May I add to that? Michael's point is very important and your question is a very important one. If we want to use the medical term it is "dysmorphism", which is people's false belief in their appearance. In my personal practice, the maximum number of patients that I would see in any typical full day would be between 10 and 15. Why? Because it takes at least half an hour to do a proper consultation, and that includes patients that I may have known for quite a long time. I smiled when Michael said that we are assessing the patient right from the word go.

I spend at least five minutes talking to my patients, no matter how well I know them. They all know me by now. I say, "You know that I am examining you, don't you?" They say, "Yes, I know that you are looking at my face and thinking about what my problems are." So, trying to pick the patient who has a body dysmorphic disorder problem is very important. That comes back to my opening remarks, where I emphasised the importance of learning when to say, "No, this is not an appropriate treatment." In some severe cases—in my practice I have seen two severe cases—of dysmorphic disorder, I have referred them to psychiatrists for further management of their dysmorphic disorder.

Dr MOLTON: I would like to add to that. Yesterday, one of our panel members asked about this. It was almost, "How do you approach this?" I was a co-author of a paper which has more than 60 citations in other psychiatric papers on body dysmorphic disorder. When you say to a patient, "I am not sure. Your blemish seems so trivial to me. Does it seem so trivial to you? Has it affected your life such that you cannot leave the house, that you cannot mix with other people, that you cannot be a member of the community?", they may say, "Yes, you are right." You would think that if you said to a patient, "I think you need psychological care" that they would go, "What? How dare you!" but they do not; they recognise it, and they are not to be treated.

Mr AUSTIN EVANS: I have some clarifying questions, Dr Molton. The submission you put into us was in your name. Is it on behalf of the Cosmetic Physicians College of Australasia?

Dr MOLTON: Yes, there was a separate submission before I was president of the Cosmetic Physicians College of Australasia. The submissions closed, I believe, on 22 May. I was elected on 16 June. So that is a private submission.

Mr AUSTIN EVANS: Is it broadly consistent with the members' of the college, though?

Dr MOLTON: I think that in principle the concept of accreditation of medical practices is a good one. It is something that we need to work towards. My practice is accredited with the Australian Council of Healthcare Standards, and I would recommend it to anyone in medical practice.

Mr AUSTIN EVANS: You also said, "We do 80 per cent of the procedures." Who is "we"? Are you saying that you do 80 per cent of cosmetic procedures? What are those procedures?

Dr MOLTON: The vast majority of procedures are cosmetic medical procedures, not surgical procedures. There has been a declining proportion of cosmetic surgery procedures and a subsequent increase in cosmetic medical procedures.

Mr AUSTIN EVANS: What sorts of things are done in that category?

Dr MOLTON: We use the term "to look better, not different". So we are using an integrated approach to facial rejuvenation, for instance, using a number of various applications—light-based and energy-based devices, dermal fillers and anti-wrinkle injections. No one size fits all.

Mr AUSTIN EVANS: When you say "medical procedures", you are talking about injections, lasers and—

Dr MOLTON: Correct—non-invasive, non-surgical procedures.

Dr GROSE: Outpatient procedures which can be done in rooms, basically.

Mr AUSTIN EVANS: When you say "we" you mean members of—

Dr GROSE: Not our college members. What we are saying is that 80 per cent of cosmetic procedures are cosmetic ones, not surgical ones.

Mr AUSTIN EVANS: Okay.

Dr GROSE: That was a misunderstanding, sorry.

The Hon. LOU AMATO: Dr Molton, in your opening statement, you mentioned that two patients have been permanently blinded. Can you elucidate on exactly what caused the blindness? Was it a procedure? Was it performed by a registered practitioner or a registered nurse? How was the complaint dealt with? Who dealt with the complaint?

Dr MOLTON: We do not know exactly the circumstances because of litigation. These have been reported by other members of the profession. The cause of permanent blindness is a matter of extreme importance, and is studied within the cosmetic field at the moment. Every procedure that has prescription-only medication is in our hands because of those risks. The important thing is to be able to manage those risks. Patient safety is the essential component, here, and the best way for the patient's safety to mitigate those risks and to be able to manage those risks is for these procedures—

The Hon. LOU AMATO: What did they use? What was the actual procedure?

Dr GROSE: The product was fillers.

The Hon. LOU AMATO: Yes, that is what I am asking.

Dr GROSE: The products were fillers. The anxiety is that depending on what part of the face you are treating there is a possibility of intra-arterial injection of the substance, which can then move up into the retinal artery and affect the circulation to the eye.

The Hon. LOU AMATO: Was it performed by a registered practitioner or a registered nurse?

Dr GROSE: We understand that it was a registered nurse.

Dr MOLTON: I do not think that matters. The ultimate responsibility comes back to the prescribing medical practitioner.

The Hon. LOU AMATO: No, it still matters. We have to know who performed it—whether it was a registered person or not or whether it was just—

Dr MOLTON: They would be delegated procedures from a prescribing medical practitioner.

The Hon. LOU AMATO: That complaint would have come in. It did not go to your organisation; it went to someone else, did it?

Dr GROSE: It did not involve a member of ours, so the complaint—

The Hon. LOU AMATO: Yes, okay.

Mr MARK TAYLOR: Dr Molton, your organisation has different levels of membership, does it?

Dr MOLTON: Yes.

Mr MARK TAYLOR: How do you progress through those levels—like from full member to fellow and things like that?

Dr MOLTON: The basic medical degree already incorporates certain skill sets and an understanding of anatomy and physiology, but that does not give them an automatic inroad into putting a syringe or a laser into their hands. The levels are designed to help people gather that information along the way and be examined to make those progressions to fellowship. We have affiliate membership, membership and then fellowship. At each of those stages the individuals are examined before progressing on to the next stage?

Mr MARK TAYLOR: You have courses in such things as injectables and laser?

Dr MOLTON: Correct.

Mr MARK TAYLOR: Do you provide any courses in having an initial consultation and forming a relationship?

Dr MOLTON: Yes. As I mentioned before, with your basic medicine degree you are taught to identify those features, as Dr Grose was saying, to establish a rapport. Whether you know the patient or not, you are evaluating the patient at all times. Yes, the consultation process begins, as I mentioned, from the moment you see the patient. We then look at the appropriateness of whatever the patient is requesting to be changed. Sometimes the patient will say to me, "What do you think I should do?" My response is, "I am not you. It is not my face, it is not my body. I need to hear from you what you would like to change and I will tell you in the most honest way what is the best way forward, whether or not that can be achieved, to what degree that might be achieved and what side effects and complications and aftercare will be involved in that."

Dr GROSE: Can I add to that, sir? I have been involved with training in cosmetic medicine for a very long time. If you come to me to be trained in how to use a filling substance, one of the first things I would want to do is explain to you the indications for that particular product and the things that you need to look for in a patient in how to use that product. That is all part of the deal. It is not just a matter of, "Here is a syringe, go and inject." We have to show them the indication, the way it should be used, where it should be used and where it should not be used, which is the most important.

Dr MOLTON: This is quite contrary to what we are seeing at the present time of people offering two-day courses. These are run and often supported by the manufacturers of the products. There is a great deal of competition that is at a fever level between the various manufacturers and distributors of products, and this is driving the two-day courses and producing a false belief in the people who have done those two-day courses to go out tomorrow and start practising.

Mr MARK TAYLOR: As Dr Grose says, your one-day or two-day courses contain the initial component of ethics, consultation, diagnosis or explanation?

Dr MOLTON: We do not have one-day or two-day courses that result in the fact that we can then say, "You are off". That is totally wrong. You cannot learn anything in two days.

The Hon. WALT SECORD: Gentlemen, thank you for coming. I am trying to grapple with your college. Do your members get reimbursed through Medicare?

Dr MOLTON: No.

The Hon. WALT SECORD: They are doing procedures that are outside the Medicare system?

Dr MOLTON: No, they are not outside the medical system.

The Hon. WALT SECORD: No, I said, "Medicare."

Dr MOLTON: Medicare system, yes.

The Hon. WALT SECORD: Are you zapping unwanted hair and things like that?

Dr MOLTON: Do we do that?

The Hon. WALT SECORD: I am trying to get a sense of what you do. If you do not do invasive procedures, what do you do? Is it hair removal and things like that?

Dr MOLTON: That is one of the components that we do.

The Hon. WALT SECORD: Tattoo removal?

Dr MOLTON: Yes.

Dr GROSE: Can I jump in and answer that as well, if I may, because it is a little bit technical. Most of the people that we deal with are people who are trying to manage the changes associated with ageing. Ageing mostly involves loss of volume in the face in respect of appearance. There are two ways you can deal with that. You can pull the skin much tighter over a face that has shrunk or you can try to return the face to its natural youthful proportions. We are the group that can do the latter procedure because it is done with injectables; it is not done with surgery.

The Hon. WALT SECORD: Do you do non-surgical facelifts such as pulling the skin back?

Dr MOLTON: No.

Dr GROSE: No, we do not. We use fillers, botox, thermal devices and those sorts of things to achieve that.

The Hon. WALT SECORD: Can you guarantee that your members are not doing surgical procedures?

Dr MOLTON: We could not guarantee that.

Dr GROSE: We cannot guarantee that. Those doctors are individuals. Our college membership focus is on non-surgical procedures, but that does not mean that a member of our college might not have surgical skills or perform.

The Hon. WALT SECORD: Are you doctors in the sense of what the normal person on the street would see as a doctor? Are you a doctor, a GP, in the sense that if I had a cold and I went to see you guys, would you be able diagnose why I am coughing?

Dr MOLTON: Would we be able to diagnose what, sorry?

The Hon. WALT SECORD: You put the honorific "Dr" in front of your name. Are you in fact doctors in the traditional sense of what a doctor is?

Dr MOLTON: Most certainly.

Dr GROSE: Absolutely.

The Hon. WALT SECORD: I am seeking clarification.

Dr GROSE: I have been a doctor for 48 years. I actually trained next door to this building in Sydney Hospital.

The Hon. WALT SECORD: On your website, cpca.net.au, you issue a warning to your members:

> Several organisations have been contacted by Hazzard—

I assume you are referring to Minister Brad Hazzard—

> directly in relation to the proposal, including the Cosmetic Physicians College of Australasia. "The CPCA has responded to a request from Minister Hazzard to answer certain questions regarding anaesthetic and cosmetic medicine," says CPCA Vice President Dr David Kosenko.

Why did you feel compelled to put that on your front page of your website?

Dr MOLTON: I am not familiar with that document.

The Hon. WALT SECORD: I thought you were the President?

Dr MOLTON: I am the President, but I am not familiar with that.

The CHAIR: Can I suggest that if you do not know the answer and cannot answer today, you might want to take the question on notice.

The Hon. WALT SECORD: Does your colleague know?

Dr GROSE: No, I do not. I am not familiar with that particular post, I am sorry. Could you read it to me again? I must admit I was not able to get the gist of what you were saying.

Dr MOLTON: Yes, I am not understanding.

The Hon. WALT SECORD: There is a warning to your members that Minister Hazzard has contacted you directly, including the Cosmetic Physicians of Australasia, and you are warning your members that you have responded. I am curious why you felt compelled to put that on the front page of your website?

Dr MOLTON: Warning? "Warning" is an inappropriate word.

Dr GROSE: That is advice to our members that we have been contacted to appear before this Committee and to make submissions.

The Hon. WALT SECORD: It does not relate to that. It relates to tightening up rules and regulations in the cosmetic surgery industry.

Dr MOLTON: There is no warning.

Dr GROSE: I do not see it as a warning.

The Hon. WALT SECORD: I would say it is a warning if you are advising your members that the Minister has contacted you.

Dr MOLTON: Your words are that it is a warning?

The Hon. WALT SECORD: I think it is warning.

Dr MOLTON: It is not a warning. It is advice.

The CHAIR: The question has been answered. You confirm you do not believe it is a warning?

Dr MOLTON: It is not a warning.

The CHAIR: I suggest if you would like to formally respond to the Committee in writing on behalf of the college, you are more than welcome to do so.

Dr MOLTON: Thank you. I think we have done that.

Ms KATE WASHINGTON: Dr Molton, in your submission you have said:

The public is entitled to believe that they are protected by regulatory bodies such as AHPRA and the TGA.

Do you put the HCCC into your concerns around the failure of authorities to protect patient safety?

Dr MOLTON: You are referring to my personal submission which is No. 1 submission to the HCCC in May 2018, correct?

Ms KATE WASHINGTON: I am referring to your submission to this Committee.

Dr MOLTON: Yes.

Ms KATE WASHINGTON: Your personal submission to this Committee.

Dr MOLTON: Yes. My practice is in Adelaide in South Australia, so I make no reference to the New South Wales HCCC in relation to that. Those comments were generalised for across Australia.

Ms KATE WASHINGTON: In respect of the percentage of men versus women that you see in your practice or that your members see, what is the breakdown?

Dr MOLTON: It is increasing with men. In my practice it is something like 7 per cent to 8 per cent men, whereas five years ago it was 3 per cent to 5 per cent. The largest demographic would be women who are between the ages of 35 and 55. Many of them come to us in an effort to improve their appearance to re-enter the workforce, to stay within the workforce, or they have come from a relationship breakdown or divorce. Twenty-three years ago you could have described what we do as vanity. Today, it is in fact much more oriented towards the aging and the longevity that we find ourselves in and having to stay in the workforce longer, or maybe even returning to the workforce longer.

Ms KATE WASHINGTON: The evidence Dr Grose gave earlier was that generally the people that you are seeing are vulnerable, not informed and bowing to peer pressure. You are talking about women?

Dr GROSE: Not always, no. My practice is probably a little bit different to Dr Molton's. I tend to have a slightly higher male proportion. My particular passion in life happens to be acne and the management of acne. Sadly, males tend to be probably more severely affected than females. Females have the great advantage to be able to put makeup over it, which boys do not. Boys have massive issues with self esteem and all sorts of anger issues and so on, quite commonly associated with their appearance.

I believe that the work that we do is the self esteem business. What Dr Molton alluded to is that—unfortunately I am not a social media fan so I probably do not see as much of it as young people do—on social media there is apparently a massive influence on young females, particularly, about their appearance. They can then be pressurised into having cosmetic treatments which are totally inappropriate. Again I come back, we need a medical model not a commerce model. Because in the medical model if they came to somebody such as me, they would be advised very carefully that they do not require any treatment.

Ms KATE WASHINGTON: There have been previous submissions made to this inquiry about the use of the term "surgeon". Do you have an opinion about that and who is entitled to use that title?

Dr MOLTON: The Cosmetic Physicians College of Australasia is totally confined to the practice of cosmetic medicine. We do not have any view on the issue of surgery. We just do not do it.

The CHAIR: In New South Wales does your organisation receive inquiries or complaints about cosmetic surgery, and if so how do you deal with them?

Dr MOLTON: About surgery?

The CHAIR: Yes.

Dr MOLTON: We do not receive complaints about surgery because we do not do it.

The CHAIR: I will expand that to include cosmetic procedures. If your organisation receives a complaint from New South Wales how do you deal with it?

Dr MOLTON: If it is an issue that surrounds one of the fellows or members of the college, then we would look into those situations to determine if there has been a gross negligence or incompetence that we need to notify the authorities on.

The CHAIR: You may wish to come back to us with a detailed description of how your complaints process works and the steps that your organisation would follow should you receive a complaint with regards to a cosmetic procedure. Are you willing to do that?

Dr GROSE: We have within the constitution a quite detailed description of how disciplinary action can be taken in relation to membership of the college. It is covered by the constitution of the college.

The CHAIR: It would be helpful if the Committee could receive a copy of that.

Dr GROSE: Sure, absolutely no problem.

The CHAIR: Thank you for appearing before the Committee today. We may send you some additional questions in writing. Your replies will form part of your evidence and will be made public. Would you be happy to provide a written reply to any of those further questions?

Dr MOLTON: Absolutely.

Dr GROSE: Absolutely.

(The witnesses withdrew)

RONALD FEINER, Councillor, The Australasian College of Cosmetic Surgery, affirmed and examined

RONALD BEZIC, Councillor, The Australasian College of Cosmetic Surgery, sworn and examined

The CHAIR: Would either of you like to make a short opening statement before we begin with questions?

Dr BEZIC: May I begin by commending the Committee for holding this inquiry. On behalf of our fellows I thank you for inviting us here today to give evidence. We hope to assist the Committee in its investigations and deliberations. Parliament has no higher nor more important duty to the people of New South Wales than to protect its citizens' lives. It is our hope that the tragic death of 35-year-old Jean Huang last year—which acted as a catalyst for this inquiry—leads to the lasting change that we never see such an avoidable fatality occur again. We have seen a number of deaths across various Australian jurisdictions which stemmed from preventable errors, all of them tragic, yet all of them preventable.

As a medical practitioner of 20 years experience I am incredibly saddened whenever I see someone place their life in the hands of a person who claims to have all the necessary qualifications and experience, only for that person to breach that absolute fundamental trust. We are here today representing our colleagues to help ensure that we do not see a repeat incident in New South Wales, and hopefully Australia, ever again. By way of introduction, the Australasian College of Cosmetic Surgery was established in 1999 as a not-for-profit multidisciplinary fellowship-based body of surgeons and other doctors from a range of backgrounds who practice and specialise in cosmetic surgery and medicine. Today we are a college of 180 medical practitioners across Australia. Fundamentally, the college exists for patients. Indeed, our motto is "Raising standards and protecting patients".

As a college it is in our interest to ensure that our patients receive high quality and above all safe cosmetic procedures. The way we do that is by providing a rigorous training and examination regime to ensure our fellows meet extremely high international standards. By seeking out a fellow of the college to perform a cosmetic procedure a patient knows they are in safe hands. To become a surgical fellow of the college a person must complete a medical degree of Bachelor of Medicine and Bachelor of Surgery at an Australian university, which takes at least six years of full-time study; undertake a minimum of five years general surgical training and be considered surgically competent; undertake a further two years specialist cosmetic surgical training; satisfactorily sit three separate examinations at this point; produce and have published a clinical research paper or review article; and be registered with the Medical Board of Australia. This training and accreditation means that we are the leading association of experts in the field of cosmetic medicine.

While some practitioners may have experience in similar or related fields the fact of the matter is that the college is unique. Our specific training program means that we are the most qualified and experienced practitioners of cosmetic surgery in Australia. Despite this, "cosmetic surgeon" is not a protected term in Australia. The sad truth is too many practitioners call themselves "cosmetic surgeons" without undertaking any relevant training, let alone the rigorous training which we require of our fellows. Due to a gap in the Commonwealth law, which states that a term can be protected only if it is therapeutic, the result is that any medical practitioner can call themselves a "cosmetic surgeon", despite having no training whatsoever in the field of cosmetic medicine.

When patients see the term "cosmetic surgeon", they expect, and reasonably so, that the practitioner has the requisite training and experience behind that title. But, as we have all seen, this is not necessarily so. In fact, the Australian Medical Council [AMC] identified this problem in its report on surgical accreditation late last year when it said, "There is currently a deficit of experience available to trainees with regards to aesthetic surgery. Currently training sites have difficulty providing aesthetic surgery experiences and so those graduating from the training program will have a gap in this area of practice." That is referring to plastic surgery training.

For example, we are the only college to provide specialist liposuction training to our fellows. We are the only college to provide two years specialist training in cosmetic surgery. By comparison, the Australian Society of Plastic Surgeons provides an optional sixth month cosmetic surgery module for its fellows. This is a gap highlighted in the quote above from the AMC. I note that in Victoria in 2007 a 26-year-old, Lauren James, died as a result of a liposuction procedure performed by a specialist plastic surgeon. The coroner found that, "He failed in his obligation to provide adequate postoperative care to Mrs James and his clinical response was both wholly inadequate and disturbing." While this surgeon by all accounts is a leading reconstructive microsurgery expert, he is not qualified nor experienced to perform liposuction. This lack of training experience meant he was unable to recognise the symptoms of sepsis from which young Lauren was suffering. This led to Lauren collapsing and dying in her home three days after surgery, despite contacting the surgeon's clinic repeatedly.

Numerous expert medical witnesses testified before the coronial inquest to remark that Lauren, being a fit and healthy young woman, probably, if not undoubtedly, would have survived if she had been sent to hospital much sooner. While this occurred interstate, the fact is that this tragedy could easily have occurred and could still occur here in New South Wales for the very reasons highlighted by the Australian Medical Council [AMC]. But even among plastic surgeons, there is a distinct lack of cosmetic surgical training. As I said at the start of my remarks, the reason that the college is here today, and why we are all here today, is to help to ensure that we never have to see a Jean Huang or Lauren James die at the hands of an unqualified practitioner ever again.

As I said in our submission, having a national accreditation scheme for cosmetic surgery will go a long way to mitigating this issue. This issue is not within the remit of the Health Care Complaints Commission; nor is this problem entirely within the jurisdiction of the New South Wales Parliament. This is a national challenge, chiefly because health policy is split among all three levels of government and change requires support through the Council of Australian Governments [COAG] framework. However, this challenge is emblematic of the fragmented legislative and regulatory quagmire in which the commission operates. As highlighted in the college's submission, increased information sharing between jurisdictions would drastically support the commission's mission.

Similarly, a harmonised approach across all Australian jurisdictions to legislation and regulation to capture all people in the cosmetic medical field of practice—not limited to medical practitioners—with increased penalties for wrongdoing should be adopted. This is especially needed at the Commonwealth level whose exclusive jurisdiction in product importation needs to be strengthened, with punishments greatly increased for wrongdoers. Moving on to other parts of the college's submission, in the interests of time I do not wish to repeat what already has been submitted. Suffice it to say there is a need to sift complaints from the gravely serious to the vexatious and everything in between. Those in the latter end need to be triaged more effectively. It is not in the public interest for the commission, whose remit is health care, to become a complaints hotline for procedures that are medically sound but have not met the desired aesthetic outcome.

Indeed, those forms of grievances would be better addressed by a public education campaign, including improved disclosure prior to the procedure so that the expectations of patients can be reasonably set. This will free up the commission's resources to pursue those issues in the other end of the spectrum—namely, medically negligent and reckless operators who are putting the public at risk. The commission was an essential part of the medical regulatory space in New South Wales. In the college's opinion, the commission is an excellent organisation, which needs support from Parliament to perform its vital work in the cosmetic medical space. The college has an excellent working relationship with the commission. To date we have referred a significant number of issues to the commission for investigation.

One such example is the Cosmetic Institute [TCI], which I know has been the subject of some scrutiny. For the Committee's information, it was the college who blew the whistle on TCI, which was overseen by plastic surgeon Dr Eddy Dona, and referred it to the commission for investigation. I have a copy of the original complaint to table. I note that for all the concern of other organisations, it was us who took action. Patients' safety is paramount for the college. Indeed, the college has sought to be at the forefront of best practice in regulation—not only in New South Wales but around Australia. Just last week the college hosted a roundtable to discuss a range of pertinent issues, including the growth of cosmetic injectables and how training regulation and public education should evolve to meet this new demand. I am pleased to say to the Committee that the commission attended this roundtable and was leading conversations in these and other areas.

I would like to make particular mention of Dr Tony Kofkin, who is the Director of Investigations at the commission, and thank him and his team not just for their input at that roundtable but for their ongoing good work in cracking down on unscrupulous operators in cosmetic surgery across the State. The college stands ready, willing and able to assist in this important work, whether that is by providing further information to this inquiry, deepening engagement with the commission, sitting on advisory panels for future implementation, or any other matter in which we can be of assistance.

I will make one final point: we understand that yesterday some claims were made about the college by other witnesses. We have not seen the *Hansard* from yesterday so we cannot respond directly to those claims at this point in time. That said, I have covered off in my opening remarks that the college provides the most rigorous training program for medical practitioners looking to specialise in cosmetic medicine. There is no rational reason that accreditation, which recognises rigorous training at high international standards, should not be mandatory across the nation. Anyone suggesting otherwise should be held suspect. Again, thank you. We look forward to your questions.

The CHAIR: Thank you, Dr Bezic, for a very detailed opening statement. We appreciate that. We note that you have a proposal you want to table to the Committee as well.

Dr BEZIC: Yes. I have some stuff.

Documents tabled.

The CHAIR: My opening question is: When the college receives complaints about a practitioner—you probably heard me address that question earlier to other witnesses—what are the college's procedures for dealing with a complaint with regard to cosmetic surgery—

Dr BEZIC: Or medicine, yes.

The CHAIR: —or a cosmetic procedure.

Dr FEINER: I am happy to answer that. We have a four-step disciplinary process. That disciplinary process is this: If a complaint or a concern about a fellow or member of our college is brought to the attention of our college, we can investigate; we can refer, if it is appropriate, to regulatory bodies, such as the Australian Health Practitioner Regulation Agency [AHPRA] or the Health Care Complaints Commission; we can choose to suspend that practitioner; and, if necessary, expel that practitioner. I might say that that is not common among many colleges to have an in-place process such as that.

The CHAIR: Further to that, you mentioned taking action, including expulsion. Does the college make that information available to the public? Should you expel a member, is that information made public?

Dr FEINER: I should imagine that expelling a member would also have been brought to the attention of the regulatory bodies. To go to that degree, undoubtedly it already would be in the regulatory framework.

The CHAIR: Would you like to confirm to us in writing and formalise what the college would do.

Dr FEINER: We are more than happy to confirm that in writing.

The CHAIR: Thank you very much.

The Hon. WALT SECORD: Taking up your answer, how many people have you actually expelled or suspended?

Dr FEINER: I think in total four that I can recall.

The Hon. WALT SECORD: Four?

Dr FEINER: So far.

The Hon. WALT SECORD: Over what period?

Dr FEINER: You must bear in mind, sir, that overwhelmingly it is a safe field that we work in and there are complications.

The Hon. WALT SECORD: I tend to disagree with you on that.

Dr FEINER: You may disagree with me, but overwhelmingly there are 500,000 cosmetic procedures performed in Australia every year and a billion dollars spent. Overwhelmingly it is a safe field. But complications do occur, especially in surgery but also in cosmetic medicine, as they occur across all fields of surgery. I have been involved in neurosurgery, orthopaedic surgery, gynaecological surgery—

The Hon. WALT SECORD: But we are talking about cosmetic surgery today.

Dr FEINER: Okay, but we can make a reference—

The Hon. WALT SECORD: No. I want to take it back to four people over what period were suspended?

Dr FEINER: The college has been running for 19 years and I think we have had possibly one suspension. I do not want to give you information that is—

The Hon. WALT SECORD: No. This is very important.

Dr FEINER: Sure.

The Hon. WALT SECORD: This is very important because you represent the cowboys.

Dr FEINER: Oh, I am sorry. I really reject that comment.

The CHAIR: Mr Secord?

The Hon. WALT SECORD: I want to go back to the number. You have said one or four in the past 19 years.

Dr FEINER: No. I would say that four people have gone through that process, sir.

The Hon. WALT SECORD: That is hardly clamping down.

Dr FEINER: I will take that on notice and supply you with the details.

The Hon. WALT SECORD: You do not know. You were very confident in your opening remarks.

Dr FEINER: We have a process. I am confident of that.

The Hon. WALT SECORD: You just do not know how many people go through that.

Dr FEINER: Bear in mind, sir, that we have this process. Other colleges often do not have the process at all.

The Hon. WALT SECORD: Other colleges are not under scrutiny and examination because of the death of patients. We want to know how many people have been kicked out of your organisation, or expelled or suspended.

Dr FEINER: As I say, I would like to take that on notice.

The CHAIR: The witness has confirmed that he will take it on notice.

Dr FEINER: I am aware of one.

The Hon. WALT SECORD: For example, is Eddy Dona one of the people who was expelled or suspended?

Dr BEZIC: Eddy is a plastic surgeon.

Dr FEINER: He is a plastic surgeon. He is not one of our fellows.

The Hon. WALT SECORD: He is not one of yours?

Dr FEINER: No.

The Hon. WALT SECORD: Tell me about the four that you know of. What do you have to do to be expelled or suspended from your organisation?

Dr FEINER: An expulsion from an organisation is a very serious matter.

The Hon. WALT SECORD: What? Kill a patient?

Dr FEINER: Oh.

The CHAIR: Let the witness answer the question.

Dr FEINER: I do not believe—I do not think any of our members has killed a patient.

The Hon. WALT SECORD: This is why we are holding the inquiry.

The CHAIR: Mr Secord, I understand that it is important, but it would be nice if you let the witness answer question.

The Hon. WALT SECORD: He is not answering my questions.

The CHAIR: You keep interrupting him.

The Hon. WALT SECORD: He was very confident, but the number of expulsions he does not know.

The CHAIR: Just let him answer the question.

The Hon. WALT SECORD: Okay. The floor is yours.

The CHAIR: Please continue to answer the question.

Dr FEINER: Mr Secord, I believe one person has been expelled from the college.

The Hon. WALT SECORD: One?

Dr FEINER: I believe so, yes.

The Hon. WALT SECORD: In 19 years, one?

Dr FEINER: Well, I go back to the case—

The Hon. WALT SECORD: What do you have to do to be expelled? One in 19 years.

The CHAIR: Order! Will you please let the witness answer the question and stop speaking over him?

Dr BEZIC: Excuse me, Mr Secord. We will take this question on notice. We are not exactly sure of the numbers.

The Hon. WALT SECORD: Dr Bezic, you must know. You are a professional. One person expelled in 19 years?

Dr FEINER: I will take this question on notice. We are not 100 per cent sure. It am pretty confident it is more than one person who has been expelled.

The CHAIR: The witness has confirmed he will take it on notice.

The Hon. WALT SECORD: What about the Cosmetic Institute at Bondi Junction which later evolved as the Cosmetic Evolution?

Dr BEZIC: I would like to discuss that.

The Hon. WALT SECORD: What involvement does your organisation have with it?

Dr BEZIC: We have zero involvement.

The Hon. WALT SECORD: Tell me a bit about it.

Dr BEZIC: Zero. If you remember actually.

The Hon. WALT SECORD: I just want to go back to a question I asked earlier. Your organisation raised the spectre of expulsion or suspension, not me. I asked a subsequent question because you had raised it and I expected that you would be across it. It is extraordinary that in 19 years, one person.

Dr BEZIC: Let me just answer the question about the Cosmetic Institute. Yesterday one of the submissions devoted a lot of time on the issue of the Cosmetic Institute. You are well aware that our college took a lead in exposing its unsafe anaesthetic practices. We were concerned that they may be administering unsafe doses of local anaesthetic and we became outright alarmed that there was a documented cardiac arrest on its premises on 31 January 2015. We were the first learned college of association to initiate a complaint to the HCCC on 23 March 2015, a copy of which I will table.

The Plastic Surgery Association was sitting on its hands for at least 18 months whilst the lives of patients were being put at risk. Why would this be the case? Well, the surgical director of TCI was a plastic surgeon and a member of the Australian Society of Plastic Surgeons [ASPS]. He accredited and trained these doctors over weekend courses to perform these breast augmentations and supervise their surgeries. None of our fellows worked at TCI—none. I visited your office, Walt, on a Saturday in August of that year with my great friend the member for Rockdale to see if we could press the matter further with authorities. To your credit, you shared our concerns.

The Hon. WALT SECORD: I have been following this issue for three years.

Dr BEZIC: Yes. Upon discussing the issue with you, we both realised that they had admitted to you, during a recent visit by yourself to their facilities—

The Hon. WALT SECORD: Which I referred to the appropriate authorities—

Dr BEZIC: Yes. We both realised that they were administering illegal general anaesthetics. It was my conversation with you that made you realise they were doing the wrong thing.

The Hon. WALT SECORD: That is not true.

Dr BEZIC: No. We discussed it and we looked up the licensing list and they were an unlicensed facility.

The Hon. WALT SECORD: Absolutely.

Dr BEZIC: So then we were working at the same time on a *7.30 Report*, and I provide a transcript of that, to do an expose on them. They contacted you for that information that was useful to the program. This all ultimately culminated in further regulation which made cosmetic surgery safer for patients in New South Wales. We, as a college, worked closely with Minister Skinner's office to provide a framework of what can and cannot be done in unlicensed facilities. This template was ultimately replicated in Queensland, South Australia and to a degree in Victoria.

The Hon. WALT SECORD: What should happen? Should the title of "cosmetic surgeon" be protected? Should you be only able to call yourself a cosmetic surgeon if you have the minimum required years of experience?

Dr BEZIC: Yes, we agree with that in principle and that is tabled in our submission. We agree there should be a national accreditation process. Only people who meet that criteria—and that criteria is from the Australian Quality in Health Care Standards—

The Hon. WALT SECORD: In principle, you support the recommendation?

Dr BEZIC: Yes, but we think this should be an open framework made up with members from our college, plastics and other people to decide on what the threshold requirement is. There are too many cowboys out there, unrelated to us at all, that are calling themselves that, and this is what we are pulling our hair out over.

The CHAIR: Dr Bezic, will you confirm that the people mentioned by the Hon. Walt Secord were not a member of your college?

Dr BEZIC: None of them were fellows of our college.

The CHAIR: None of the people working at TCI were members of your college?

Dr BEZIC: No. None of them were fellows of our college. There was one trainee working for them. I immediately suspended his training upon hearing this, because I was so upset by this matter, until he resigned from the place.

The Hon. LOU AMATO: Do you have any examples of public awareness campaigns that you think would be suitable in New South Wales to help to understand the risk and complications of cosmetic procedures and the options following the adverse outcome or complaint?

Dr FEINER: Did you say are we aware?

The Hon. LOU AMATO: Are there any examples of public awareness campaigns that would be suitable in New South Wales to help people understand the risk of cosmetic procedures and their options following an adverse outcome or complaint?

Dr FEINER: As a college, if you look at our web site, we have awareness statements, handouts that are electronic on risks and identifying comfort with a practitioner, identifying questions one should ask. As a college we have been doing that for a long time, and we have a code of practice and we inform the public through our web site.

The Hon. LOU AMATO: Apart from a website, do you think there should be more information available?

Dr FEINER: Should there be? I agree entirely.

The Hon. LOU AMATO: As in media, television and that nature?

Dr FEINER: Absolutely sir. This is a huge concern for us as a college and as a profession, I would think anyone ethically involved in this profession would endorse that 100 per cent.

Dr BEZIC: If I may add, the Hon. Lou Amato. We also are concerned about vulnerable women presenting for cosmetic surgery. We have found that in the sub-population of women actually presenting for cosmetic surgery, 17 per cent of them have a condition called "body dysmorphia" which means that they have an issue with their body image—it can be related to eating disorders or other disorders. It is 3 per cent of the general population, 17 per cent in this sub-population. That could lead to a lot of unnecessary surgery and heartache for both the patient and the surgeon. We are the first surgical college that is working on a partnership with a non-profit organisation to develop a public awareness campaign for this and a referral pathway to treat it.

Mr AUSTIN EVANS: I want to clarify a comment you made earlier when you said that 500,000 cosmetic procedures are done per year.

Dr FEINER: Individual cosmetic procedures.

Mr AUSTIN EVANS: What is the split between medical and surgical?

Dr FEINER: I cannot give you the breakdown.

Mr AUSTIN EVANS: Roughly?

Dr FEINER: There is a move towards less invasive procedures. So there are more cosmetic medical procedures like the injectables and minimally invasive procedures but, of course, breast augmentation, tummy tucks and that sort of thing are still very popular.

Mr AUSTIN EVANS: Witnesses have told the Committee that they would like to have the term "cosmetic surgeon" removed. Is your premise that it should be regulated? You said you could not do that because it is not therapeutic.

Dr FEINER: Exactly right.

Mr AUSTIN EVANS: What needs to happen to allow that term to be protected?

Dr BEZIC: Through COAG Health. The ministerial advisory council has to make a recommendation which the Ministers will decide on. We think the appropriate way forward is in a submission we are tabling to you of an accreditation framework we agree on. It is in accordance with the way the national standards are set out for scope of clinical practice. If surgeons of various backgrounds, be they from us, be they general surgeons, plastic surgeons, or ear, nose and throat surgeons have met the threshold criteria they can use the term. Other people below that criteria who have had minimal training should not be able to use that term.

Mr AUSTIN EVANS: You also talk in your submission about the various areas of practice being accredited. Earlier you referred to the Victorian case of liposuction being done by a plastic surgeon who was probably not experienced in that procedure.

Dr BEZIC: Yes.

Mr AUSTIN EVANS: If you are not able to protect the term "cosmetic surgeon" and it is eliminated, is that the way forward.

Dr BEZIC: Is that more a procedural pathway?

Mr AUSTIN EVANS: Yes.

Dr BEZIC: If you demonstrate procedure proficiency, that is a possibility, yes.

Mr AUSTIN EVANS: You are talking about it happening federally, is New South Wales able to go alone on it? Is that not a good way forward?

Dr BEZIC: The AHPRA legislation sort of precludes that.

The Hon. MARK PEARSON: What do you consider is the difference between an invasive medical procedure and surgery?

Dr FEINER: An invasive medical procedure is where you are operating, let us say, deeply under the skin. So the skin, which has skin, sub-cutaneous tissue being fat, and various connected tissue layers within muscle—

The Hon. MARK PEARSON: Including muscle.

Dr FEINER: Yes, including muscle. You may go to muscle levels and go through layers of muscles. Would you agree with that?

Dr BEZIC: Incising the skin.

Dr FEINER: Incising the skin and operating deeply. There are minimally invasive procedures when dermatologists or dermasurgeons will incise the skin to take out a skin lesion. You must understand that the term "surgeon" means that you are cutting skin and doing something under the skin. It is a question of depth sometimes and complexity is what makes the difference. It is very difficult because all surgery is becoming less invasive. When I first started training, an operation for a gallbladder was an operation with a large scar; today it is a keyhole. Our field is going the same way. There are less invasive surgeries. People do not want scars. There is a saying from a famous Mexican plastic surgeon: "A centimetre scar on the face is a kilometre in the soul". Everybody wants something less invasive, but there is still a need to do some complex and deep surgery at times.

The Hon. MARK PEARSON: Former witnesses referred to medications, substances that are being used in cosmetic surgery and other invasive procedures as being a problem. There is a problem with disclosing the products in detail or their names. Is it an issue for substances being used in the surgical procedures?

The CHAIR: Brand names?

Dr BEZIC: Are you talking about invasive or non-invasive surgical procedures?

The Hon. MARK PEARSON: Both.

Dr BEZIC: In invasive surgical procedures, it is more an issue about the venue at which the operation is conducted: a hospital, day surgery or private rooms. The medications that we use—the local anaesthetics and general anaesthetics—are exactly what you would find in any hospital. I do not think there is any issue there. It is

more the job of the anaesthetist to discuss the complications of the anaesthetic than it would be for the surgeon. The procedure-specific consent for us would be about the danger of the actual surgery itself and the complications that arise from that.

The Hon. MARK PEARSON: If a person with qualifications—or perhaps not—chooses to do cosmetic surgery or procedures, is it a requirement that they must register with your college or any other college in order to practise?

Dr BEZIC: There is no requirement. That is the issue that brings us back to the core. You have identified the core problem here: untrained people performing procedures on the public. The biggest and newest issue at the moment—which killed the last patient in New South Wales—was that of a foreign national with not even a working visa, unregistered in Australia using a foreign product that was unregulated in Australia. That is completely outside the scope of the law.

Dr FEINER: I will comment further; it is a very important issue. There are colleges but there are two that are involved—in one way or another—in cosmetic surgery: the Australasian College of Cosmetic Surgery, which we are fellows of; and the Royal Australasian College of Surgeons [RACS], which includes the Australian Society of Plastic Surgeons [ASPS]. Both organisations train doctors in surgery really well. Our organisation trains doctors in a mandatory sense for two years in dedicated cosmetic surgery. The Australian Society of Plastic Surgeons and the Royal Australasian College of Surgeons train in the plastic surgery course for a voluntary six months in cosmetic surgery.

This has been known for years. I used to work with the plastic surgeon who was the president of ASPS for years. I know plastic surgeons wanting to achieve proficiency in cosmetic surgery. It happened usually after their training at some point on a voluntary basis. That has not changed all that much. Our training is for a dedicated two years. I think this has unfortunately developed into a bit of a turf war. I do not think it is the remit of the Committee such as this and an organisation such as this to place the laurel of victory on the head of a victorious college. This is not a turf war; this is a discussion about safety. We have two very good organisations training surgeons here.

The Hon. WALT SECORD: How many other operations in New South Wales are operating similar to The Cosmetic Institute?

Dr BEZIC: I think there is still a significant number. A lot of them are operating in ethnic groups that often advertise on foreign language platforms such as Weibo and WeChat which are hard for the regulators to keep track of. The industry is growing and there is a black market that we do not even know about. So I think it is still a significant problem.

The Hon. WALT SECORD: Dr Bezic, when they come to your attention what happens? What does your college do if you discover that they advertise on WeChat?

Dr BEZIC: We have a very good relationship with HCCC via Tony Kofkin. We phone them straightaway. We also work with the Therapeutic Goods Administration and NSW Health if it is an issue about illegal imports.

The Hon. WALT SECORD: Are there groups that are targeting particular ethnic communities?

Dr BEZIC: Yes, I think so.

The Hon. WALT SECORD: Which communities are they?

Dr BEZIC: If I could name them—Chinese, Korean and some Arabic communities.

The Hon. WALT SECORD: Yesterday we had a lengthy discussion on incentives to receptionists, front staff and nurses. Does your organisation have a policy or a response? What do you say if you discover that you have members who are upselling or have receptionists who are given incentives to upsell and encourage particularly young women to undertake procedures?

Dr BEZIC: If you go back to 2008, we approached the Australian Competition and Consumer Commission—not the HCCC—to initiate a code of conduct for cosmetic medical practice. This code of conduct was the first by any college basically for the issues that you have highlighted: on-selling, discounts, Groupon and so on. We went through an arduous process. RACS opposed it originally, but we got it through. A large part of that code of conduct was adopted by the Medical Board of Australia as the current code of practice in cosmetic surgery, the suggested code of practice. If it comes to our attention, our first point of call is to reprimand the member. If they do not heed our advice then we go for the complaints process. We find that, by and large, our members are compliant with the code.

Mr MARK TAYLOR: Mr Secord put to you that you represent the cowboys of the industry. I do not think you were given an opportunity to respond to that.

Dr FEINER: I think it is a really offensive thing to have said. We do not regard ourselves as cowboys. I find that insulting. We have a college that has a rigorous training program in cosmetic medicine and surgery that is unique. We cover the entire spectrum of non-invasive and invasive surgery in cosmetic surgery. We take our work very seriously. We have a rigorous training program that leads to fellowship. That is by examination and surgery. That examination is taken from the independent American Board of Cosmetic Surgery. It is an independent, verifiable examination. It is a tough examination—people fail it. Should they pass that exam, they need to go on to oral vivas. It is a traditional, serious college setting, and much the same in cosmetic medicine. To term us as cowboys, to put us in the same light as occasional surgeons or people who have had no training in surgery other than a day course is misleading and inaccurate.

The Hon. WALT SECORD: Point of order: I would like an opportunity to respond to the response about my comment about cowboys.

The CHAIR: I will consider it but after having given other members the opportunity to speak.

The Hon. LOU AMATO: One of my grave concerns is vulnerable women. Other Committee members would agree that the industry is taking advantage of a lot of women. In fairness, hypothetically, what percentage of procedures—minor or invasive—would be unnecessary?

Dr BEZIC: It could be up to 17 per cent which I nominated before.

Dr FEINER: Actually, it goes beyond that. A responsible cosmetic practitioner spends a lot of time in the first consultation forming a view of the suitability for that patient for cosmetic surgery or non-invasive cosmetic work. Certainly in my practice, and I am sure in most of our fellows' practices, we not only look for body dysmorphia, which is a very, very serious psychiatric complaint where people have a distorted view of their own image, but beyond that, whether the motivation is correct, is there pressure from somebody else to have that surgery? Have they been influenced by social media? Are they unrealistic about their expectations?

All that forms an opinion and certainly in my office, as I say, this is the way we train our fellows that one should desist if one is in doubt about the motivation and suitability and the risk-benefit ratio of surgery—it all comes into our consideration and that is what makes a responsible surgeon, not only the training which we have but the way we approach a patient. It should not be simply about making a living; it should be about safety and appropriate surgery. I feel very strongly about that and I know our college does.

The Hon. MARK PEARSON: Has the college or your members ever grappled with or turned your mind to the very ethical question as to not just body dysmorphia or amorphia, whatever you call it, disorders but the question as to whether the whole issue of cosmetic surgery, except in necessary surgery, deserves a social licence?

Dr FEINER: A social licence? Can you expand on what you mean by social licence?

The Hon. MARK PEARSON: If you step back and look at this whole issue, the number of people who are seeking cosmetic surgery and all of the resources going into that when there are so many necessary treatments and surgeries and a business almost has grown out of this.

Dr FEINER: I understand your question.

The Hon. MARK PEARSON: Is it not appropriate to turn one's mind to the ethical question as to whether this should be flourishing or it should be put in question?

Dr FEINER: I think it goes back to what we are as a society. We are, I guess, an affluent society and people are not only influenced by what happens in Australia but globally—we live in a global environment—and I think that as long as people seek out this sort of surgery for the reasons that they do I think it is a fair thing, but it has to be done correctly with the right ethics. There is a huge benefit to patients that people who are not involved in this work might not realise. I have a lot of patients whose lives are turned around in terms of their self-esteem and wellbeing, and even issues such as mental illness and depression, by actually having a better view of themselves.

If you have been through a divorce or a catastrophe or a break-up and as a woman, let us say, but even as a man, you have lost your self-esteem, lost your sense of self, you can regain it by just turning back the clock a little bit or looking a little better so that when you wake up in the morning—women look in the mirror; we guys shave, women look at the mirror intensely at themselves and if they feel better about themselves it is an amazing benefit. I can quote you one patient who we did just a little work to turn the clock back. She had been through a nasty divorce, she was an educated woman, a teacher. She said, "You've changed my life by making me feel good

about myself again. All the counselling that I had was for nothing compared to what you've done for me." That is an amazing sense of satisfaction for me as a practitioner and anyone who is in that position, and I can tell you it is common. It is not just about money; it is about actually improving people in many ways.

The Hon. WALT SECORD: Point of order: I would like to respond to Mr Taylor's comments about cowboys.

The CHAIR: I will let you do so.

The Hon. WALT SECORD: I made the comments based on the expulsion of one member in 19 years, which indicates that you do tolerate cowboys. One expulsion in 19 years.

Dr FEINER: I totally reject your comment.

Dr BEZIC: What I will add is that we have asked—and I will get the number on notice for you—many fellows to leave voluntarily without going through that process if they are behaving in that manner, and that there are easily more than five of those members I can think of.

The CHAIR: Mr Secord, ask the question.

The Hon. WALT SECORD: You have just led to another thing. You said that members are allowed to leave if they have done the wrong thing rather than—

Dr BEZIC: Resign. You cannot stop them leaving.

The Hon. WALT SECORD: So you allow a wrongdoer to simply resign and walk away.

Dr FEINER: We cannot stop people resigning. We can send them to the regulators but we cannot stop them—

The Hon. WALT SECORD: You give them the option. Rather than taking action you allow them to resign.

The CHAIR: He was trying to answer the question, Mr Secord. Again, you keep speaking over him.

The Hon. WALT SECORD: He dug himself deeper, showing that wrongdoers are allowed to resign.

The CHAIR: It is not a matter of digging himself deeper.

The Hon. WALT SECORD: Wrongdoers are allowed to resign and only one in 19 years is expelled.

The CHAIR: Dr Bezic, did you want to finish answering the question? You will be tabling evidence to this Committee about the number of resignations and/or expulsions from your college?

Dr BEZIC: Yes.

The CHAIR: Thank you. I have a closing question. Dr Bezic and Dr Feiner, as part of the training that your college organises do you outline an opportunity for a business model for a particular practice? If someone wishes to take up a cosmetic surgery practice or cosmetic procedures practice, do you provide any sort of description of a business model for such an organisation?

Dr FEINER: No. Other than sending people out with the culture of their being ethical in terms of their business or practice we do not have any such structure.

The CHAIR: So there is no formal business training and no formal business model?

Dr FEINER: Not that I am aware of, no.

The CHAIR: The document you wish to table, can you confirm what that document is?

Dr BEZIC: We have basically got our original complaint about The Cosmetic Institute to the HCCC, a transcript of that ABC story, my opening comments, and we have also got, I think, 20 case histories of complications that our members have seen at the hands of plastic surgeons, just for a sense of balance from yesterday.

The CHAIR: Is this all relating to the same case?

Dr BEZIC: No, different cases.

The CHAIR: These are different cases in addition to the ones from TCI that you mentioned earlier.

Dr BEZIC: Nineteen cases there. Also our accreditation proposal that we have been sending to COAG Health.

The CHAIR: Thank you for appearing before the Committee today. We may send you some additional questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Dr BEZIC: Yes, indeed.

Dr FEINER: Yes.

(The witnesses withdrew)

(Short adjournment)

JOANNE MULLER, Legal Member, Nursing and Midwifery Council of New South Wales, sworn and examined

JENNIFER KENDRICK, Chair, Performance Committee, Medical Council of New South Wales, sworn and examined

The CHAIR: Do you have any questions about the hearing process?

Dr KENDRICK: No, we do not.

The CHAIR: Do either of you have a short opening statement you wish to make to the Committee before we commence our questions this morning?

Dr KENDRICK: I do not.

Ms MULLER: The Nursing and Midwifery Council has provided a submission. I would like to correct a typographical error on the front page—"submission" with one "m". Would the Committee like to have an amended version provided?

The CHAIR: That will not be necessary. Do you have an opening statement other than that?

Ms MULLER: No, thank you.

The CHAIR: Would it be useful to have some form of accreditation—a system effectively—for consumers to be satisfied that they are choosing cosmetic health service providers who have an appropriate qualification and also expertise to carry out the procedures that they advertise, and also to ensure that they are safe and legal? We have heard evidence, obviously, about customer and patient expectations of what they believe they are going to receive. Does the Nursing and Midwifery Council have a position or opinion on that?

Ms MULLER: As to whether there needs to be an accreditation system, I think the Nursing and Midwifery Council would work with any accreditation system that was put in place. At the moment, the Nursing and Midwifery Board of Australia has a position statement, which it published in March 2008. That applies to nurses in New South Wales. That is a document titled "Nurses and Cosmetic Procedures". Is that a document that the Committee has?

The CHAIR: Could you organise to supply the Committee with a copy of that document? You do not have to do it right now, obviously, if you can supply it to us.

Ms MULLER: Yes, we can.

The CHAIR: Does the Medical Council of New South Wales have a position on my question?

Dr KENDRICK: Yes, I think the Medical Council thinks that it would be helpful to have accreditation standards—not only for the practitioners providing the services but also for the premises that they are provided in. That would help a lot with being able to set criteria for undertaking the procedures.

The CHAIR: As part of this inquiry, one of our key focuses is looking at the HCCC and its role in policing to some degree and also informing the public with regard to the differences between cosmetic surgery and cosmetic procedures, and also the public's ability to lodge complaints with the HCCC. You can answer separately on this, obviously. Do you believe that the HCCC could be doing more? If so, what do you believe the HCCC could be doing to notify the public? What sort of suggestions could be made to the HCCC that this Committee could recommend to the HCCC to try and inform the public and/or protect the public to a greater level with regard to cosmetic surgery and cosmetic procedures?

Dr KENDRICK: Exactly what the HCCC can do in that regard is a little bit beyond my ability to answer, because I am not quite sure what the rules might be, but I think it would be useful for the HCCC or an organisation like that to better inform the public. I think there is a lot of misinformation in the public about the difference between people undertaking different sorts of cosmetic work and the different titles that are used. What is a cosmetic physician? What is a cosmetic surgeon? What is a cosmetic doctor? What is the difference between those and a plastic surgeon? I think the roles that people are undertaking need to be much better defined, and the public needs to understand what those roles are. I think it would be helpful to have some sort of website where people can access information that could be promoted publicly that there is such a resource there for them to get that sort of information.

Ms MULLER: I am also thinking that there should be better information, and possibly the protected title provisions of the national law could be more specific regarding the use of titles. For instance, the title "cosmetic nurse" is not one that is currently protected, as I understand the national law, and if a member of the public sees "cosmetic nurse", they are probably provided with a degree of comfort that they are being treated by

a nurse. If the legislation was beefed up in that regard so that a person was not able to use a title that was misleading a member of the public to thinking that this person has got the expertise, that is probably your first line of defence. The second line of defence is probably in mandating the accreditation that you mentioned in your opening question—mandating some sort of accreditation before a person could include cosmetic work in their scope of practice.

The CHAIR: Can I confirm you believe it would be better to have a national accreditation set by the Federal Government and standardised across all States or could New South Wales go it alone?

Ms MULLER: The problem is beyond New South Wales. It extends across the whole of Australia. I do not think there is anything in particular that is different in New South Wales. I am probably going beyond representing the Nursing and Midwifery Council, but on my personal observation the introduction of the national registration scheme in 2010 has had a very beneficial effect on the standards of health practitioners across Australia and the members of the public are well served. Although it was an interesting process, they have been well served by the standardisation across Australia. I would think this would be an area that would fall into that category. The national law is based on scope of practice and a person is allowed to determine their scope of practice, but if there was some accreditation put in place around these cosmetic procedures that was able to be accessed on the internet by members of the public, that would also assist in providing a firm foundation for regulatory action to be taken by regulators such as the Medical Council and the Nursing and Midwifery Council.

The Hon. MARK PEARSON: Thank you for coming. Do nurses do specific training if they are interested in working in the area of cosmetic surgery or cosmetic intervention?

Ms MULLER: There are is no specific training. However, to work in any area of nursing, the person should have satisfied themselves that they have got the appropriate training and experience. In the guidelines for registered—

The Hon. MARK PEARSON: How do they satisfy themselves?

Ms MULLER: That is a very interesting question. I will do my best to answer it and maybe I will have to provide further information on notice. The way in which the national law is framed, it is a protection of title and also it expects practitioners to work within their scope of practice and each practitioner has to decide what that scope of practice is. For instance, a registered nurse, upon registration, will meet all of the accreditation standards to be a registered nurse. However, if they wanted to go to a specialised area, they will need further training, further experience and probably supervision. It is really a matter for the individual to decide.

The Hon. MARK PEARSON: In many areas, mental health, et cetera, there would be an examination, a standard or requirement that they would have to meet to then say, "I am now a registered psychiatric nurse", or specialising in emergency or specialising in anaesthetics, whatever.

Ms MULLER: Yes, there are postgraduate qualifications.

The Hon. MARK PEARSON: Not in cosmetic work?

Ms MULLER: Not as far as I am aware. There are institutions that run training courses, but they do not seem to be formally recognised within the Australian quality framework as a proper diploma or a masters might be.

The Hon. MARK PEARSON: Have any concerns been raised with you by nurses who are working or have chosen to work in the cosmetic area that they are grappling with or your organisation is grappling with the notion of supervision under which they are asked to do certain procedures or practices? What constitutes supervision and is there a grey area that is of concern to you?

Ms MULLER: They have not raised it. They are from the anecdotal reports. They were surprised that they needed to be supervised for the provision of schedule 4 drugs. There is a decision in the matter of Piper which is referred to in the paper and, as I understand it, from reading the tribunal decision, the practitioner was surprised that a registered medical practitioner had to, first, prescribe the schedule 4 in a face-to-face consultation and then had to be available, if required, during the providing of that schedule 4 drug.

The Hon. MARK PEARSON: Who was surprised?

Ms MULLER: The practitioner. If you read the tribunal's decision, it indicates that the registered nurse, Ms Piper, did not appreciate the responsibilities regarding the face-to-face consultation with a medical practitioner for the prescribing of the schedule 4 drug, or that they needed to be available whilst it was happening, not that they were there immediately, but they are available.

The Hon. MARK PEARSON: Going back, if she was surprised and there is surprise, does that not mean that there is a vulnerability and no clarity as to the legal requirements and responsibilities of a registered nurse in that particular scenario when there is cosmetic intervention or surgery or procedures are being done. Is that of concern?

Ms MULLER: The fact that you need to have schedule 4 medications prescribed by a medical practitioner should be known to all registered nurses. The fact that there is a requirement for a medical practitioner to be available is also known. A document was published by the Medical Board of Australia on 1 October 2016, which is headed "Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures". Paragraphs 7.2 and 7.3 clearly set out those requirements.

Mr AUSTIN EVANS: The phrase "cosmetic nurse". People cannot use "nurse" in their title if they are not a nurse?

Ms MULLER: They cannot use "registered nurse", they cannot use "enrolled nurse", they cannot use "nurse practitioner". It is using a title where the perception is that they are a registered nurse or hold registration. You can hold registration as a registered nurse. You can hold registration as an enrolled nurse and you can hold registration as a nurse practitioner. It is a little confusing because of the enrolment and registration. They are titles that came from the historical foundation.

Mr AUSTIN EVANS: I understand that but my question is using the word "nurse" if you are not a nurse at all. Is that illegal? I am not a nurse. Can I walk out and call myself a cosmetic nurse and not be illegal?

Ms MULLER: If you are using it in the context where it would be leading a person to believe that you are a registered or accredited nurse, yes then it would be illegal. That would be a matter for the Australian Health Practitioner Regulation Agency [AHPRA] to be prosecuting under the powers that they have in the national law. It is the circumstances that you are using that term.

Mr AUSTIN EVANS: As to the concept of "cosmetic nurse", "cosmetic surgeon" and all those phrases that the Committee has been dealing with over the last couple of days and is part of this inquiry, some people would like to remove the phrase completely and others would like to regulate it. What is your point of view on "cosmetic nurse" and "cosmetic" anything else?

Dr KENDRICK: I think titles are very confusing, particularly for the public. They are even becoming confusing for people in the medical profession because they are proliferating. It probably needs a bit more thinking and an exercise of collaboration between the different professions to work out whether we are better to have a title for people with some quite defined scope of practice around that, or whether you do not have a title. Because cosmetic medicine—whatever you want to call it—is such an expanding field it seems reasonable at this stage to think about having a title that would encompass the scope of practice that constitutes cosmetic work. Otherwise it becomes more difficult to decide on the qualifications and experience required to undertake that work. My feeling is that to have a recognised title would be a reasonable way to go but I think it would require further discussion with the people involved to decide whether that is best or how best to do that. Because if you are going to have a title it needs to be an accredited, recognised title that you can only use if you have got certain qualifications.

Ms MULLER: From the Nursing and Midwifery Council of NSW, the council has not had an opportunity to discuss that. I only give you my personal view but that is not what we are here to do.

Dr KENDRICK: I should say that is probably my personal view too.

The Hon. LOU AMATO: Earlier witnesses mentioned approximately 17 per cent of cosmetic procedures were unnecessary. There are providers taking advantage of vulnerable women. Do you believe a better system could be put in place to protect those women, make them aware and make practitioners and nurses accountable?

Dr KENDRICK: That is a really important thing. The vulnerability of patients in all of this is quite significant, both men and women. There are ways that we could reduce the risk of vulnerability.

The Hon. LOU AMATO: Let us say 20 per cent, or one-fifth. That is a high figure.

Dr KENDRICK: Yes.

The Hon. LOU AMATO: It is a very high figure.

Dr KENDRICK: That is a percentage of what?

The Hon. LOU AMATO: Of unnecessary procedures.

Dr KENDRICK: I guess it depends how you define unnecessary procedures, whether it is unnecessary for the health of the patient, or whether you are defining it as unnecessary in terms of whether the patient wanted it or not.

The Hon. LOU AMATO: No, if I can define it by women who do not need a procedure but are being taken advantage of. In other words, it is purely a business. They are not looking after the interests of the patient.

Dr KENDRICK: That is what I was getting at. I think there is scope to try to reduce that risk. The Medical Council of NSW currently has a policy around people who are 18 or under, that there has to be a three month cooling off period and a recommendation that in that time they see a general practitioner to discuss what they are planning to have done and whether it is appropriate for them. There is scope to expand that type of model. Again, you have to relate this to the extent of the cosmetic work that is being done. It is quite broad, from having an injection, to having surgery done.

The rules you put in place will differ depending on the risks to the patient and the extent of the work being done. But to have something in place that requires an assessment of somebody's psychological wellbeing by an independent person, be that a general practitioner or psychologist, before the person embarks on having significant cosmetic work done I think would be worth exploring. People also have rights to have some degree of cosmetic work done that we may regard as unnecessary from a medical point of view, but there is also within that group people who are making that decision from a point of vulnerability because they have low self-esteem, because they have other mental health issues, and they are the group that particularly need to be protected.

The Hon. LOU AMATO: A unified national standard system would be the way to go.

Dr KENDRICK: Yes. For all of this, following on what Ms Muller was saying, to have any of these policies national where we can is a good thing because otherwise people move interstate, people do all sorts of things to get around specific State rules.

Ms MULLER: In my answer I would add that informed consent is extremely important in this particular area, and also the practitioner putting the needs of the patient first. That is a very important factor and I can hear the concern of the Committee that there may be practitioners out there who are not doing either of those things. In the code of conduct there is that a person must not diagnose or treat an illness or condition without adequate clinical basis. If we look at the guideline that has been published by the Medical Board of Australia, they give some guidance about where the presenting problem is that the patient perceives that they would like a more desirable appearance or boosting a patient's self-esteem. It puts in place some requirements regarding, particularly vulnerable groups of people. The under 18s are one group that it puts some parameters around.

The Hon. LOU AMATO: Usually with under 18s you need parental consent.

Ms MULLER: Yes, that is right.

The Hon. LOU AMATO: So there is some form of safeguard there?

Ms MULLER: Yes.

The Hon. LOU AMATO: It is the people who do not need parental consent, who are over the age of 18, and are at a higher risk because of their vulnerability.

Ms MULLER: I agree. By definition anyone who is a patient is vulnerable. It is the degree of vulnerability and the recognition of the degree of vulnerability. In the Medical Board of Australia's document, if there is any concern about mental illness there is a requirement to have the patient assessed by a psychologist, a psychiatrist or a general practitioner. That would go a long way. If we were getting informed consent and we were recognising mental illness and that vulnerability, and if we were putting the interests of the patient first, that may go a long way to addressing your concerns about the 70 per cent of unnecessary surgery.

The Hon. LOU AMATO: Should a cooling-off period be applied as well to give the patient, the consumer, the client or the customer, whatever it is in the cosmetic industry, a cooling off period?

Ms MULLER: I guess we—

The Hon. LOU AMATO: Rather than have a high-pressure used car salesman approach?

Ms MULLER: I guess if there was a clear line where you stop calling a person a customer and you started calling a client a patient, that might be of great assistance because it would change the focus very much from a business model to a healthcare model.

The Hon. LOU AMATO: Thank you very much.

Mr MARK TAYLOR: Yesterday we heard some evidence about nurses working in cosmetic clinics, if I can use that term, either being lowly paid, paying back training costs, or being on commission-based pay. Have you or your organisation ever received complaints from nurses about payment or working conditions in those clinics?

Ms MULLER: In the decision of Piper, which is the tribunal decision, it is summarised in the submission that is made. It is available publicly on the internet. I was not involved in that particular tribunal but as I read the decision the nurse involved was receiving the schedule 4 medications—the injectables and other items—from the medical practitioner, who was also taking a significant portion of the fees that she was receiving when she was working. If that falls into the category that you are asking about, there is a significant amount of information on the public record regarding that type of thing.

Ms KATE WASHINGTON: Ms Muller, I see that you are here as a legal member. Does that mean that you are a lawyer, or are you a nurse?

Ms MULLER: No, I am a lawyer.

Ms KATE WASHINGTON: As am I. In the submission from the Nursing and Midwifery Council, there is a reference to the number of complaints received by the council increasing since 2010. However, the numbers relating to cosmetic industry services is relatively small. From everything that we are hearing, that seems to belie the reality of what is actually happening in the sector. I wonder if you have any thoughts about what the HCCC could be doing to see the complaints reflect reality a little bit more.

Ms MULLER: I will just take part of your question. We actually do not code for cosmetic surgery. Our executive officer manually went through all of our cases in preparation for the Committee and looked for those keywords. Our numbers may not be exact, but they certainly would indicate a reflection of what people felt anecdotally was the case. So, yes, given the nature of the complaints or the issues that this Committee is considering, those numbers do seem to be quite small.

As to what the Health Care Complaints Commission can do, I can really talk to the matters that came before the council. On page 16 there are 68 matters that have been put before the council and already considered. There are about 11 that are currently open. In 45 of those matters, they were discontinued at the initial assessment. Basically, the information that was provided after the Health Care Complaints Commission had done that assessment, there was no basis for the council to take action based on the information that was provided. The council has very limited investigation powers itself and relies upon the Health Care Complaints Commission.

Ms KATE WASHINGTON: Just to be clear, those figures relate to complaints that have been raised about your members in the cosmetic sector?

Ms MULLER: Registered health practitioners.

Ms KATE WASHINGTON: Again we come to the fact that there seems to be very few of them. Are there concerns among your membership that the HCCC's focus is sometimes more on the person actually delivering the treatment, as in the nurse who ostensibly is under the supervision of a doctor, or a corporation? Are there concerns that it is more focused at the lower level and the HCCC should be looking at the system within which they are working, or the corporation that is responsible, or indeed the doctor who is responsible?

Ms MULLER: I am not sure that it is the role of the council to be looking at those questions because we are charged with the responsibility of dealing with complaints regarding individual nurses who hold registration as a nurse—an enrolled nurse, a registered nurse or a nurse practitioner. It is not the role of the council to look at systemic issues that would fall within the Health Care Complaints Commission's role.

Ms KATE WASHINGTON: Dr Kendrick, in the Medical Council's submission there is a reference to the HCCC and the Medical Council considering complaints in the last 12 months. I can see that there has been a breakdown provided of the types of complaints made. I will refer you also to a submission made by the Australasian College of Cosmetic Surgery where they say this:

> Overwhelmingly, it appears that patient generated complaints to regulatory bodies or the broader civil litigation arena relate more to unmet expectations rather than from negligent practice.

Would you agree with that submission in the context of your own submission in relation to the breakdown provided?

Dr KENDRICK: I think certainly unmet expectations is a significant issue. I think that relates back to what is informed consent. It is impacted by the conflict of interest in an entrepreneurial sort of setting, which often cosmetic surgery is. Patients have expectations that they are going to have a much better outcome than they are going to have, and they are not always adequately informed and warned about the potential for less than ideal

outcomes. They are also not always adequately informed about what the alternatives would be in terms of referral to people with better qualifications.

From what we see at the Medical Council, a lot of them is around that mismatch in terms of reality and risks versus patient's understanding. Some of it is about not understanding the outcome and some of it is about not understanding the risk of the procedure in terms of infection and other problems. It has been to a lesser extent that someone has not had the actual skills to perform the procedure, but that is also an issue in some of the breast augmentation arena where the skills have not really matched what the patient might need.

Ms KATE WASHINGTON: For me, from the perspective of formerly having been a medical negligence lawyer and knowing how difficult it is in the HCCC complaint process and the civil litigation process, people do not undergo those processes lightly. Whether or not the breast augmentation has resulted in exactly the same outcome that they were presented with, I feel that there is a tendency to perhaps belittle the poor outcomes and the suboptimal outcomes as unmet expectations whereas what we are talking about, I would say more broadly, are some very serious poor health outcomes. Is that not the case?

Dr KENDRICK: No, I would agree. I am sorry I might not have fully understood your question. I think there is an element of not understanding expectations. But, you are right, there is an element of poor outcomes that should not be tolerated. I think we have taken action against doctors where there have been some quite significantly poor outcomes, you know, of people that really should have had different procedures done. That is what I meant when they have not actually been informed of where they could have done better by somebody that is better skilled. I think it is a combination of factors, but certainly doctors performing procedures that they are not really skilled to do has been an issue, and restrictions have been placed on the scope of practice that some of those doctors can do when the complaints have come to us.

The Hon. WALT SECORD: I looked on your website which states that you handle complaints in conjunction with the HCCC. How does that occur?

Dr KENDRICK: What happens is that when the complaints come in—and they usually come in through the HCCC—if they come in to us, they would be passed on to the HCCC. Those complaints are all put together each week. Both the medical director, who is sitting behind me, from the medical council and someone from the HCCC will go through all of those complaints and then they have a meeting once a week to look at the complaints and work out what complaints maybe need no further action at all, what complaints should be handled by the medical council, and what complaints the HCCC wishes to prosecute, which would be the more serious ones, and investigated.

The Hon. WALT SECORD: What is the typical duration of time from receiving a complaint to wrapping it up, so to speak, putting it in the "finished" basket?

Dr KENDRICK: That would depend on the nature of the complaint and the process it is going through.

The Hon. WALT SECORD: A serious complaint—not something that you would reject immediately but something that in your weekly meeting you would say, "Okay, this warrants attention"?

Dr KENDRICK: Again there are two pathways. If it comes to the medical council then it would be divided into whether it is a conduct, health or performance matter. If it is a conduct matter, we have meetings once a month for the conduct committee. It would be considered there, determined again whether further action is needed and what that action is. If it needs immediate action, even before it goes to a committee, there is the opportunity to hold a section 150 hearing whereby a doctor could have their registration suspended immediately.

The Hon. WALT SECORD: How often does that happen?

Dr KENDRICK: I do not have the exact figures but I can ask for them.

The Hon. WALT SECORD: Is it a handful a year, or two or three?

Dr KENDRICK: Can I just ask?

The CHAIR: I suggest that you may want to table that information at the end of the hearing.

Dr KENDRICK: Yes. It is not uncommon and I would say it is more than a handful a year that go to a section 150. So that is for something where we need immediate action. If it was going through that process it would then also be going through the Health Care Complaints process and its investigative processes obviously take a lot longer but there are protective things that can be put in place prior to that. Sometimes it might be a registration suspension, sometimes it may be conditions that can be put on a registration to stop them doing particular things while the matter is being—

The Hon. WALT SECORD: For example, are the doctors who work at The Cosmetic Institute fully accredited and operating in New South Wales at this moment?

Dr KENDRICK: I believe a number of the doctors who have had complaints made against them have conditions on their registration which would preclude them from doing certain procedures.

The Hon. WALT SECORD: What sort of conditions?

Dr KENDRICK: The conditions can vary. The conditions may be that you cannot undertake particular procedures. The conditions may be that you cannot prescribe particular medications. The conditions may be that you can only work under supervision or that you need to work in a practice with X number of other doctors so that somebody has got some oversight. It may be that you need to have a supervisor. It may be that you need to have a mentor. It may be that you are being monitored. Any of those conditions that are put in place are monitored by the Medical Council.

The Hon. WALT SECORD: Are the doctors at The Cosmetic Institute, Bondi Junction or Parramatta, in any those categories? Are they being monitored, supervised or out there working away?

Dr KENDRICK: I would need to take on notice specific doctors because I do not have that on hand.

The Hon. WALT SECORD: Dr Eddy Dona?

Dr KENDRICK: No, I mean I do not know the information about a specific doctor right at this moment but I can provide that information, if required.

The Hon. WALT SECORD: Does it occur rarely? Do many doctors have complaints against them—for example, those at The Cosmetic Institute who are still working away?

Dr KENDRICK: If doctors have complaints they are assessed either by the medical council under conduct performance or health and then if it is considered that to protect the public they need conditions on their registration they would have conditions on their registration.

The Hon. WALT SECORD: Does it take a long time for that to occur? I am trying to get an indication back to the original question. If you had found out about the activity at The Cosmetic Institute would you have acted within one or two weeks or was it eight or nine months or a year? What is the timeliness?

Dr KENDRICK: Exact time lines I might need to take on notice and get back to you. But I can say that a preliminary assessment is done by the medical director and the HCCC. If it is considered that urgent action is needed then a section 150 can be called within one week to set conditions.

The Hon. WALT SECORD: What is "urgent action"? Is it a day, two days, a week, a month?

The CHAIR: The witness just confirmed it is a week.

Dr KENDRICK: It is a week. We can have it in a week. What happens, the council will contact the people when it is called. A section 150 happens within about a week of the concern being raised. It could be done more urgently than that if it is needed but it is quite an urgent sort of process and happens quite quickly.

The CHAIR: A section 150 hearing can be called at any time within a seven day period?

Dr KENDRICK: Yes.

The Hon. WALT SECORD: Does it happen very often? Is it just one or two doctors a year? I have asked previous witnesses how many people were expelled or suspended from their organisation over a 19-year period and it was either one or four. It may be quick and timely but it may not actually ever happen.

Dr KENDRICK: There were 127 section 150s in the past financial year, and there were 18 suspensions.

The Hon. WALT SECORD: Eighteen suspensions last year?

Dr KENDRICK: Eighteen suspensions, through a section 150. In addition to suspensions, some of the other doctors of the 127 that went to the section 150, they would have had conditions. I do not have the number that had conditions put on their registration. But 18 were suspended out of 127 and there were 127 section 150s in the financial year.

The Hon. WALT SECORD: How many doctors would be in that pool statewide? You are talking of 18 out of how many doctors would that be?

Dr KENDRICK: How many complaints do we get?

The Hon. WALT SECORD: How many doctors in New South Wales would fall into that category? For example, 18 out of a pool of 5,000 people?

The CHAIR: I think the Hon. Walt Secord is asking how many practitioners could effectively be sanctioned under section 150?

Dr KENDRICK: Do you mean, how many doctors exist in New South Wales?

The CHAIR: Yes.

Dr KENDRICK: There are 33,000 doctors in New South Wales.

The CHAIR: A section 150 suspension can take from one to seven days, depending on their urgency. In relation to a section 150 do you automatically notify the HCCC of your concerns? If there are major concerns about a particular practitioner, you automatically call for a section 150 but at the same time do you notify the HCCC that you are taking that action simultaneously?

Dr KENDRICK: Yes.

The CHAIR: Did you say you met weekly or fortnightly with the HCCC?

Dr KENDRICK: Weekly.

The CHAIR: When you would go through the section 150s automatically they would be notified immediately that you are doing that. In addition, you then follow that up with a weekly update on the non-section 150 issues effectively. The medical council says these are, for simplicity, the most serious and the minor issues. You in conjunction with the HCCC disseminate a level of triaging of those issues effectively. Is that right?

Dr KENDRICK: That is my understanding. There are probably approximately 100 complaints coming in a week and they would look at those and then independently a decision is made by the medical council and by the HCCC as to what they think the outcomes should be from those complaints. When it gets discussed whatever is the more stringent outcome is the one that applies. So if the medical council says it probably does not need any further action but the HCCC thinks it needs to be further action then there would be further action, or vice versa. It does not matter which organisation. The system errs on the side of taking the action versus inaction, I guess, or the higher level of action. If the HCCC felt it did not need to prosecute something but the medical council thought it should be prosecuted then it would be prosecuted.

The CHAIR: My last question is to the Nursing and Midwifery Council. On page 16 of your submission, you mention that there were 68 complaints. Were they directed directly to your organisation first? Like the council, do you then disseminate what does or does not need to be referred to the HCCC? If someone lodges a complaint with your council, what is the process of that complaints handling?

Ms MULLER: Immediately upon receipt of a complaint, it is shared with the HCCC. Similarly, if a complaint is lodged with the HCCC and it is regarding a registered nurse, an enrolled nurse or a nurse practitioner, it is shared with the council. It is then the preliminary consideration of the seriousness of the matter and potentially the referral to section 150 of the Health Practitioner Regulation National Law (NSW) for immediate action. There is a joint consideration between the HCCC and the council as to whether or not the matter should be dealt with by the council. Similarly, the Nursing and Midwifery Council has a performance pathway, a conduct pathway and health pathway. Otherwise, it stays with the Health Care Complaints Commission for investigation.

The CHAIR: Do you have the same sort of time lines as the other council about processing those issues? For instance, if a section 150 case comes up, you notify the HCCC instantaneously. Other than that, you meet on a weekly basis?

Ms MULLER: On a fortnightly basis.

The CHAIR: Weekly and fortnightly, depending on the severity. If there was a serious issue, such as Mr Secord highlighted with a particular organisation, that could be escalated to section 150. It would then be dealt with within no longer than a week.

Ms MULLER: It goes in accordance with the severity. It would not be a complaint about an organisation but about an individual. I also have further information in answer to Mr Pearson's question. The Nursing and Midwifery Board of Australia has a decision-making framework to assist nurses to decide on their scope of practice. It is quite a detailed document.

Ms KATE WASHINGTON: Could you provide an example of what type of complaint would trigger section 150?

Dr KENDRICK: Any complaint where there are boundary issues will automatically trigger section 150. Outside of that, an assessment is made on how much of a risk there is to the public. It is a bit difficult to give an exact example of that, but if the public is potentially at immediate risk from a doctor going forward, then there would be action under section 150. Otherwise, it gets funnelled into the conduct performance or health pathways.

Ms MULLER: It would also be triggered if they were charged with a serious criminal offence, if they were scheduled and there were concerns regarding that, if it was a matter involving an unexplained death of a patient and those sorts of things. There is a risk assessment tool.

Ms KATE WASHINGTON: We are talking about the really pointy end of the scale of behaviours and activities.

Ms MULLER: There could also have been a number of previous complaints of a lower level and this is of a similar nature, so a pattern of conduct is now emerging. A lot of factors would have to be taken into consideration.

The CHAIR: Thank you for appearing before the Committee today. We may send you some additional questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Dr KENDRICK: Yes.

Ms MULLER: Yes.

The CHAIR: Thank you.

(The witnesses withdrew)

KYM AYSCOUGH, Executive Director Regulatory Operations, Australian Health Practitioner Regulation Agency, affirmed and examined

JAMIE ORCHARD, National Director Legal Services, Australian Health Practitioner Regulation Agency, affirmed and examined

JOHN SKERRITT, Deputy Secretary, Australian Department of Health, affirmed and examined

TRACEY DUFFY, Acting First Assistant Secretary, Australian Department of Health, sworn and examined

The CHAIR: Would any of you like to make a brief opening statement?

Ms AYSCOUGH: Thank you. I would take that opportunity. My name is Kym Ayscough. I am the Executive Director of Regulatory Operations for the Australian Health Practitioner Regulation Agency [AHPRA]. Joining me today is Dr Jamie Orchard, the National Director of Legal Services of AHPRA. In my role, I lead the team of AHPRA staff delivering our core regulatory functions from each of our capital city offices across the country. I am supported by a National Director for each of these core regulatory functions, including Dr Orchard who leads our legal team, as well as State and Territory Managers in each jurisdiction. AHPRA Chief Executive Officer Martin Fletcher made a written submission to this inquiry in April 2018. Mr Fletcher extends his apology that he was unable to appear before the Committee today. He is in Alice Springs for the meeting of the Council of Australian Governments' health council.

We recognise that the structure and operation of the National Registration and Accreditation Scheme for health professionals is complex. In a few minutes, with these opening remarks I would like to outline the role of AHPRA and the 15 national health profession boards and highlight a couple of key issues from our written submission. Together, AHPRA and the 15 national boards regulate health practitioners in 16 professional groups. Our primary role is public protection. We take a risk-based approach to regulation, which means taking action proportionate to the risks to public health and safety that are identified in the matters that we deal with.

For the regulated health professions, each national board sets out its expectations of good practice, ethical and professional conduct in published standards, codes and guidelines. These guidance documents also take into account the expectations of professional peers and the community. Codes of conduct generally require registered practitioners to practise within their scope of practice based on their education, knowledge, competence and lawful authority. Registered practitioners are also expected to be aware of, and comply with, any specific guidance issued by the board, such as the additional guidance on cosmetic procedures issued by the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Dental Board of Australia.

It is important to note—and I note from your prior evidence that you will be aware of this—that in New South Wales, complaints about a registered practitioner's conduct or performance are not managed by AHPRA or the national boards. They are managed by the Health Care Complaints Commission and the relevant New South Wales health professional council. However, in New South Wales, a breach of a national board's code of conduct may lead to the Health Care Complaints Commission or the relevant health council taking action against a registered practitioner on the grounds of professional misconduct or unprofessional conduct.

The Health Practitioner Regulation National Law does prescribe a number of offence provisions. Relevant to this inquiry, in New South Wales AHPRA receives, manages and, where appropriate, prosecutes those offences. There are offences that relate to unlawful use of protected titles. These are the titles reserved for use by those registered in the relevant professions and they are specified in the national law. That includes titles such as "medical practitioner", "nurse", "registered nurse", "dentist" et cetera.

Then there are offences that relate to holding out, that is making claims as to registration if you are not registered in a profession. There are a limited number of practice protections set out in the national law. They restrict to registered practitioners' acts, but they are dental acts, prescription of optical appliances and spinal manipulation. In March 2017, health Ministers agreed that new multi-year custodial sentences, increased fines and additional prohibition powers are needed for these holding out, title protection and restricted practice offences. These important reforms are to be fast-tracked.

The national law also regulates the advertising of regulated health services, making it an offence to advertise a regulated health service, including cosmetic procedures, in a way that is false, misleading or deceptive, offers inducements without terms and conditions, uses testimonials, creates an unreasonable expectation of beneficial treatment or directly or indirectly encourages indiscriminate or unnecessary use of regulated health services. AHPRA has not completed any prosecutions relating to cosmetic clinics in New South Wales. We have, however, completed a number of prosecutions for unlawful use of protected titles, unlawful claims as to registration and unlawful advertising, and details of those prosecutions were provided in our written submission.

As you can see, there is only a small overlap between our statutory role in health practitioner regulation and the broader scope of this inquiry into cosmetic health service complaints. Nonetheless, we recognise the importance of collaboration across national and local regulators and we have worked collaboratively with other co-regulators and other agencies in New South Wales to carry out search warrants and to ensure that appropriate regulatory force is utilised to address identified serious risk to the public. In recent years AHPRA has worked closely with the HCCC to ensure that complaints that are received by them about statutory offences are referred to AHPRA for investigation in a timely manner. This timely referral is critical because the Criminal Procedure Act in New South Wales mandates that any prosecution for a summary offence must commence within six months from the date of the alleged offence being committed.

AHPRA also participates in the consumer health regulators group, which was formally established in April 2017. This group is currently chaired by the Australian Competition and Consumer Commission. Members include the Private Health Insurance Ombudsman, the Therapeutic Goods Administration, NSW Health Care Complaints Commission, with the Department of Health participating as an observer. The group meets quarterly, or otherwise as required, to exchange information and to ensure responsibilities and functions of each regulator within the consumer health industry are understood and consistently applied. I hope these opening remarks have been of assistance to the Committee and welcome any questions you may have.

The CHAIR: Thank you very much. Obviously, we have heard a lot of evidence over the last day and a half with regards to confusion about the understanding and definition of the title of surgeon and I think all of us here are being led to believe that there is huge confusion not only in New South Wales but also nationally about the roles and rights and obligations and responsibilities and training of a surgeon. How is AHPRA working with other States in addition to New South Wales and what are AHPRA's suggestions about how this confusion relating to the terminology "surgeon" could be dealt with?

Ms AYSCOUGH: The way that the protection of title works under the legislation is that practitioners may be registered in a general registration category or hold specialist registration. In medical registration there are 23 fields of specialty practice, one of which is surgery, and associated with that field of specialty practice there are a number of restricted or protected titles. However, amongst those protected titles you will not find the title simply "surgeon" or "cosmetic surgeon". We are aware that government policy officers across the country have been meeting together to discuss the potential for expanding the list of protected titles including "surgeon" and "cosmetic surgeon". Those discussions are progressing and we also understand that there is a consultation paper likely to be released fairly soon which will invite comment about the potential for restricting those titles.

The CHAIR: Further to that, does AHPRA have a particular position on the term "surgeon" and does AHPRA believe that it should be added to that protected titles list?

Ms AYSCOUGH: AHPRA has been involved with the government policy officers discussing that question and looks forward to the consultation.

The CHAIR: You mentioned in your opening statement deceptive or misleading advertisement. Again, we have had extensive evidence about patient expectation based on advertising that is being conducted here in New South Wales. I think you mentioned before–correct me if I am wrong—that there were no prosecutions with regards to advertising under AHPRA with regards to cosmetic services in New South Wales. Is that correct?

Ms AYSCOUGH: No prosecutions relating to cosmetic clinics, that is correct.

The CHAIR: Are there any ongoing investigations with regards to advertising with regards to cosmetic clinics?

Dr ORCHARD We have a number of investigations on foot in New South Wales that could broadly be referred to as relating to cosmetic-related issues—some might relate to holding out, some might relate to use of titles—but I do not have the data in front of us in respect to whether any of those particular investigations relate to advertising.

The CHAIR: Could I request that you table the details about how many investigations are ongoing in New South Wales with regards to advertising and complaints that could be before AHPRA at this stage? I think it would be beneficial to the Committee if we had an idea of what those sorts of numbers were if they exist at this time.

Ms KATE WASHINGTON: Could I suggest that not just be in relation to advertising but in relation to holding out and other—

The CHAIR: If we could have that information provided to the Committee it would be very valuable for us.

Ms KATE WASHINGTON: I am going to refer to a submission that we heard evidence on earlier today from Dr Molton from the Cosmetic Physicians College of Australasia. In his personal submission to this inquiry he said that "the public is entitled to believe that they are protected by regulatory bodies such as AHPRA and the TGA, yet this is far from the case". Have you got concerns around the way that AHPRA is currently being perceived in the sector, the ways it is being effective and are there things that could be done at a regulatory level to make AHPRA's role more effective so that more consumers are protected in the cosmetic services industry?

Ms AYSCOUGH: I think that is potentially a very broad question.

Ms KATE WASHINGTON: It is.

Ms AYSCOUGH: As a health practitioner regulator we work within the statutory framework of the Health Practitioner Regulation National Law. I think that it is probably reasonable to say that all regulators continue to seek opportunities to make the existence of the regulatory scheme known to members of the public and to make it accessible to members of the public and we certainly have continuous streams of work underway to improve the visibility of the regulatory scheme and to improve the ease of access for members of the community who have concerns they want to raise with us as a regulator.

The Hon. WALT SECORD: I just want to make sure that I am correct. In your earlier evidence you said there were no prosecutions in New South Wales relating to cosmetic surgery.

Ms AYSCOUGH: That is prosecutions for the title protection offences, holding out and advertising, which are the statutory offences for which we are responsible in New South Wales.

The Hon. WALT SECORD: So none in New South Wales—zero?

Ms AYSCOUGH: Since the commencement of the national scheme in 2010.

The Hon. WALT SECORD: So you could understand why we have received representations and correspondence from the community saying that there is disquiet about pursuing or successfully pursuing medical practitioners who have been found to have done the wrong thing if you had zero for an eight-year period.

Ms AYSCOUGH: If I could just confirm my earlier statement that in New South Wales AHPRA has no role in regulating the conduct or performance of registered health practitioners including medical practitioners. That is within the jurisdiction of the Health Care Complaints Commission and the Medical Council of New South Wales for medical practitioners. Our opportunity to be involved in the regulation of conduct in New South Wales is limited to prosecuting those statutory offences.

The Hon. WALT SECORD: So, if, in fact, "cosmetic surgeon" became a protected title, would you then have involvement in activity in New South Wales?

Ms AYSCOUGH: If the title "cosmetic surgeon" was a protected title and was being used by a person who was not entitled to use that title then we would have the jurisdiction, under the national law, to prosecute an offence, in the local court for the use of that title.

The Hon. WALT SECORD: Thank you, you answered my question.

The Hon. LOU AMATO: Thank you all for coming. Has there been an increase in the number of unapproved and unregistered and counterfeit therapeutic goods in the cosmetic industry? Are these kinds of goods usually imported from overseas or are they produced locally? Is it mostly registered or unregistered practitioners involved in this kind of activity?

Professor SKERRITT: If I may, I would like to indulge in an opening statement and then return to the honourable member's question. I am Deputy Secretary of the Commonwealth Department of Health. One of my main line responsibilities is the Therapeutic Goods Administration [TGA]. My colleague Tracey Duffy is Acting First Assistant Secretary, which encompasses medical devices. These products are devices, not medicines. I will explain that in a minute.

TGA regulates import, export, manufacture and supply of therapeutic goods, medicines, devices, biological supply products, cells and tissues within Australia. So we are a product regulator. Our role in that sense complements the practice regulators that you have received testimony from this morning. Substances like collagen or hyaluronic acid, polyacrylamide or poly-L-lactic acid—these dermal fillers—even though they are listed as prescription medicines in the poison standard, in regulation are treated as devices. The reason for that is that they exert their action by physical means—they puff out the skin; they have bulk—rather than acting as a medicine on the cells and tissues of the body. That may sound like hair-splitting but it has implications for how they are regulated now and how they were regulated in the past.

All of the products that are able to be legally supplied in Australia have to be on the Australian Register of Therapeutic Goods. They go through an evaluation process and they are, generally, so-called class 3 medical devices. On the register they have a unique product identifier. That register is publicly searchable. So someone—a member of the public or a healthcare professional—can see if the product is a legally registered product in Australia. We have taken a number of actions in concert with partners. We heard about the consumer health regulators group from our colleagues a minute ago. We are active members of that. Over the last 12 months we have established a cosmetic industry regulatory compliance plan. Because of the number of issues with products and with practice—although our role is with products—that have risen to the surface and the number of adverse events—

The Hon. LOU AMATO: Could you elucidate the issues? What issues?

Professor SKERRITT: What issues does this group cover and what is covered in the compliance plan? Four broad things. First of all we wanted to look at the way that products are regulated and whether improvements to the regulatory system were possible. They were. I will return to them. Second was regulatory compliance—to launch a range of compliance actions, again in conjunction with other bodies, including the police, Border Force and AHPRA. The others are advertising compliance and education.

Those are the four broad themes. We have strengthened the regulations in the last 12 months in a number of ways. Firstly, we have brought in a requirement that even though these products are devices they have to have medicine-like labelling that says that it is a prescription medicine and that it has to be kept out of the reach of children. It also gives a very strong signal to doctors and nurses about whether or not it is an officially approved product. That answers your earlier question.

Secondly, we have developed guidance documents for industry as to how these products have to comply with the legal requirements—a thing known as the poison standard. We have also written to individual companies in Australia who are, in our terms, the sponsors—the companies legally responsible for providing those products. Some of the other regulatory changes we have made were to clarify. There was a bit of a loophole with one of the major fillers. If it was used for tissue augmentation it was a prescription medicine but not for other reasons. We have just said that if it is injectable it now has to be treated as a prescription medicine. That tightens the regulatory oversight of that product.

Finally, there was a change in regulations that came in earlier. From December this year any new devices that are coming in as dermal fillers have to have a patient leaflet. From 2021 there will have to be cards for implants—in other words information provided to the patient saying, "You have received a dermal filler. Here are some of the potential risks." That will be for both existing products and new products. Those are changes to the Medical Devices Regulatory Scheme. We have also undertaken a number of compliance activities. I am not at liberty to give a lot of details because some of those may end up being before the courts. We have conducted 10 what I would call, euphemistically, "regulatory visits". It is not the sort of visit you would like to have!

The Hon. WALT SECORD: Would you call them raids?

Professor SKERRITT: You may call them that, Mr Secord. That has been done together with members of the Australian Border Force and with other authorities, including with Police.

The CHAIR: Can I clarify? Those 10 visits, are they in New South Wales alone or is that nationally?

Professor SKERRITT: They have been in New South Wales. We are talking about the need for them in at least two other states, although, for whatever reason, from our intelligence there seems to be a majority of activity in New South Wales. But it is not limited to New South Wales. I guess New South Wales is the State of the beautiful. Apart from that, we have issued 31 warning letters. These figures are a little bit out of date—they are of last month. We have also, together with Border Force, destroyed 689 items that have come in through mail and courier services. Because of legal requirements we have sent 280 of those items back to where they came from.

A key part of this is therefore working with Border Force to intercept products that are not appropriate and are not appropriately approved as medicines. The other thing that Border Force is doing is profiling certain incoming passengers. So if you are a beauty therapist from Taiwan and you just happen to have visited Australia three times for extended periods in the last year, you might—as you seen on the TV shows—be pulled aside for an interview. And, you never know, you might get the contents of your suitcase looked at. Finally, we have just obtained new compliance powers over advertising of therapeutic goods—as of 1 July. We have also become the sole source of management of advertising complaints.

I do not have figures about what we have received since 1 July in the area of advertising complaints but prior to that, when we had a lesser role in advertising, we did send out letters—133 obligations notices—to

organisations that were inappropriately advertising prescription cosmetic products. We have essentially asked them to no longer advertise a product by name. For example, you can say, "We are a cosmetic centre," but you cannot say, by name, "We provide botox." I just use that as an example—hyaluronic acid. You can say what service you provide in general terms but you cannot advertise particular prescription products. In the same way, you cannot advertise, "I am a doctor and I provide Viagra." So we have sent notices out—essentially, cease and desist—and then we monitor. It appears that the companies have got the message. We have followed that up with fact sheets and—

The CHAIR: Sorry to interrupt. Can I confirm, were those 130-plus compliance letters that you sent just for New South Wales?

Professor SKERRITT: No, that was Australia wide. Finally, we have a range of education activities—twitter feeds, Facebook posts, fact sheets and so forth.

The Hon. LOU AMATO: Has there been an increase in the number of unapproved, unregistered and counterfeit therapeutic goods in the cosmetic industry? Has there been an increase, overall?

Professor SKERRITT: We have detected more. I guess the challenge is that until we developed a closer relationship with Border Force, you do not know what you do not know. We do not have an idea. I cannot say, "With Border Force, in 2010, we found this many and, in 2011, we found that many", because it has really only been over the past 12 months we have ramped up a specific focus with Border Force on this particular product, along with other targeted groups of products. I cannot comment whether it is an increase or not. What I can comment is that they are quite common products that are picked up as illegally imported.

The Hon. LOU AMATO: The bulk of it is usually imported, is it?

Professor SKERRITT: The evidence on the products that are coming in are illegal imports. Depending on the jurisdiction, if they are locally manufactured illegal products it is the jurisdiction of New South Wales Ministry of Health. It does seem, however, there is often some relationship between inappropriate clinics and inappropriately and illegally imported products. We have a register of all the products that are officially and legally allowed to be provided in Australia.

The Hon. LOU AMATO: If they are illegal, are they mainly going to unregistered practitioners in the cosmetic industry?

Professor SKERRITT: We do not keep records and we do not have any legal powers to keep records of who is purchasing those products. However, it is an offence in law for a prescription medicine to be provided by someone who is not authorised to do so.

The Hon. LOU AMATO: It may be of interest to have that on a system so you can target those certain areas?

Professor SKERRITT: The targeting would be when there has been visits—

The Hon. LOU AMATO: By law enforcement?

Professor SKERRITT: We have had visits to clinics and we have found in some of these visits, to use that word, that there have been prescription medicines but no evidence of an authorised practitioner providing those. That is where the State regulatory system comes into play because the State is the regulator of medical practice.

Mr AUSTIN EVANS: A lot of the evidence over the past couple of days has been around terminology, specifically cosmetic surgeon and, to a lesser extent, cosmetic nurse. One of the reasons given as to why that cannot be used is because it is not a therapeutic service. Do you see that as a problem for introducing or regulating that term, or is that a bit of a furphy?

Ms AYSCOUGH: The primary thing for us to reflect on is, as I said, that we operate under the Health Practitioner Regulation National Law, which has as its foundation the protection of the public in the access of health services. I can understand why there has been some evidence that suggests that might be a challenge. In respect of the sorts of things that are required to lead to both specialty practice and the restriction of title, you need to be looking at a framework that provides for accreditation standards for education, registration standards and eligibility requirements for admission to the specialty practice area, professional standards that define the requirements for practice and competency of practitioners, professional standards that define the minimum standards of behavioural conduct and then any additional requirements for practitioners in advanced areas, such as for the use of scheduled medicines.

Mr AUSTIN EVANS: Is that an impediment or is it not too difficult to get around?

Ms AYSCOUGH: If the intention were to protect a new title under the national law, then there would need to be a link to that registration requirement, which requires the framework I have just outlined, for the creation of a new area of specialty practice, if we were talking about cosmetic surgery, because that is not currently an area of registered specialty practice. The protection of the title flows, as I think I indicated earlier, from the registration type. The structure under the national law is that there are a number of areas of specialty practice and the titles associated with those specialties are those that are protected under the national law.

Mr AUSTIN EVANS: It strikes me as strange that we are struggling to protect those titles when we are protecting a Chinese medicine practitioner and some of those that seem a bit more obscure to me.

Ms AYSCOUGH: The profession of Chinese medicine is one that is regulated under the national law. It is not a component of medical registration.

Mr AUSTIN EVANS: Okay.

Ms AYSCOUGH: There is a Chinese Medicine Board of Australia, and they register Chinese medicine practitioners. It is not a specialty within the purview of the medical board.

The Hon. MARK PEARSON: The regulatory agency also oversees advertising, the practitioners, their websites, and the way they communicate what they offer the community. Is that correct?

Ms AYSCOUGH: Yes. The Health Practitioner Regulation National Law includes some provisions that limit the approach to advertising of regulated health services, and AHPRA has the jurisdiction to prosecute offences.

The Hon. MARK PEARSON: Do you investigate as to whether the advertising might be misleading or deceptive?

Ms AYSCOUGH: That is one of the bases on which we could prosecute a person, the way they advertise a regulated health service.

The Hon. MARK PEARSON: Would you refer anything to the ACCC, or would you take up an investigation yourself with a view to prosecution?

Ms AYSCOUGH: We work collaboratively with other agencies, including the ACCC. We have different powers, and one of the advantages of these multi-regulator forums is to understand the different powers of each regulator and which would be most appropriate to bring into play to most effectively protect the public.

The Hon. MARK PEARSON: You mentioned that there was a six-month limitation that if there was evidence gathered and an investigation put in place, that the prosecution must take place within six months once the investigation started. Is that statute of limitations a limitation?

Ms AYSCOUGH: Yes, it is. It is a statutory limitation in New South Wales, which requires that any summary offence, which these offence provisions in the national law are, requires that the proceedings be commenced within six months of the offending being identified.

The Hon. MARK PEARSON: Has it been recommended to be extended to 12 months or two years?

Ms AYSCOUGH: There have been discussions at the Council of Australian Governments' Health Council around the question of limitation periods which vary between the States and Territories.

Mr AUSTIN EVANS: You said "identified". It is from when the offence is identified, not from when it occurs?

Dr ORCHARD: From when the offence occurs through to when charges are filed it is a six-month period. It is six months from when the offence occurs or is alleged to have occurred to filing the charges. It is in the Criminal Procedure Act of New South Wales.

The Hon. MARK PEARSON: Considering that cosmetic surgery or procedures are proliferating, and it is obviously in question, which is why we are here, is there a mechanism, whether it is flagged, that certain practices need to be investigated proactively rather than waiting for a complaint?

Ms AYSCOUGH: In the structure of the legislation that we work under, we are primarily responding to issues of complaint and I need to be clear, too, that we regulate individual registered practitioners, not practices. If you mean practice as in the place at which people provide a service—

The Hon. MARK PEARSON: If it came to the regulatory authority that that practitioner is now involved in suspicious practises or that are questionable, would that flag a more proactive investigation of the practitioner than responding to a complaint?

Ms AYSCOUGH: Outside of New South Wales we deal with concerns about registered health practitioners. In New South Wales, questions are best addressed to the Health Care Complaints Commission and the Medical Council or Nursing and Midwifery Council, depending on the profession.

The Hon. MARK PEARSON: But they would only respond to a complaint, would they not?

Ms AYSCOUGH: From the perspective of the national boards, you will have seen in evidence and it is certainly referenced in our submission that the approach from the national boards is that they are able to promulgate guidance to members of the registered professions, and they certainly do that when specific aspects of practice are raised as a concern, and hence the existence of specific guidance from the Medical Board of Australia, for example, to registered practitioners involved in cosmetic procedures. Their primary regulatory tools are the promulgation of standards, codes and guidelines to the registered professions, as well as responding to complaints about conduct and performance.

The Hon. MARK PEARSON: Has it become a concern at all to your regulatory authority that cosmetic surgery and practices are proliferating? Has it been discussed as a concern in itself?

Ms AYSCOUGH: As I have indicated, the concern for the relevant boards has been to understand the role played by registered practitioners in the delivery of these services and to understand what is required to ensure that the involvement of a registered practitioner does not give rise to risk of harm to the public.

Ms KATE WASHINGTON: Today the Committee heard evidence about a flourishing black market, particularly within multicultural groups in New South Wales, and presumably it straddles the Therapeutic Goods Administration [TGA] and AHPRA's remit in terms of advertising and products being used. It is being promulgated through WeChat and all sorts of other social media channels. Is there a role for the HCCC in that space as well or is this purely your territory? How do we better protect individuals who are seeking services through these kinds of conduits?

Professor SKERRITT: There are really two issues here; there is the service and whether it is an appropriately approved service, (practitioner), and the products they use. We are doing a little bit of work. We could do more and it is always up against other areas of pressure but we are doing a little bit of work, especially with the Australian Border Force on products that are coming in to support some of these services. If we identify through foreign language or social media or through a street address in suburban Gladesville every week getting boxes of stuff, and they are not just Amazon fans, they are getting all their stuff, it starts to build an intelligence pattern that perhaps something is a little bit awry. That is some of the work that we have been doing, together with Border Force.

Where there has been potential practitioners involved, the relevant State authority has been notified as well. In some cases there has also been interaction with the NSW Police. Clearly, there is, as we heard earlier today, a significant line among certain expatriate and immigrant communities and short-term immigrants, of cosmetic services, and they are often accompanied by use of unapproved product, because frankly they are a lot cheaper. You can even go to a website today and purchase from Korea or China or Vietnam, a number of these products for a fraction of the price that they would be available through the appropriate sources here in Sydney.

The Hon. WALT SECORD: Are you referring to people buying cheap, substandard lasers and things such as that?

Professor SKERRITT: I was talking about cosmetic products themselves. I do not know if my colleague wants to talk about lasers and some of the work that has been done with laser devices. There is a bigger challenge with a whole lot of medical devices and medicines being brought in illegally. We actually have an intelligence team in-house. A lot of these people have come from organisations I cannot mention, with a background in intelligence and they look at both the official web and the dark web and other sources of intel for the activities of some of these groups.

Ms DUFFY: Certainly though the question of lasers is a bit complex as well because it does depend on what the instructions for use and the intended purpose is and there are many lasers that do not have a therapeutic use listed on their labels but are being used.

The Hon. WALT SECORD: What could you use a laser for?

Ms DUFFY: You can use lasers for all types of treatments. We only regulate the lasers that have an intended use for therapeutic purposes and they are the ones that we assess and place on the therapeutic register as an approved good. Those other lasers, they do not apply to the TGA for registration.

The CHAIR: Can I clarify, you would be monitoring the import of such a product potentially to target misuse of it?

Professor SKERRITT: It is very hard. It is the same as anything, you can take it home and do what you want with it. It is very hard to allege misuse of a product up-front.

The Hon. WALT SECORD: What else could you use a laser for other than to remove hair or a tattoo? What else could you possibly use a laser for?

Professor SKERRITT: Some processes that are purely cosmetic in nature are not considered medical or therapeutic. For example, cosmetics are not therapeutic goods, even though they can make claims such as moisturising and so forth. Of course, lasers are used for a whole lot of other things, such as cleaning and workshop, electronic purposes and so forth. As a result, it is often hard when a product ostensibly manufactured for one purpose is used illegally for a medical purpose.

The CHAIR: You are identifying illegal products being imported into the country, can I clarify that the visits you have made are to registered organisations procuring illegal product and then utilising it without the appropriate authority to do so?

Professor SKERRITT: We have interest in both. Our intelligence people, together with Border Force, do visit registered healthcare professionals. For example, in some areas, not necessarily this one, we visited pharmacists who have cut corners and decided to use unapproved products. My understanding in this area—again because charges may be pending I do not have too much information to divulge—there have been visits to both registered facilities and facilities that appear to be operating without any registered healthcare professionals.

The CHAIR: Can I confirm, if you are making such a visit do you also notify the HCCC in advance of such a visit or post that visit, depending on the outcome, especially if it is a registered practitioner?

Professor SKERRITT: We generally do it together with the HCCC. There are different powers of entry. If my memory serves me right, in New South Wales the NSW Health Ministry and its subsidiary bodies can actually enter a facility without a warrant. We usually would have to obtain a warrant to make an unapproved entry to a facility. We are often doing that in joint visits. Of course, Border Force have their own set of powers for making entries.

The CHAIR: As the HCCC is the regulatory body in this State, they are notified of someone in breach?

Professor SKERRITT: Yes. We work very closely with them. As my colleagues here have said, we have a working group that involves them, involves us, involves the other parties, and we do a lot of sharing of intelligence and that intelligence is also shared with Border Force where it relates to importation of product or it relates to people coming in and out.

The CHAIR: Thank you all for appearing before the Committee today. We may send you some additional questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide written replies to any further questions from the Committee?

Professor SKERRITT: Yes.

(The witnesses withdrew)

(Luncheon adjournment)

KERRY CHANT, Chief Health Officer and Deputy Secretary Population Health, NSW Health, affirmed and examined

LEANNE O'SHANNESSY, Executive Director, Legal and Regulatory Services, NSW Health, sworn and examined

BRUCE BATTYE, Deputy Chief Pharmacist and Director Pharmaceutical Regulatory Unit, NSW Health, sworn and examined

ROSE WEBB, Commissioner, NSW Fair Trading, affirmed and examined

VALERIE GRISWOLD, Executive Director, NSW Fair Trading Operations, NSW Fair Trading, affirmed and examined

MARCEL SAVARY, Director, Regulatory Policy, NSW Fair Trading, affirmed and examined

The CHAIR: Good afternoon everyone and thank you for joining us. Before we proceed, do any of you have any questions about today's proceedings?

Dr CHANT: No, thank you.

The CHAIR: Would any of you like to make a short opening statement before we begin our questions?

Dr CHANT: I would be happy to make a short opening statement and then Ms Webb might take a few moments to talk to that. The rapid and ongoing evolution of the cosmetic health services industry presents a range of regulatory challenges. The industry itself is expansive including major surgical procedures through to minor procedures such as cosmetic mole removal and botulinum toxin injections. Unlike many other traditional health services, the cosmetic health industry brings health products and services into a more retail environment.

Cosmetic health services and cosmetic health service providers are subject to regulation by a number of different State and national agencies. The decision to have a cosmetic health procedure is a matter of personal choice, but from a health perspective the overall regulatory scheme is largely focused on minimising the health risks associated with cosmetic health procedures and ensuring that people are fully and properly informed about the nature of the procedure, the range of possible outcomes of the procedure, and the risks and possible complications of cosmetic health products and services, both immediate and long term.

New South Wales Health is responsible for regulating the premises at which certain cosmetic surgeries and skin penetration procedures are provided. The Poisons and Therapeutic Goods Act 1966 applies to many of the drugs used in cosmetic procedures, such as botulinum toxin and dermal fillers. Registered health practitioners are regulated under the Health Practitioner Regulation National Law, and standards, codes and guidelines issued by the national professional boards. In 2016 the Medical Board of Australia published guidelines for medical practitioners undertaking cosmetic procedures and surgeries. These guidelines can be used in disciplinary procedures as evidence of what constitutes appropriate professional conduct for medical practitioners.

In relation to unregistered health practitioners and also registered health practitioners acting outside their scope of practice, they must comply with the Code of Conduct for non-registered health practitioners in the New South Wales Public Health Regulation 2012. Complaints about the Code of Conduct are managed by the Health Care Complaints Commission [HCCC], which can issue a prohibition order against practitioners who breach the Code. NSW Health works closely with other State and national agencies, particularly the HCCC, NSW Fair Trading, and the Therapeutic Goods Administration. A number of steps have been taken in recent years to strengthen our regulatory approach. For example, we have made it an offence to conduct an unlicensed private health facility at which certain cosmetic surgical procedures, such as breast augmentation and vaginoplasty, are performed. We also have increased our regulatory compliance activities in respect of drugs used in cosmetic health services.

In November 2017 the NSW Health Minister raised the issue of protecting the title of "cosmetic surgeon" with the Council of Australian Governments [COAG] Health Council. We expect the COAG Health Council to shortly release a discussion paper canvassing among other things this issue. NSW Health is progressing regulatory amendments to make it an offence for medical practitioners to perform cosmetic surgical procedures in an unlicensed private health facility. We are also currently considering options available for tightening the regulations around botulinum toxin injections and hyaluronic acid. We will be commencing public consultation regarding these changes very shortly.

NSW Health has taken opportunities through the media to inform the community of the risks associated with cosmetic procedures and to provide advice to consumers of cosmetic health services. In particular, we have

referred consumers to the advice and public warnings issued by the HCCC. I acknowledge that ongoing engagement with consumers and the health profession is required. I look forward to the outcomes and findings of this inquiry. I wish to table two diagrams that may assist with the discussions this afternoon, but I am happy to defer that until Ms Webb makes a few comments.

Ms WEBB: As Dr Chant has already mentioned, Fair Trading works with other specialist regulatory regimes and cooperates with the other regulators on the issue of cosmetic health services. Consumers of beauty and cosmetic services do have certain rights and protections under the Australian Consumer Law as well as the health laws that have already been mentioned. We think it is important that consumers understand these rights and that businesses understand their obligations. Broadly the consumer law protects consumers by prohibiting misleading and deceptive conduct, for example, where a business claims it has no responsibility for loss or damage, false or misleading claims or advertising and unconscionable conduct and unsolicited sales practices.

The Australian Consumer Law also gives consumers who buy a beauty or cosmetic service certain guarantees that the service will be provided with due care and skill, is reasonably fit for the purpose that is specified by the consumer and is provided within a reasonable time. These consumer guarantees can be privately enforced by seeking a refund from the business or taking action through the NSW Civil and Administrative Tribunal.

NSW Fair Trading is actively helping consumers seek redress and also to educate the community so that consumers can make informed choices and businesses understand their obligations. We will shortly be launching an education campaign to help consumers and beauty industry operators to understand their rights and responsibilities. I have a few of the publications that have not yet quite been lodged, but I can share those with the Committee. We are doing them in Thai, Korean, Mandarin and English. We also have a fact sheet so that consumers can understand what their rights may be.

We are working collaboratively with NSW Health and the Health Care Complaints Commission in taking action. For example, on this education campaign we had very helpful input to our material from both NSW Health and the Health Care Complaints Commission. We are also making sure that our complaint handling procedure for sharing or referring complaints to each other is working well. We recently worked closely with NSW Health to issue a public warning about imported cosmetic eye liner that contained a large proportion of lead. Our investigators work closely with NSW Health on a number of similar issues.

We at Fair Trading are the generic consumer regulator and our objective is to help consumers across the whole of the New South Wales economy. There are issues that arise that require specialist expertise, particularly where issues arising in a sector are subject to a specific regulation or a dedicated oversight body, such as specifically health or medical services, we would generally refer them to a specialist regulator. However, we are always happy to work with that regulator in resolving such complex issues. Generally health regulation might be the most effective regime for some of the specific issues arising in this sector but Fair Trading will continue to work with the Health Care Complaints Commission and NSW Health to ensure that consumers are protected.

The CHAIR: Dr Chant, in the past few days it has been raised very clear to the Committee that the term "cosmetic surgeon" causes confusion. I know the Minister for Health has also raised this issue publicly and also with yourself. The Minister has outlined that he has concerns about the term "cosmetic surgeon" and its clarification. What is the position of NSW Health in relation to a cosmetic surgeon? It has been made abundantly clear to this Committee and by the Minister that there is concern about that.

Dr CHANT: Our position is that we support the position proposed by the Minister that this issue is looked at and that consumers have the ability to easily discern the qualifications of people undertaking the procedures. I can also update the Committee that we do believe that a discussion paper will be released very shortly and it does cover the issues such as the protection of title of "surgeon" and "cosmetic surgeon" and reporting of professional negligence settlements and judgements and also a complaints history register. So other issues that go to how consumers can be better informed about the qualifications of the people undertaking the procedure as well as their complaints history, that is outside our control to provide that to the Committee. But I understand that is due to be released shortly and we would be happy to alert the Committee when that document is released.

The CHAIR: Evidence given to the Committee yesterday outlined that some States are obviously on board with having a uniform description of "cosmetic surgeon". Is the position of NSW Health that we agree that New South Wales, Queensland, Victoria had already had the discussions at COAG, I think it was, whereby there was a drive to make it uniform across the nation rather one or two States going it alone. Is that correct?

Dr CHANT: Our position is that we support it nationally. As we have moved to a national registration and regulation system around registered health practitioners it is appropriate that this happens nationally. Our

Minister put it on the COAG agenda and it was discussed, I believe, in November 2017. The work I am discussing now is the product of that which is basically a discussion paper that will need to go out which canvasses all the issues to inform the next steps in moving that forward. That is under AHMAC that is leading that piece of work. We are happy to alert it to the Committee but we do believe that that is to be released very, very shortly.

The Hon. MARK PEARSON: Dr Chant, you said it is now an offence for a practitioner to operate in an unlicensed facility. Is that fairly recent?

Dr CHANT: What I am referring to there is that in 2016, which came into effect in 2017, there was a requirement that certain procedures were undertaken in a licensed facility. That took a different approach than previously the threshold was around general anaesthetic greater than conscious sedation. If you look into the table that I have provided, in terms of highest risk procedures in the second one where we look at the risk of cosmetic procedures, it used to be that they are only procedures that require general anaesthetic or less than conscious sedation.

We recognised, as a consequence of some events, that potentially there was behaviour where they were using inappropriately other forms of sedation to avoid undertaking any licensing procedures. We then constructed a list which we will continue to look at, but at the moment it contains things like breast augmentation, vaginoplasty, tummy tucks, liposuction over a certain volume and, as I said, we will continue to monitor that. The premise for that is that it is recognised that those procedures should be done in a licensed facility. That provides the greatest assurance to consumers because as part of licensing those facilities we look at the structure of the facility as well as the nature of clinical governance as well as back-up procedures in terms of emergency response. I do not know if Ms O'Shannessy wants to comment.

Ms O'SHANNESSY: Running or establishing a cosmetic class of private health facility was the first step in 2016 and it is an offence attracting a penalty of $550,000 to run an unlicensed premise and to do those procedures in unlicensed premises. More recently, in May this year, we passed another law which will make it a penalty for a practitioner to perform what we would call a prescribed procedure in an unlicensed facility. So it is like the bookend of the other side; it is illegal to run a facility and it will be illegal to perform a procedure in a facility. The penalty will be $55,000 and we are going through a process at the moment of identifying the procedures. My feeling is it will be, at the least, the same procedures that we require to be done in a licensed premise.

The Hon. MARK PEARSON: In the education material is it going to be mandatory for that material to be very available and maybe promoted at clinics?

Ms WEBB: We do not have a power to make it mandatory for people to disclose this material. We will be doing our best to make sure it is generally available.

The Hon. MARK PEARSON: Could we recommend that you had that power?

Ms WEBB: I guess you could think about whether there was some option before a person undertook a particular procedure, that they were given certain information. It might not be this particular material but we do have information standards in some parts of the law at the moment, so there could be an option there.

The Hon. MARK PEARSON: But at the moment they do not apply to cosmetic procedures?

Ms WEBB: To cosmetic or beauty procedures at the moment. But I think that is sort of the part of the law that you would look to if you were thinking about some sort of mandatory disclosure.

Dr CHANT: In relation to cosmetic procedures done by medical practitioners, I referenced in my opening statement a guideline document and that has clear information around the nature of the information that should be provided as well as specifications for cooling-off periods that are required. There is a requirement outlined and, as I indicated, failure to comply with those standards will be considered if there were complaints in terms of whether the doctor or medical practitioner has acted with professional misconduct.

Ms O'SHANNESSY: I think the representatives from AHPRA basically took the Committee through that this morning too, as I recall.

The Hon. MARK PEARSON: Yes, that was one part of it.

Mr AUSTIN EVANS: Over the last couple of days we have heard a lot of comments that people making use of these services tend to have some degree of embarrassment or concern about that being public and it seems to be affecting their lodging of complaints following through all those sorts of things. Both for Fair Trading and for the Department of Health, how do you factor that in, how do you allow for that? Are there ways you can compensate for that when you are dealing with how people can go through the process of lodging complaints about services?

Dr CHANT: I think you are raising very important issues. We do attempt to consider that. Some of the ways in which we potentially consider making it easier to complain is through accepting anonymous complaints, and although that limits what we can actually do, sometimes that can give us actionable intelligence or a pattern of behaviour. We can also highlight the role of consumer groups and point people towards advocacy groups that potentially have the skills in terms of knowing how to navigate the complaints system and support people through that. I think the language issue—it is pleasing to see that Fair Trading is doing it in multiple languages, because I think language can sometimes be a barrier.

We need to use very much plain English on our websites and information. We also need to be realistic about what we can do. I think the regulatory environment is quite challenging, so we also need to help people navigate whether it is around false and misleading conduct or whether they are talking about a medical practitioner who they think has breached their duty of care. They require very different pathways and I can imagine that people are very confused about that. So I think we can do better at helping people navigate that, but I do not think there is one silver bullet for that and I think it is something we need to be incredibly thoughtful about. I think the profession also has a key role. In some of our media and communications we have also very much raised the role of the general practitioner. I note that there is a requirement for a cooling-off period for many of the more high-end procedures and we would really encourage people to discuss it with their general practitioner as someone who can potentially work through those issues and support them.

Ms WEBB: I totally agree with everything Dr Chant said, but I thought I would add one more thing that we are looking at doing because it is correct that people are reticent to complain and also the language is a barrier. We are having a look at what we can do to look at social media in other languages where people may post concerns that they have had about a practitioner, not realising that they should come to somewhere like Fair Trading. We are just starting to do a little bit of proactive searching out to get some more intelligence about what is going on through potentially language social media sites that may raise some sorts of issues like this.

The Hon. LOU AMATO: Are the powers and functions of the HCCC, NSW Health and Fair Trading sufficient enough to regulate the cosmetic health services practitioners? Are there any gaps in regulation or resources to check compliance and deal with prosecutions?

Ms WEBB: No, I do not see the issue so much as gaps in the legislation or the resources. I think, as we have already mentioned, it is possibly the issue about identifying who is best to deal with which particular issue and making sure that consumers are directed to the right person in the right circumstance. So there is some work to be done in just making sure we are coordinating well. In terms of particular legislative changes, I think from our perspective the Australian Consumer Law is quite broad-ranging and wide-ranging and is probably in itself sufficient to cover the field.

Dr CHANT: I am looking forward to the discussion paper that is coming up from AHMAC around the protections of the titles and the dissection of some of those related issues. Clearly we have identified that we are currently taking some additional steps to strengthen it. I look forward to the outcomes of this Committee because I think we need to continue to monitor the risks and benefits and harms that are occurring in this sector and ensure that our regulatory response is appropriate to that. Regulation is one dimension but I think we cannot underestimate the importance of skilling up our consumers, but also working with our health professionals for them to better understand their responsibilities under registration and their ethical obligations.

The Hon. LOU AMATO: In regards to regulation, obviously there are some sectors there, I believe some of it is probably from the Asian community—is that message being delivered in a language so that they understand the ramifications of not following regulatory procedures?

Ms WEBB: Yes. We are cognisant that our task is not to just work with the consumer sector but also to work with businesses and to explain to businesses their obligations. We do a lot of work with language communities already and we are adding this beauty industry into our activity. I think I have got some figures here about—

The Hon. LOU AMATO: I am glad you brought that up because in some instances the two are very closely tied together.

Ms WEBB: I think that is right. Having people who are consumers ask the right questions of the person they are getting the service from is part of the answer, but also just making sure that the people who are providing the service are aware of their duties and obligations and the consequences if they are not complying with them.

Mr MARK TAYLOR: Following on from your last answer, there are some industries though that Fair Trading investigates—whether high pressure selling, imitation products or unlicensed providers. Is it your underlying feeling that in the instance of cosmetic procedures it is about education?

Ms WEBB: We have to be clear about the full spectrum of things that we are talking about. If it is at the high-risk cosmetic surgery actual medical intervention then I think there are a whole lot of licensing regimes which Dr Chant has already talked about, but it is possibly more at the other end of the spectrum where it is a beauty treatment that has some potential to cause issues for consumers on which we would be focusing. At that level licensing may not be the answer because it is a very flexible, fast moving sector.

In many cases the people providing these services may also be hairdressers and other similar sorts of things. From our perspective the Australian Consumer Law has protections against things like unconscionable conduct—there have been some cases taken where it has been seen as unconscionable to sell these types of services to vulnerable people—and that could be one answer. So there are quite a lot of options within the consumer law as it is without specifically requiring some sort of harsher or more expensive regulatory regimes such as licensing.

Mr MARK TAYLOR: There was commentary in some previous evidence about people going in for rectification or a second trip to a clinic who were being provided with legal liability exemption forms cutting out their options for legal recourse. Have you come across those experiences?

Ms WEBB: I do not know whether we have had that actual experience but it does sound to me like it is potentially misleading and deceptive to tell someone that they have to give up their legal rights in order to receive a product or a service.

Ms KATE WASHINGTON: They are being asked to sign deeds of release.

Mr MARK TAYLOR: That is the term I was looking for, thank you.

Ms O'SHANNESSY: Can I just say, as I recall the evidence was that they are of limited value. It is more the impact it has on the individual feeling that thereafter they cannot, which I think goes to what Ms Webb was saying.

Ms KATE WASHINGTON: I have been looking at the material produced by Fair Trading. In the last couple of days there has been a lot of discussion about the importance of this being considered a health procedure and for people to be considered as patients, not clients. I completely understand that this is entirely within the remit of Fair Trading but it is very much playing into the McDonald's style in the cosmetic services sector—where we are talking about cost, making sure people are not being ripped off and that type of thing—but people can be really harmed in these procedures.

If someone does not ask whether or not the person about to perform the procedure on them has the correct qualifications or whether or not they are a surgeon, I would have thought that is more a Ministry of Health issue that needs to be better advertised and understood from the health perspective as opposed to the consumer perspective. I completely appreciate that there is a dire need for general information but this is very much a health issue from what I am understanding.

Dr CHANT: In my opening statement I described the expansive nature. We have got all the things from tattooed eyeliner through to breast augmentation, vaginoplasty and penile enlargement, and health is very much in that surgical procedure dimension. If I were to show you the cosmetic health services aspects of regulation, we very much take responsibility for that high-end. We have private health care facilities legislation licences, we have inspectors going into private facilities to make sure they are compliant with those licence conditions, we have added that prescribed set of controls to make sure that only those high-risk procedures are done in licensed facilities to afford that additional protection and, as Ms O'Shannessy mentioned, we are also making it an obligation or offence for the health practitioner to do that.

At that point we also have all of the professional responsibilities that come in terms of regulation and the national law. There are very clear guidelines around the nature of the professional conduct both in terms of advertising and the professional standards. They are comprehensive documents that will protect. We have also mechanisms through AHPRA and the Health Care Complaints Commission to investigate those issues. One of the challenges here is that it is a very all-encompassing piece and there are very different controls for the different levels of risk. I think that has tried to be portrayed but notwithstanding that we still have to be vigilant. If something is commonly done, even if it has a low-risk profile, then that can be amplified so I think we need to keep vigilant.

Ms KATE WASHINGTON: I appreciate all of that. I am seeing Fair Trading looking at the lower end, which is still high risk and has significant health implications as well when it goes wrong. However, I am talking more about what the Committee is hearing—and my colleague has also talked to this—about the reluctance of people to make complaints and the general lack of understanding in the community of the risks associated with the high-risk end of the spectrum. Is there anything being done about that? Is that an activity that could be done by Health Care Complaints Commission or should it be done elsewhere?

Dr CHANT: I appreciate the fact that we do actually need to support consumers to better understand the obligations of the doctors and the risks. As I said, on my re-reading of the guidelines for this attendance I find that they are very comprehensive. I accept that we actually do need to put them in plainer English and to ensure that consumers do read them.

Ms KATE WASHINGTON: My point is that consumers do not read guidelines.

Dr CHANT: The Health Care Complaints Commission has issued a number of warnings. They have actually got some really good material on their website—and I know they are speaking after us—that goes to some of the common issues about checking the credentials, checking whether they have got complaints against them, what is the outcomes—

Ms KATE WASHINGTON: The reality is that the people are not looking at the complaints process at the beginning of the process?

Dr CHANT: No. We all have a part to play in increasing awareness. I really appreciate that.

Ms O'SHANNESSY: Can I say the legislative changes I mentioned earlier were the result of a review report that we issued in April of this year and in conjunction with that report there is a considerable amount of material, there may even be some videos—I am not sure—that talk about going back to your GP, what questions you should ask very much from that health perspective. Pretty much along the lines where you were heading.

Ms WEBB: I might just also mention that our checklist does say to check with your GP, check that the professional is qualified to perform and do not use operators who are not licenced. So we have tried to deal with the full spectrum of consumer complaints, not just the issues about pricing and hard selling but also making sure that people are aware that they should be checking these types of things.

The Hon. WALT SECORD: Dr Chant, at 1.38 p.m. you talked about the need to be vigilant about monitoring this sector, which I agree with. What can you say to reassure young women who are now going to the Cosmetic Evolution at Bondi Junction, which has replaced The Cosmetic Institute?

Dr CHANT: My role is not to reassure. I would be advising women who are contemplating cosmetic procedures to think carefully about the outcomes.

The Hon. WALT SECORD: That was not my question. You made comments at 1.38 p.m. about being vigilant, about monitoring this sector. What is NSW Health doing to assure young women going to the facility that used to be The Cosmetic Institute [TCI], which has rebadged itself as the Cosmetic Evolution?

Dr CHANT: I think my previous comments were about being vigilant about all of the new innovations in cosmetic surgery and keeping an eye on the harms and outcomes. Part of this inquiry, we are hopeful, will identify if there is any need to take any other action. In terms of that clinic, I would have to describe the nature of the procedures being undertaken in that. Mr Secord, are you aware of what range of procedures—

The Hon. WALT SECORD: I am asking you if it is okay to return to the Cosmetic Evolution at Bondi Junction? Are you monitoring it?

Dr CHANT: In terms of the role—

The Hon. WALT SECORD: NSW Health has a role in monitoring.

Dr CHANT: If there are any doctors that are working for that facility, then they have obligations under the national law and, as I have indicated, the comprehensive guidelines that are in place is what should be guiding the actions of those doctors. If there was any breach in their duty of care in relation to their professional standards, I would absolutely support any patients notifying the HCCC and being supported through the complaints process so that they can be referred to AHPRA. In terms of the poisons and the changes that are being announced, as we have indicated we are going to be consulting shortly about whether there need to be additional controls in relation to the types of products that may or may not be used. I am not familiar with the clinic. In terms of the need for clarification, we have created a special class. I indicated in my opening statement that very shortly we will be going out for consultation.

The Hon. WALT SECORD: I will rephrase my question very simply. The Cosmetic Institute rebadged itself as Cosmetic Evolution at Bondi Junction. Yes or no? NSW Health is now monitoring the rebadged facility?

Ms O'SHANNESSY: NSW Health is monitoring all these facilities. We have 98 facilities with cosmetic class licences. They all get inspected once a year. If this facility is performing cosmetic surgical procedures, which is what the TCI was doing—they shut down because they could not get licensed; that was the genesis of the licensing provisions—cosmetic surgical procedures—

The Hon. WALT SECORD: I am asking you if you are monitoring that facility.

Ms O'SHANNESSY: I cannot personally tell you exactly. What I was saying to you is that we are monitoring all of these matters. We have our licence regime. We also have a regime that we are collaborating strongly with different regulators—TGA, HCCC. There is a cross-referral of complaints. If it looks as if a licensed or unlicensed premises is doing things it should not, it will be monitored. If it looks as if medical practitioners are doing things they should not be doing they will be referred to the HCCC. And if the drugs that they are using are being used inappropriately, they will be looked at through the Ministry of Health's regulatory units.

The Hon. WALT SECORD: You said that there are 98 facilities that are visited once a year.

Ms O'SHANNESSY: No, I said that there are 98 cosmetic class facilities that have a licence as a cosmetic facility, along the lines of what I said.

The Hon. WALT SECORD: And they are inspected once a year.

Ms O'SHANNESSY: They are visited at least once a year.

The Hon. WALT SECORD: Are those announced visits or unannounced visits? Do you tell them—

Ms O'SHANNESSY: No, it varies. Very often we will not announce.

The Hon. WALT SECORD: How many of that 98 would get unannounced visits?

Ms O'SHANNESSY: I do not have that information with me.

The Hon. WALT SECORD: Can you take that on notice?

Ms O'SHANNESSY: I will take that on notice.

The Hon. WALT SECORD: Of the announced visits, how much warning are they given before they are visited by NSW Health?

Ms O'SHANNESSY: My feeling, which I would not like to act on without conferring with my regulatory colleagues is that they are generally unannounced, but we will have that information provided to the committee.

The CHAIR: If you could table that.

Ms O'SHANNESSY: We will give you that information.

The CHAIR: Thank you very much.

The Hon. WALT SECORD: I would like the hard data. Also give us, for the announced visits, the duration or the warning that they are given.

Ms Webb, yesterday and over the last couple of days we have had evidence about high pressure and incentives, where nurses and receptionists were given financial incentives to upsize or upsell. Have you conducted any investigations into that conduct?

Ms WEBB: I am not aware of any investigation that we have had or complaint about that specific type of conduct. I could take that on notice and check.

The CHAIR: Can I request that we could have some information about how many complaints have been issued with regard to potential upselling? How many of those have been investigated? What have been the outcomes?

Ms WEBB: In the cosmetic sector, yes.

The Hon. WALT SECORD: Dr Chant, in your opening statement you made reference to this as a changing or evolving area of concern. Are you familiar with so-called non-surgical facelifts, so-called threading, where they put surgical wire through and pull the skin back, and things like that?

Dr CHANT: I am not familiar with the full range of approaches that are used.

The Hon. MARK PEARSON: There was a lot of discussion yesterday and earlier today about whether there is a way to ensure that a person who is seeking cosmetic surgery—it is part of this cooling-off period, I suppose, and there might be some psychological issues as to why they are seeking surgery—is required to have a referral from a GP to have the surgery in order to be able to filter or assess the person as to whether it is appropriate for them to the be referred for such surgery at that point in time? Is that an issue in terms of Medicare?

Dr CHANT: I would see that the GP has a clear role in providing advice, as part of holistic care to that individual, around a whole manner of things. I think this falls into that. I would alert you to the guidelines for medical practitioners. It indicates here that a medical practitioner who performs a procedure should discuss and assess a patient's reasons and motivations for requesting the procedure and that should there be any concerns about the underlying motivation or the underlying mental health of the patient there is a requirement that they get assessed by a psychologist or psychiatrist.

The Hon. MARK PEARSON: Is that a requirement of the practitioner who would be doing the procedure?

Dr CHANT: That is correct.

The Hon. MARK PEARSON: I suppose the concern we have is that it has been pointed out to us that this is a very lucrative business. It is a new so-called medical issue on the horizon. It is growing very fast for, in many ways, the wrong reasons. Therefore the questions that have come up are: Should there be an assessment if a person is not going to receive any benefit from the procedure at all? Would it be helpful to the patient for there to be a mandatory requirement that they have a referral from a GP?

Dr CHANT: I personally believe that GPs play a pivotal role in supporting patients, and having a GP that provides that care is important. Personally I would strongly encourage. I think it is a matter for the Committee in that representation about the mandatory nature of—

The Hon. MARK PEARSON: That would be a recommendation that you would welcome?

Dr CHANT: I would welcome any stronger involvement of GPs in terms of providing an independent perspective. I think that a GP can also understand the broader context for the patient. I think they can provide useful input. Consultations would be a matter of a GP's skills and comfort in the role. Rather than say clearly yes or no, it would be useful to consult with the Royal Australian College of General Practitioners in terms of identifying what it would see as a role. Personally, I believe, and certainly any message I have given, I have encouraged people to consider talking to their GP first.

The Hon. MARK PEARSON: Has the notion of supervision come to your attention that nurses being asked to provide certain procedures or continue certain procedures under the supervision of a practitioner is a grey and potentially dangerous area and some nurses are undertaking potentially unlawful practices because of this so-called supervision notion?

Dr CHANT: I am certainly aware of the issues. To some certain extent, some of the changes we have made are aimed at clarifying the obligations on a prescribing doctor in relation to their duty of care in relation to ascertaining the safe administration of products. I do not know if Mr Battye wanted to add anything to that.

Mr BATTYE: From the investigations that we have done, we found in some clinics that doctors who are quite remotely situated are authorising the administration of injectable cosmetic products. In one case, we sent one of our own officers in. She made an appointment, went to the clinic. A nurse asked her about her history. The nurse then said to her, "We have to make this legal. We will have a Skype consultation." According to my officer, throughout the Skype consultation she had eye-to-eye contact with the doctor on the other end for five seconds.

The Hon. MARK PEARSON: Five seconds?

Mr BATTYE: Yes. That doctor instructed the nurse to administer a dermal filler to my officer via a fine cannula. The nurse said, "I have not done this before, doctor." He said, "No, you can do this. I went to a conference a couple of weekends ago. You can do this. You just do this and that." She said, "Okay, I will do that." She obviously had not tried this before, but she was going to carry this out on my officer.

Dr CHANT: In the interests of time, the issue is that regulatory actions happened as a consequence of that, and it is being referred—

Mr BATTYE: At that point, she identified herself. That is the type of thing that is happening.

Ms O'SHANNESSY: Can I say, it is worth adding that the other change we have recently made is to allow us to make tighter controls of the botulinum toxin, hyaluronic acid, and whatever else we have prescribed, based on some of the work that Mr Battye has done. We are about to start a consultation process. It will look at those issues of supervision, what more controls should we be putting around the use of those, because they are used in a lot of the cosmetic clinics where we found poor and illegal practices. It is a direct result of Mr Battye's work.

The Hon. WALT SECORD: Dr Chant, can you explain the difference between full sedation and twilight sedation?

Dr CHANT: This is a grey area, that is what led to the changes in the requirements and the licensing of the prescribed class of procedures that need to be done in a licensed facility. To overcome that greyness, there was a list constructed. As we indicated earlier, we will continue to monitor that list and we can amend that list if there are innovations in practice and we need to put those new emerging procedures into that which is prescribed, which gives the added safeguard that they need to be done in a licensed facility. As I said, that is the tightest control for the procedures that are at greatest risk.

The Hon. WALT SECORD: On reflection, was The Cosmetic Institute engaging in twilight sedation or full sedation?

Dr CHANT: I have to be conscious of where this is up to. It is my understanding that they were using local anaesthetic but probably the procedure was not—

The Hon. WALT SECORD: I do not understand. Can you explain that to me?

Dr CHANT: Local anaesthetic is used to stitch up cuts and whatever, but it is important that if you have a particularly long cut, even though it is feasible to stitch you up, it may be that we need to give you so much local anaesthetic that that could lead to toxicity and other complications. It is a question about the appropriateness of the procedure.

Ms O'SHANNESSY: The only additional comment I will make is that that is because we have a list. Less than conscious sedation is one thing for cosmetic procedures and then we have got the list, which is the actual procedures. My recollection is that that was a breast enhancement, and that is on the list. That is the list that, with the world changing and new things coming up, we monitor and it will be interesting if in any of your submissions you come up with new procedures that look risky, because that is where it will be put. It is not just the sedation, it is the procedures.

The Hon. WALT SECORD: What was TCI using, twilight or full sedation?

Ms O'SHANNESSY: I am not clear. It is the fact they were doing breast enhancement, and under the current law they are required to be licensed and have emergency resuscitation processes and complaints policies and all the paraphernalia.

The Hon. WALT SECORD: Yesterday we heard evidence from the President of the Australian Society of Plastic Surgeons. He said that 220 women have joined a class action against TCI, The Cosmetic Institute. How many complaints did NSW Health receive about The Cosmetic Institute before the issue of twilight sedation versus full sedation came to the public arena with the *7.30 Report*?

Ms O'SHANNESSY: We would have to take that on notice.

The Hon. WALT SECORD: Can you take that on notice and provide a breakdown and give me the date of the first complaint and the number of those?

How does NSW Health work with the HCCC to investigate complaints? What is the protocol or how does it occur?

Mr BATTYE: We administer the Poisons and Therapeutic Goods Legislation in New South Wales. Following the incident in September 2017, we decided to look at what was going on in this industry. Between then and now, we have visited 19 cosmetic clinics throughout Sydney. In about six or seven of those visits, we have involved the HCCC, so we are working cooperatively with them. We have also got the TGA involved as well. Depending on the situation, we work cooperatively with our co-regulators. I might add that this is ongoing work. There is an ongoing task force, if you like, with TGA, the HCCC and ourselves. It is ongoing and we have targeted inspections planned.

The Hon. WALT SECORD: Before the problems at TCI, were there any investigations or inspections?

Mr BATTYE: Not from my unit.

The Hon. WALT SECORD: It only occurred because of the incidents at TCI?

Mr BATTYE: No, the reality is that over the last, say, two or three years, there might have been half a dozen complaints that came our way. Quite often they are referred from the HCCC, so we were aware there were issues, but they were not of a high risk. Although we carried out some inspections in that period, the facility you refer to was not one of those that came to us so we did not go there.

The Hon. WALT SECORD: What has happened to the non-TCI facilities? What has happened to those cases?

Mr BATTYE: Of the 19 that we have been into, which included the original one, we were there right from the start with the police and we assisted police. We went back a couple of days later. We researched the place. We seized a lot of drugs and documents. Coming out of those documents we ended up referring four nurses to the HCCC. We referred one doctor, a New South Wales placed doctor, to the HCCC. We also then enlisted the assistance of our Victorian colleagues from Victoria Health and referred two doctors and a pharmacist to AHPRA after getting some information from Victoria Health. They were outside of our jurisdiction. We have also since then referred another three doctors and one dentist to the HCCC or councils in New South Wales and we have some ongoing ones as well. There are some in the pipeline as well.

The Hon. WALT SECORD: Dr Chant, if you receive a complaint at NSW Health about medical misadventure, something that a patient is not happy with, to use the quote here the "unmet expectation" of a patient, what happens? What is the process? Someone calls into NSW Health and they have had an "unmet expectation" involving a medical procedure, in either the public or private system. It happens in New South Wales.

Dr CHANT: NSW Health does not perform cosmetic procedures.

The Hon. WALT SECORD: I am talking about medical in general, a complaint about unmet medical expectation. Someone complains to NSW Health, what happens?

Dr CHANT: The question would really be the nature of the complaint. That is a very broad issue.

The Hon. WALT SECORD: How does someone in New South Wales complain about treatment? What do you do?

Dr CHANT: We have a complaints mechanism in our local health districts. If you have had an experience which you are concerned about the outcome or it has been about care, then we have a complaints mechanism at the local hospital. We also indicate that you have the right to refer your complaint to the HCCC if you are not happy through that process. I would like to say that we would like to take a few steps backward and have a very preventative approach and say if you are unhappy with your care in the hospital, please raise it with the nursing unit manager early before it does get to a complaint. We want to make sure that the patient experience is strengthened in our facilities. That is one mechanism. If the complaint relates to a private provider, the question is whether it relates to a private health facility. If it is related to a complaint about a private health facility it will go to the private health care regulatory branch. Ms O'Shannessy can talk about the process there in terms of complaints.

Ms O'SHANNESSY: The Regulation and Compliance Unit will deal with that complaint, will identify if there are any issues and go to the private health facility. It is hard to be anything more than a bit vague because there is such a variety. The other point to recognise, if we have a complaint in our public health facilities there is an obligation, and in private health facilities, there is an obligation if the licensee or the chief executive considers that this could raise unsatisfactory professional or professional misconduct they are obliged to notify AHPRA, which will take the individual clinicians into the regulatory regime as well.

The CHAIR: My question is to NSW Fair Trading, which also extends on from the Hon. Walt Secord's question about incentives being offered to employees of cosmetic service providers. In a lot of businesses if you are providing a service to somebody and you are receiving an additional bonus, you have to disclose that to the person you are selling it to. In the finance industry, if you are receiving financial advice the provider has to disclose they are getting a percentage as an incentive. Is there something that Fair Trading could do, or would do or is doing? The evidence that has been given here today is that it is a common practice that some non-registered employees, such as administrative staff, are employed on a retainer basis. Is there something that Fair Trading would look at doing to target this sort of behaviour to change regulations so that the person has to disclose if they upsell your facial treatment to other procedures they will receive financial benefit from that?

Ms WEBB: Generally, and not related to this specific industry, I think there are two issues that are raised by that. One is that conduct of people who are receiving a financial benefit and not disclosing it can be misleading and deceptive, particularly if they imply to a person that there are particular reasons why they should have a service and do not disclose that really the main reason they are suggesting that is because of their incentive. But more generically, the Government at the moment is looking at this whole issue of disclosures about people receiving commissions and we have got some current consultations that we are doing generically in relation to better transparency over things such as commissions and payments that people are receiving.

The CHAIR: Would this be a multiagency review of this?

Ms WEBB: Yes.

The CHAIR: There are different authorities taking responsibility for different areas, yet they are all combining back into the one issue?

Ms WEBB: This issue about the way in which people are selling things is probably falling a little bit more into the Fair Trading arena but subject to the things that Dr Chant has mentioned about the requirements.

Dr CHANT: The issue is the community needs to understand there are very stringent guidelines for the behaviour associated with surgical procedures for registered medical practitioners and registered nurses in terms of the code of conduct and their expectations in this area, this particular codification of that. Therefore those would apply in circumstances that the doctor, notwithstanding what else is happening in the practice, has got obligations to make sure that the patient is adequately informed and it has not been under a particular misinformation or duress that they are making that consent. We do need to highlight that notwithstanding what other activities are happening, the professionals have got very clear obligations under professional practice.

The CHAIR: That extend not just to themselves but also to their employees.

Dr CHANT: To understand that they in the end are having to ascertain that the patient is fully and appropriately informed, that they have cooling off periods. There are a number of obligations on the practitioner that they, regardless of whether they own the practice, have professional obligations, notwithstanding what else is happening in the broader environment.

The CHAIR: We are all going to be keen to see the discussion paper come out. Can I clarify, that discussion paper will be going out to not just State level but also Federal level to look at potential changes to existing legislation that has been in place since pre 2011?

Ms O'SHANNESSY: Yes, it is the national registration system. That was 2010.

The CHAIR: Thank you very much everyone for appearing before the Committee today. We may send you some additional questions in writing. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions from the Committee?

Dr CHANT: Yes.

(Short adjournment)

SUSAN ELIZABETH DAWSON, Commissioner, Health Care Complaints Commission, affirmed and examined

TONY EVAN KOFKIN, Executive Director, Complaint Operations, Health Care Complaints Commission, sworn and examined

The CHAIR: Before we proceed, I just want to check whether the commissioner or Mr Kofkin has any questions?

Ms DAWSON: No, Chair.

Mr KOFKIN: No.

The CHAIR: Does either of you have an opening statement to make before we commence questions?

Ms DAWSON: I will make a very short comment. I observe, as you would now have detected over the last couple of days, that this is an extremely complex area. It is an evolving service delivery environment. There are dispersed models of business. There are registered and unregistered practitioners and there are State and national regulators in the space. The issues here really sit squarely at the intersection of consumer protection and health regulation. I appreciate the terms of reference and the interests of members of the Committee steering us in a direction related to the adequacy of the powers of the Health Care Complaints Commission [HCCC]. I guess I would also observe which agency head does not enjoy the idea of new powers, provided that resources follow.

But I would observe in this case that success and effectiveness in addressing the issues that are before us really demand multiple layers of intervention. Success will rely on the judicious and effective use of the opportunities and powers that rest with a range of different regulatory and non-regulatory bodies. I think that is a really important point. There are opportunities that arise for improved public education. We know that those need to cover the risks and issues associated with protecting consumers. We also know that that there is room always for improvement in assisting consumers to know how to make a complaint when something goes wrong: So we know there are areas of improved public education. We know that there is room for improvement, and opportunity too for improvement, in provider education and accountability.

Consumer protection from misleading and deceptive actions is imperative. Health regulation and finessing health regulation, as things move quickly, is important; needing to deal with or consider the various possible moving parts of health regulation, whether it is regulating facilities, medicines and goods, advertising or procedures; and then, of course, excellent complaints management always needs to be central to the integrity of any response. Finally, there is a whole question of collaboration and appropriate enforcement at national level. All of those domains of the intervention are important. The Health Care Complaints Commission stands ready to have a lead and a central role in many of those. In other areas it will have more of a support, influencing and partnership role. In responding to questions today, I look forward to the opportunity to elaborate on those things.

The CHAIR: My first question to you is a question similar to the one I asked Dr Chant and others. From the HCCC's perspective, what does the term "cosmetic surgeon" mean? Over the past two days there has been ongoing concern or confusion around the term "cosmetic surgeon" and what it represents to the consumer/patient. As I said to Dr Chant earlier, obviously the health Minister has raised concerns very publicly about this. I believe we have had evidence given today that there will be a discussion paper going out very shortly from the Department of Health. From the HCCC's perspective, can we have clarification in regards to the terminology about what a clinician's experiences and knowledge are, especially when it comes to "cosmetic surgeon". From the commission's point of view, what is your feedback on that?

Ms DAWSON: My view is that I start from the position of looking at the issues that sit before us in complaints. It is abundantly clear to me that consumers are confused. They have an apprehension, perhaps, depending on the title that is used that there will be skills and capabilities that are very specific to the business of conducting a cosmetic procedure. From a consumer perspective, any steps that can be taken to raise awareness of not just what the skills and qualifications of the practitioner are but also, importantly, what the procedures themselves are, will be welcome.

The other thread that has been running through this whole conversation is distinguishing between surgical and non-surgical procedures. For instance, whether a consumer has a broad enough apprehension about how to make a choice whether their breast augmentation is suited for surgical intervention or a non-surgical intervention, knowing that the injectable procedures are increasing. In short I think that there is a great deal of scope for clarity that is oriented towards the consumers understanding the environment that they are in and the choices that they can make.

The CHAIR: Further to that, do you believe that by clarifying the term "cosmetic surgeon" or "surgeon" to some degree, would also enable the HCCC to more effectively prosecute or investigate specific cases when it comes to either cosmetic surgery versus cosmetic procedures? This is the other thing with which we have had difficulty and the lack of understanding about the invasiveness or lack of invasiveness of a particular procedure. Would allocation of that term "cosmetic surgeon" assist the HCCC to investigate and its powers to prosecute, if necessary, because of someone going to a clinic and expecting to see a cosmetic surgeon, but really that is not what they are seeing at all?

Ms DAWSON: In short, yes. I think you have probably heard during the course of today and yesterday that an important part of moving towards specialties and, potentially, protection of title on the back of a specialty really turns on the question of defining quite sharply the scope of practice in that specialty. Anything that helps a regulator or a complaints manager to be clear about the scope of practice, and therefore identify circumstances where there have been actions taken that may be outside that scope of practice, is of assistance.

Ms KATE WASHINGTON: You say that the regulators benefit from regulation, surprisingly. Is there adequate regulation in this sector to be able to achieve the success that you mentioned that we ought to be trying to achieve in terms of improving consumer education and improving patient outcomes? Is greater regulation needed?

Ms DAWSON: I think the issue is that there is a plethora of guidelines, standards and codes of practice in place. Indeed, the question is what strategies you can use to ensure that those standards, codes of practice and so on do their job. Now I guess one of the questions that the Department of Health may have touched on is whether there is room for regulatory clarification that allows you to actually codify matters that are currently embedded in codes of practice that are produced by the various professional boards, the national boards and the like. That goes to the idea of, if central to the experience of a consumer is the whole question of, have they had informed consent. If they are vulnerable do they have an opportunity for a cooling off period? What protocols and practices are there for ensuring that those who may be motivated differently might need some psychological support in entering that process? All of those things are in standards and guidelines at the moment but if you codified them would that bring them into greater visibility for consumers?

Ms KATE WASHINGTON: And enforceability—

Ms DAWSON: And enforceability could be a benefit that flows from that.

Ms KATE WASHINGTON: I do not know about my colleagues but I took from the Ministry of Health that everything was good, everything was fine which was quite contrary to most of the submissions that the Committee has received. Certainly that is my interpretation. I am hearing from you something that is a little bit more sensible, I would think, in terms of the need to create more robust and very clear obligations for providers so that then there is greater enforceability for HCCC to be able to adequately improve regulation in this space.

Ms DAWSON: The bottom line of what I am trying to say is I think that there are good platforms setting out the obligations for individual practitioners. The question is: how do you drive the uptake of those accountabilities and good practices? That is where the whole question of effective regulation comes in. For me, as I said in my opening statement, there is something for everybody to do here. In relation to the colleges and the boards there is a great deal to be done to ensure that every practitioner understands their responsibilities and accountabilities under the guidelines for the delivery of cosmetic surgery.

There is something in the question of how health regulation—I have used the word "codification" and I am sorry to be obtuse in using that term—but how do you draw on those accountabilities that are in guidelines and those sorts of documents that are a persuasion to the professionals in those areas and perhaps entrench them a little bit more in regulation so that they become a real touchstone for consumers understanding what they can expect, how practitioners will behave when they go to see them and, in turn, as I said earlier, when a complaint comes before a complaints body, what standard are they evaluating a particular incident against? I think it is drawing out from those standards and guidelines the things that really make a difference for people to have a good experience when they seek a cosmetic health service.

The Hon. WALT SECORD: In evidence provided earlier by NSW Health Dr Kerry Chant said that the HCCC was investigating four nurses and one doctor involving The Cosmetic Institute. What is the status of those investigations?

Ms DAWSON: I am going to be very cautious in responding about the status of any particular investigation. You will be well aware of the reasons for that. What I can tell you is that there has been a great deal of very intensive investigative activity right across this whole question of cosmetic procedures. That investigative activity covers issues ranging from the nature of sedation provided, to consent procedures, did somebody who needed a breast lift have the opportunity to get a breast lift or was a breast augmentation all that was offered and

so on? All of those issues run throughout and various investigations are at different stages. I would like to just leave it there if I may.

The Hon. WALT SECORD: The Cosmetic Institute has morphed into the Cosmetic Evolution. Can you assure young women who go into that facility that they will get proper and safe treatment and proper care?

Ms DAWSON: What I can assure you is that if any of those patients find that the service that they get is found wanting, and they bring forward a complaint, we will assess and respond to that complaint appropriately. That is the only assurance I can give. That is what is in my gift. What I can do in relation to the broader issue is be a very active participant in policy development and the development of the regulatory framework, and be an astute contributor to things that will make a difference to individual people seeking those procedures to inform themselves, and be informed of, the risks that those procedures present.

The Hon. WALT SECORD: You used the phrase "responding appropriately to their concerns". Earlier you talked about an excellent complaints management program. How important is that in reassuring and assuring the community that if they actually take the brave step of coming forward—especially a young woman who has had a very personal procedure that has gone wrong—knowing that it will be treated promptly and investigated thoroughly?

Ms DAWSON: The answer to the first part of the question is that when something goes wrong anybody is entitled to want an adequate and appropriate response to that. That is the function that an independent Health Care Complaints Commission offers. That is extremely important to the integrity of the health system as a whole. Of course, making sure that those responses are timely and proportionate to the issues, and guided by the seriousness of the issues, is central to the way we endeavour to do our business at the commission.

The CHAIR: The Hon. Walt Secord has asked three questions. I will come back to you.

The Hon. WALT SECORD: My colleague, Kate Washington, asked one question.

The CHAIR: She asked two. I will not argue over the number of questions.

The Hon. WALT SECORD: If I knew you were going to count questions, I would have already asked my next question—

The CHAIR: If that was your priority that is your issue.

The Hon. WALT SECORD: No, I did not know that you were going to change the rules.

The CHAIR: I am not changing the rules. You will get another chance after further questions.

The Hon. WALT SECORD: If I knew you were going to do that I would have asked a different question first.

The CHAIR: You will still have a chance to ask another question.

Mr MARK TAYLOR: I address my question to the chief investigator. The Committee has heard about different business models or different business structures of some of these clinics or operations. From the investigator's experience, are enforcement or sanctions difficult in some circumstances or is there room for a regulatory change to assist the commission because of some of these business structures or the way the business models are set up? Are there impediments to sanctions of investigation? Do you understand that question or I will rephrase it?

Ms DAWSON: I am going to take the liberty of perhaps an initial response and then I will pass on to Mr Kofkin. I just want to make one comment, if I can. As a matter of principle, one of the things we know with these highly dispersed business models is that whatever you do you need to adopt operational strategies that tackle the issue at the earliest point in the risk arising and you need to be really effective in your collaboration with others that can make a difference. For us, if we are thinking about, for instance, the risks associated with injectables, then we are deeply interested in the collaboration that we can have with the Therapeutic Goods Administration who in turn are partnering with Border Force to understand what is happening with product coming in, the point of supply, disrupting the distribution, confiscating product that is risky.

Then we go through to the point of delivery of those products and the important collaboration that we have with the Pharmaceutical Services unit and for them to understand what is the quality of the product that is sitting in the shelves at a particular clinic, and then we go right down to what is happening in the procedure of administration. As a matter of principle it is not just about the powers that we have but how we leverage off and collaborate in terms of the powers that others have, recognising—and I am sure this is where Mr Kofkin will go with his response to the question of powers—that various of the regulatory bodies have slightly different

provisions in relation to powers of entry, seizure, search, search warrants and so on and being able to get good coverage there.

Mr KOFKIN: In relation to the commission's powers when investigating health organisations—for example, The Cosmetic Institute—the commission made a raft of recommendations to TCI and I think it is fair to say that those recommendations were the genesis of the change in the regulations as well in terms of the Private Health Facilities Act. So the commission can make recommendations to public and private health facilities. When it comes to individual practitioners, the commission can investigate and, in consultation with the health professional councils, conditions or suspension can be put on their registration, and that protects the public.

The issue at times is when you have an organisation, for example, who may be based overseas. You could have an organisation which could be based in the US or in South Africa and you could have medical practitioners who are carrying out Skype consultations overseas, and then you could have pharmacies who are filling prescriptions, for example in Victoria, and then the patients who are receiving the so-called care and treatment are in New South Wales. So you have scenarios there that are crossing State, national and international borders. The commission has a really important role in terms of the individual health practitioners and making recommendations where we can to private and public health organisations.

But what motivates these companies is money. There are companies such as MWI and AMI who can make millions and millions and millions and millions of dollars very, very, very quickly, and for each time the commission or another health complaints entity investigates a practitioner, cancels their registration or there are interim conditions on their practice—in New South Wales there are 33,000 doctors—there is another one to take their place. There are issues in terms of how do we grapple with these organisations who are there just to make money extremely quickly and they do not really have the concerns of the consumer at heart in any way, shape or form? So you could say that there is so much we can do in New South Wales and Australia but how do we tackle these international companies in the global environment?

Ms DAWSON: One thing at the heart of health regulation though to remembering all of that, even though these business entities are evolving, is that individual doctors cannot recreate themselves. So if you can embed in the health regulation system a deep and well-entrenched set of accountabilities for how each and every doctor conducts themselves, that provides real ballast and always will provide real ballast in managing these issues and it is a really important part of the picture.

Mr MARK TAYLOR: Just following on from that, there was an inference in some of the previous evidence yesterday that some doctors may have been working under a different name. Have you ever had that type of complaint or allegation?

Ms DAWSON: Mr Kofkin could comment, but we do find in some of the investigations that we undertake that some practitioners will, particularly with longer names and Chinese names in particular, use a shorthand name and be known by that across their practice. So that does happen. Tony, do you want to comment in more detail?

Mr KOFKIN: Are you thinking about the fake doctor type of scenario?

Mr MARK TAYLOR: It was only raised in evidence, that is all.

Mr KOFKIN: That is exactly what you are thinking though, is it not?

Ms KATE WASHINGTON: Yes.

Mr KOFKIN: Very rarely, in my experience. Certainly in my experience in the commission in the past eight years I have not come across the fake doctor type scenario where somebody has obtained registration using fraudulent documentation and practising within the New South Wales health system.

The Hon. LOU AMATO: Do you think if the New South Wales Government had a broad public education and advertising campaign it would be beneficial to assist the public in choosing a safe and legal cosmetic health service operator, ensuring patients are well informed, and minimising adverse outcomes? There is nothing really out there advising the public of the adverse effects of choosing some of these obviously not registered cosmetic providers.

Ms DAWSON: I think there are a couple of things about that, and thank you for that good question. Public education and public awareness is central to tackling the set of issues and challenges that are confronting us here, but I think there are a number of dimensions to what the public education needs to cover and that, therefore, influences who needs to be involved in delivering the education. First of all, as I said earlier, I think it is really important that we lift general understanding about the types of cosmetic procedures that people might be seeking and, as we touched on earlier, the distinction, for instance, between a surgical procedure versus a non-

surgical procedure and what factors might influence you seeking those and what different risks they may pose. So there are issues about the procedures. Then there is a question about what we should be telling consumers about what they should expect from a facility in terms of the systems—what should consent look like, what information brochures should they be given, what should their aftercare look like? So that sort of education—

The Hon. LOU AMATO: That could even be co-sponsored by some of the providers in conjunction with the Government.

Ms DAWSON: And this is where I was heading, so thank you for taking me there more quickly. Quite aside from the question of what you educate about, there are some people who are really, really well placed to participate in both framing and delivering that education, and that goes to the role of the colleges, the role of the boards, the role of providers themselves—what responsibilities should they be obliged to have? Then there are some quite simple things like signage and so on and patient information at the point of service delivery. All of that goes to who should be producing and delivering this information and how can we make sure that it is reliable and an individual consumer can be confident that they are getting the right information? Then I guess there is the final thing of what is the role of government in terms of informing consumers about their rights and the complaints pathways when things go wrong, and that is the space at the moment with the work that Fair Trading are doing, and we are contributing to it, in terms of informing consumers about the responsibilities of businesses and that their consumer rights are really important.

The Hon. LOU AMATO: Do you think the penalties available to the HCCC to deal with complaints relating to cosmetic health services need to be reviewed? If so, what needs to change?

Ms DAWSON: The outcomes of our complaints are not penalties per se in the sense that we are a protective jurisdiction. From the HCCC's perspective we are satisfied that there is the ability to determine the appropriate outcome for matters that come before us. Where I think the issue of penalties does come into the whole regulatory regime is in aspects such as: What are the penalties for misleading and deceptive conduct? Are they a sufficient deterrent for entities in false and misleading advertising? That is the area where I think penalties fit, which is a bit distinct from the Commission's own area of involvement.

Mr AUSTIN EVANS: My question relates to the process for patients who are unhappy with the level of service they have received. Over the last couple of days the Committee has heard there a number of vulnerable groups in the area of cosmetic surgery—that might be socially, economically or culturally vulnerable. When they are unhappy they go back to the provider—I guess in any complaints situation that is the first port of call—and the HCCC is the other end of the spectrum. The Commission is basically the final umpire and its processes lead to any potential sanctions, protective orders, recommendations to bodies such as councils to impose penalties. Does anything exist between those two extremes? If not, particularly for some of these vulnerable groups that cannot perhaps advocate well for themselves, should there be?

Ms DAWSON: That is a good question and I thank you for it. I think there are a number of things to be said about that. The first thing is that in terms of those vulnerabilities we really do need to make sure that the obligations regarding consent, proper information and cooling off really address and attend to that possibility of vulnerability because that is the very best place to prevent the problem from occurring in the first place. Once a problem occurs, which is where you are coming from, a little bit depends on what outcome the individual wants. If what the individual is seeking is some quick revision of a procedure that has gone wrong or the ability to get reimbursement for the cost of it in order to go somewhere else and get it revised, then that is really something that can best occur right at the service provision interface and providers should be very responsive to dealing with situations where things have gone wrong.

The third point is that when things do find their way to the Commission either because the individual does not feel empowered or strong enough to go back to the service provider then the Commission has a whole spectrum of things it can do. It is not just disciplinary: Can we resolve it or do we refer it to council? We have got an assisted resolution service whereby we can bring the provider and the complainant together to work through issues that may have gone wrong. That is available to us right across the full spectrum of complaints and it may well be that there is scope to do more work in there. It is a voluntary process so it does rely on the provider being willing to engage in having a conversation about what has gone wrong and what could be improved but it is nevertheless available. Perhaps there is scope to work across the industry to see what more they could do themselves in terms of dealing with those issues and vulnerable consumers.

Mr AUSTIN EVANS: Over the last couple of days the Committee has been hearing a bit about that. I suspect we have people who have been to a provider, they have not been able to get a satisfactory result and they do not know where to go next. They feel powerless. They go to the Commission and the Commission says that the first port of call—and I understand the natural justice side of this—is to go back to the provider. That action alone for some has put an end to what they wanted to do because it is back to the provider. Then the provider

stonewalls them or sends a letter from their solicitor and that is the end of the matter. Is that the first thing that happens automatically in every case—namely, the HCCC goes back to the provider?

Ms DAWSON: May I clarify something? Is your question whether we require the individual to go back to the provider first before we will engage or is your question whether we—

Mr AUSTIN EVANS: The second one—whether the HCCC automatically goes back to the provider?

Ms DAWSON: These sorts of cases are actually susceptible to some early resolution techniques. Under that model we would usually go back quite quickly to the provider to understand what has gone on and whether there is any scope for attending to the problem—that is our preferred scenario actually. Rather than converting something into a complaint that becomes contested space, we do like to try as early as possible to get some understanding of what has gone wrong and whether there is a solution to resolve it. I acknowledge that there is more that we need to do in that space.

The Hon. MARK PEARSON: We know that cosmetic health services have proliferated because they are very lucrative. Has that opened up a whole set of new challenges for the Commission?

Ms DAWSON: Not necessarily new challenges.

The Hon. MARK PEARSON: Because of the vulnerability of the group of people who are seeking the help and the highly questionable practises of the different service providers at a scale quite different to almost all other medical and health procedures?

Ms DAWSON: Certainly the question that arises is how you navigate your way through the complex questions relating to clinical departures and the way in which a procedure has been conducted. The emphasis on that versus situations where—I know that I am about to traverse space that will be challenging—there are certain situations where the scenario is much more that the individual's expectation has not been met. How do you work your way through that whole pool of different types of complaints? Just because your expectations have not been met does not mean that there is not a legitimate complainant to be dealt with. There is a fusing of those two issues and how do you unpack them?

The Hon. MARK PEARSON: There is a good example I can give you that points to this dilemma. A surgeon was treating someone for the serious consequences of cosmetic surgery that went very wrong and the patient basically begged them not to divulge their name or make an actual complaint. That surgeon did not realise that he could still lodge a complaint with the HCCC without divulging the patient's name. I think we were a bit surprised that he did not know that but I suppose there are not many cases where a surgeon would be in the quandary of having to protect a patient because of the embarrassment and various other reasons as to why they did not want to have that divulged. Is it possible to make an anonymous complaint to the commission, or make a complaint where the source has to remain anonymous?

Ms DAWSON: Yes.

The Hon. MARK PEARSON: How is it dealt with differently?

Ms DAWSON: Tony may want to elaborate; it is his area of deep expertise. Basically, we can receive an anonymous complaint. We can also receive a complaint where the complainant identifies themselves to the commission but wishes not to have their identified notified to the practitioner. Broadly speaking, the question becomes: do we have sufficient information that can be de-identified to enable us to progress the complaint without the practitioner discerning who the patient was, by default? That is obviously a live issue. The second question is that those complaints can be useful because, even if we are not at liberty to release the identity of that particular complainant you may well have other complaints about that practitioner. You can have this knowledge about this complaint in the background as a piece of information that sits as context for other investigative or assessment work.

Mr KOFKIN: Mr Pearson, in terms of your first question and that example, if the medical practitioner is of the view that there is a significant risk to public health and safety due to the incompetence of that surgeon, then he or she is obliged to make a mandatory notification. Therefore, I would expect a health practitioner in those circumstances to make a mandatory notification. Secondly, as the commissioner stated, we can receive anonymous complaints. It is very difficult for us to progress a complaint if we do not know the details of the patient because we need to offer procedural fairness and natural justice and we need to obtain a response and the records. It is very difficult to do that if we do not know the identity of the patient. But we can still record the complaint, and we can still do whatever we can to try and obtain details and build up a picture, because each time the commission assesses a complaint we always look at the cases prior to that. We always look at the previous complaints to see if there is anything of a similar nature.

The Hon. MARK PEARSON: A legal practitioner was before us yesterday, and they expressed concern because they claimed that they had run several successful prosecutions after the client or patient had been to the HCCC and the investigation was closed because the HCCC formed the view that there were not enough grounds to prosecute or take it further. Does the HCCC look at any successful prosecutions in the courts of cases which you have closed to see why it was successful and to review what procedures occurred in the assessment of the complaint?

Ms DAWSON: This goes to a really important policy debate that is occurring nationally at the moment, which is whether, in the context of the national registration system, it is appropriate for previous settled claims against a practitioner to be listed on their registration. It is not the case at the moment, but there is a live discussion as to whether that should occur. That would provide a device for us to use that as part of our evidence base, but it is not the case at the present point in time.

The Hon. WALT SECORD: Ms Dawson, we ended on the question of a timely fashion to assess complaints. What is your definition of the timely processing of a complaint by the HCCC?

Ms DAWSON: The statutory timeframe within which a complaint should desirably be assessed is 60 days. That is a challenging objective in a complaints environment where double-digit increases in the volume of complaints occurs year on year, and the complexion and complexity of complaints changes.

The Hon. WALT SECORD: So you are saying that the statutory requirement is 60 days.

Ms DAWSON: For the initial assessment.

The Hon. WALT SECORD: I refer to a leaked PowerPoint presentation from the 18 July staff meeting. It is labelled "security sensitive" and it shows that 304 days is the average period for an investigation. That is up from 273 days in 2016. That is 39 more days. Do you believe that 304 days to assess a complaint is appropriate? In fact it is your own PowerPoint, with you as the author. Is 304 days to assess a complaint when the statutory period is 60 appropriate and timely?

Ms DAWSON: First I will observe that there is no need for you to rely on a leaked document. All of that information is available in the quarterly performance reports that are received by this Committee.

The Hon. WALT SECORD: I would like you to comment on the data.

The CHAIR: Mr Secord, the commissioner is answering your question.

Ms DAWSON: The second thing I would observe is that it is important not to confuse the business of the timeframe associated with an assessment for a complaint—60 days for an assessment—with the time taken to proceed to a formal investigation of a complaint. The year before last the timeframe for investigation was 274 days—

The Hon. WALT SECORD: It was 273.

Ms DAWSON: Thank you, 273 days. Yes, that is an increase in the number of days. The number of investigations being handled at that time, and the complexity of them, was considerably larger, as well. If your question is am I sanguine about that, not I am not. From my point of view, the commitment that we have is to continue to improve our timeliness. You will find commentary on that observation and the acknowledgement that we need to do more timely investigations in that quarterly report.

We are now talking about the most serious and complex complaints that we get—formal investigations. From my point of view, I will not trade off quality investigations that deliver a 96 per cent success rate when they progress through to prosecution. I will stand by that any time. If it takes another 37 days or what have you then I think that that is something we need to reflect on and continue to improve. It is the outcome that we are looking for of effective, robust complaints.

The Hon. WALT SECORD: Ms Dawson, you said there was a 60-day statutory requirement. Your own data shows that 54.6 per cent were assessed within the 60 days. The average assessment was average assessment was 72 days and the overall assessment was 304 days. I go back to my original answer. Is that timely, and what are you doing about that?

Ms DAWSON: I have answered the question, Mr Secord. I have acknowledged that our assessment timeframes are longer than is acceptable. Yes, the 54.7 per cent performance rate against that is a deterioration in timeliness of the initial assessment, but we should not confuse that with the timeliness of investigations. They are two separate things.

The Hon. WALT SECORD: Yesterday we received evidence from lawyers that there were cases that were rejected or unresolved or which were wrapped up by the HCCC; however, when they took it to the courts

they had victories in the courts. The cases were rejected by the HCCC. Now you are telling me that 304 days is an acceptable period. Now you can understand why people have concerns and why people did not lodge complaints about botched operations. It is quite clear: 304 days for the average complaint and 54.6 per cent not processed within 60 days—the statutory requirement. You can understand why there is no faith in the complaints mechanism process.

Ms DAWSON: I did not hear a resounding message about a lack of confidence in the complaints system. I think things to be observed are that the purpose of a civil claim of the kind that may have been referred to by the legal practitioners involved is completely different from the purpose of a disciplinary action under the Health Care Complaints Act. So you cannot compare the two. Quite separate from that, the question of time frames is one that goes to the fact that the outcomes that we get from our prosecutions are astoundingly positive and highly successful, and that reflects on the great quality of the investigations that are undertaken.

The Hon. WALT SECORD: Is 304 days timely or not?

The CHAIR: The question has already been asked twice, Mr Secord.

The Hon. WALT SECORD: She did not answer it.

The CHAIR: The commissioner answered the question twice.

Mr MARK TAYLOR: I assume that thorough assessment saves valuable investigative resources. I understand that, but you did not have an opportunity to explain the depth and breadth of the assessment process.

Ms DAWSON: The assessment process or the investigation process?

Mr MARK TAYLOR: The assessment process.

Ms DAWSON: The assessment process is a rigorous process. Generally in a complaint of a clinical nature we would be seeking the medical records of the individual involved either at the time of the incident and/or before and after the incident to see if there are issues relating to consent or whatever prior and/or issues relating to aftercare. We would be seeking responses from any providers that are involved, whether that is the individual provider or whether it is the organisation in which the provider works. We would be looking for a very clear picture of what has gone on. We would then, in cases that relate to clinical matters, take the opportunity to seek medical advice from our internal medical advisers to apprehend whether there has been a perceived departure in standards. They may or may not need to consult with a peer specialist in a particular area and then provide this body of evidence to the assessment committee which, in turn, or typically in the case of registered practitioners, will consult with one of the relevant professional councils—soon to be 16 of them.

That will lead to either the gathering of further information—there may be a view that there is not sufficient information available—or a decision will be made. The only final thing I will say before I check in with my colleague Mr Kofkin as to whether there is anything further to add is that if there are other actions going on by other investigative or service delivery agencies, then we would get information from them. For instance, if the Coroner were undertaking an inquest or if, in the case of a private facility, they were doing any private investigation into an incident, or whether there was a root cause analysis report, all of that potential information would be gathered as well. All of that occurs in the assessment process.

Mr KOFKIN: I would like to say one more thing. Mr Secord has been speaking about negligence cases. As you well know, in terms of the Health Practitioner Regulation National Law, there is a distinct difference in the thresholds and standards of proof and a negligence case. It is unfair to equate the two. You were talking about the performance of the commission.

The Hon. WALT SECORD: Your threshold is too high.

Mr KOFKIN: I do not make the law, Mr Secord.

The Hon. WALT SECORD: They do.

Mr KOFKIN: One more thing. The commission received well over 7,000 complaints last year—I think 7,300. We received 406 complaints for investigation, which is a 23 per cent increase on the year before. Over about a three-year period it is probably about a 100 per cent increase. The investigation division closed 282 matters last year. Some of those were the most complex we have ever closed in the commission's history. Even though 54.7 per cent does not favour greatly compared to previous years in respect of assessing complaints, if it was not for the incredible hard work of every member of the team of the commission, we would not have got anywhere near assessing 54.7 per cent. I think it is really important to say that the commission has been working under difficult circumstances. Processes have been changed, performance is improving. As you have heard, we are in

an environment of every evolving complexity, and the commission is front and centre of that. I think your comments are quite unfair in respect of the independent regulator.

The Hon. MARK PEARSON: After the inquiry aspect of the investigation, does it go to a vote as to whether a prosecution is proceeded with, or is it totally on legal advice?

Ms DAWSON: In the statute, there is an independent director of proceedings. That person is independent of me and independent of the commission. They cannot be directed to make a decision to take a prosecution forward.

The Hon. MARK PEARSON: Are they a lawyer?

Ms DAWSON: Yes. The factors that they must consider are set down in the statute. There are statutory factors to be considered and weighed and a decision will made on that basis, but, again, in consultation with the relevant professional council. The director of proceedings will assess all of the evidence. They will receive a comprehensive brief of evidence, mostly in volumes and, in that investigation process—I talked about the assessment process and all the elements of evidence-gathering there—there is a whole extra round of evidence-gathering and deep dive into the matter at the point of investigation. Statements will be taken, evidence will be gathered—if necessary, through the use of coercive powers—witnesses will be involved, expert opinions and expert reports will be sought on the particulars of the complaint, all to form the equivalent of a brief of evidence. That is what the investigation process is, to build on the good solid platform of the assessments that are undertaken.

The Hon. MARK PEARSON: As has been the result, usually the measure of whether to go ahead with a prosecution is the likelihood of success. Is that correct?

Ms DAWSON: Yes.

The Hon. MARK PEARSON: Is it up to you, commissioner, to make a decision whether a prosecution should go ahead in the public interest as opposed to the likelihood of success? Is that ever considered when looking at a matter?

Ms DAWSON: The likelihood of success is not the definitive item. It is one of four statutory factors to be taken into account. Another is the protection of public health and safety. The second one is the seriousness of the alleged conduct that is the subject of the complaint. There is then the question of the likelihood of proving the conduct. The fourth limb is any submissions and mitigating observations that have been made by the practitioner in response to a section 40 notification that they would have had of the investigation. All of those matters are considered in an agile way by the director of proceedings and it is her decision as to whether a prosecution ultimately progresses.

The CHAIR: I have a couple of closing questions for you. The evidence we have received over two days has shown a dramatic increase in the growth of the cosmetic surgery and cosmetic procedures industry across New South Wales. That does not seem to be up for debate. Based on that, do you think that the penalties available through the HCCC to deal with complaints relating to those specific industries—at the end of the day, we have had a lot of discussions about other issues as well, but the focus is on how the HCCC can either better deal with or more sternly deal with these providers. Do you believe that as the commissioner and the HCCC you have sufficient penalties to enforce on these providers should they breach the appropriate level of—I hate to say customer care. There has been a thing about customer care versus patient care. Do you believe the commission has the suitable penalties at this stage or do you believe they should be reviewed?

Ms DAWSON: I think that there are very, very strong powers in our legislation and there is a broad spectrum of possible outcomes, including disciplinary action, that provide us with really good nuanced solutions to the problems that arise. There are a couple of areas relating to the powers of the commission as opposed to the penalties and outcomes that are probably just deserving of a little bit of consideration, given that some of the other jurisdictions that have had more recent legislation in this area have got some slightly different powers but only at the margins, I would have to say. I probably do not have time to elaborate on them but I am happy to provide some supplementary information.

Those are powers relating to whether public warnings can name individuals. They are relating to things like whether interim or broader protection orders can be issued against health organisations as opposed to just unregistered practitioners. There are some questions around whether our powers of entry are sufficient. But frankly, we have such good working relationships with the Department of Health that some of the narrower elements of our powers of entry are not an impediment to us doing effective work.

The CHAIR: Do you believe yourself as the commissioner that the penalties imposed after the investigation are commensurate with the offence?

Ms DAWSON: I am hamstrung in a sense in answering that question. I do not wish to be evasive but the commission itself, particularly where we pursue a prosecution, is a matter for either the tribunal or the relevant professional standards committee. Generally, given that we have a high success rate, I would have to say that I find the outcomes acceptable.

The CHAIR: With regards to multi-jurisdictional—we have heard from NSW Fair Trading, NSW Health and yourselves—are the mechanisms across agencies acceptable enough to carry out the necessary procedures for an industry such as this one where there has been such massive growth? Are the resources and agencies able to work constructively together?

Ms DAWSON: We are better than we have ever been, and there is room to improve. I think we have mobilised amazingly well, I have to say, around this whole industry over the last couple of years. The level of operational collaboration between the commission, the Therapeutic Goods Administration, the Pharmaceutical Regulatory Unit, the operational frontline of Border Force, those are all interactions that would have been just a whimsical wish two or three years ago. They are now part of our everyday practice. We have the consumer health regulators group that makes sure that there is senior level oversight of that. I personally go to that. It is a very important forum for us to cast our minds forward to what more needs to be done. There is also a NSW Health regulators forum, that has been in operation for about 18 months. The question for both of those forums is how do we keep ahead of the game and that is the topic of conversation on a meeting by meeting basis.

The CHAIR: Thank you both for appearing before the Committee today. We may send some additional questions in writing to you. Your replies will form part of your evidence and be made public. Will you both be happy to provide written replies to further questions that the Committee may have?

Ms DAWSON: Yes.

(The witnesses withdrew)

The Committee adjourned at 3:34 p.m.